Wai - Research

KIMIHIA TE HAUORA HINENGARO - PATHWAYS TO MENTAL HEALTH

April 2018

TE WHĀNAU O WAIPAREIRA
KOKIRITIA I ROTO I TE KOTAHITANGA
Progressively Act in Unity

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MIHI

Tihei wā mauri ora. Mānawa mai te mauri nuku. Mānawa mai te mauri rangi. Ko te mauri kai au, he mauri tipua. Ka pakari mai te pō. Tau mai te mauri. Haumi e, Hui e, Taiki e! E mihi ana ki tō tātou Kaihanga nāna nei i tīmata, nāna nei i whakaoti i ngā mea katoa. Nāna nei i heke iho ngā manaakitanga me te aroha ki a tātou katoa. Ka whakamoemiti ki a ia.

Huri noa ki ngā mate i hinga atu ki ngā marae maha. Haere, haere, haere koutou. Haere koutou ki tāwāhi, kei waenganui i ngā tini karanga maha me ngā tūpuna. Mai rā anō, mai rā anō, mai rā anō. Moe mai i roto i te aroha o te Ariki. Haere, haere, haere atu ra.

Huri noa, ki te karanga o ngā iwi Māori o te takiwā a Waitākere, he whakamarumaru ki te whenua o Ngāti Whātua rāua ko Te Kawerau a Maki. Karanga mai, karanga mai, karanga mai. Kia koutou ra e ngā kaiwhakaurunga i tautoko i te kaupapa rangahau nei - Kimihia Te Hauora Hinengaro. Ka mihi ka tika, mō ngā pitopito kōrero o aua kaimahi, whānau me ngā tāngata whaiora i homai aroha mō taua mahi rangahau. Ki te kore te tangata, ka pērā rawa ki te rākau māmori, ā, he rākau matemate noa. Ngā mihi aroha ki a rātou.

Ko te tumanako, ka hāpai ake i te kaupapa nei i te mana me te oranga o ō koutou whānau, ngā tāngata whaiora o Waitākere me Aotearoa whānui. Ko te aroha anō he wai e pupu ake ana he awa e māpuna mai ana i roto i te whatumanawa. Ko tōnā mātāpuna he hōhonu ā inā ia ka rere anō he tai timu, he tai pari, he tai ope, he tai roa, he tai nui, he tai nui. He Tainui!

Āpiti hono, tātai hono, rātou te hunga wairua ki a rātou. Āpiti hono, tātai hono, tātou te hunga ora ki a tātou huri noa, huri noa, tēnā koutou, tēnā koutou, tēnā ra tātou katoa.

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EXECUTIVE SUMMARY

i. **This is a report on 'Kimihia te Hauora Hinengaro: Pathways to Mental Health', a study conducted by Wai-Research which explores the relevance of the inclusion of Māori cultural elements in therapeutic care for Urban Māori in West Auckland.**

ii. **The aims of this study were to answer the questions:**

- What and why Māori cultural elements were incorporated into therapeutic services?
- How relevant were those Māori cultural elements for tāngata whaiora?
- How relevant were those Māori cultural elements from the perspectives of whānau?

iii. **The methods used in this study were:**

- A literature review of kaupapa Māori models of psychological therapy and mental health services which highlighted that:
    - i. More than 50% of Māori are likely to suffer a mental health problem during their lifetime however service engagement for Māori is typically low
    - ii. Māori mental health is unlikely to improve unless linked to broader strategies for Māori health development including education, housing, urbanisation and culture
    - iii. While mental health services throughout Aotearoa are moving to align with the needs of Māori, there has been minimal focus on the specific needs of Urban Māori
- Interviews across 4 West Auckland mental health service providers:
    - i. Family Action
    - ii. Man Alive
    - iii. Waipareira
    - iv. Whītiki Maurea.

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- From these providers a total 45 interviews were conducted with:
    i. 17 kaimahi
    ii. 23 tāngata whaiora (service users)
    iii. 5 whānau.

iv. The key findings of the study were:

- Services should focus on the needs and expectations of tāngata whaiora so that health outcomes are relevant and meaningful to tāngata whaiora.
- Services should ensure that both cultural and clinical interventions are offered and for these to have the maximum effect, they need to operate alongside each other and in concert.
- While models of Māori health, such as Te Whare Tapa Whā, are used to guide service delivery, the manner in which these were interpreted or applied may be less aligned to cultural tradition and more to the realities experienced by Urban Māori.
- Cultural and ethnic diversity should be considered as part of treatment and care plans and will impact on the mode and method of service delivery to Māori.
- Services alone are unlikely to impact rates of disease, but rather they must work together with broader health promotion and public health initiatives to more broadly support and highlight the role of socio-economic, educational, and behavioral factors.
- Adequate and sustainable resourcing is required in order to maximise health outcomes.
- Given the size and diversity of urban environments as well as the complex needs of tāngata whaiora, integration with other social service providers is imperative in order to address broader social issues as a means of promoting mental health outcomes.
- The culture of being Urban Māori can be of more relevance to the identity of tāngata whaiora than the culture of ethnicity.

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The Framework below is used to highlights key points and opportunities:

Item	Description	Opportunity
Tāngata Whaiora Focus	Ensuring that services focus on the needs and expectations of tāngata whaiora	Health outcomes meet the expectations of tāngata whaiora
Cultural/Clinical Interface	Ensuring that both cultural and clinical options are available	Comprehensive care is provided
Culturally Inspired Interventions	Appreciating that cultural modes of care will vary	Innovative and bespoke cultural models are developed
Cultural and Ethnic Diversity	Increasing cultural and ethnic diversity will impact on the mode and method of service delivery to Māori	Cultural and ethnic diversity is considered as part of treatment and care plans
Environmental Drivers	Services alone are unlikely to impact rates of disease	Consideration as to the broader drivers of mental ill health
Resourcing	Adequate and sustainable resourcing is required	Resourcing to maximise health outcomes
Integration	Integration with social services providers is imperative	Addressing broader social issues as a means of promoting mental health outcomes
Urban Māori Realities	Urban realities are drivers of Urban Māori culture	Using urban culture as a driver of mental health outcomes

INTRODUCTION

'Kimihia te Hauora Hinengaro: Pathways to Mental Health' explores the relationship between culture and mental health. It is framed within an Urban Māori context unique to the West Auckland community and further aims to assist with the design of more culturally responsive and relevant therapeutic interventions. While much inquiry has focused on prevalence, levels of disability, or access issues - little is known about the service experiences and expectations of Urban Māori.

In order to bridge this gap, Wai-Research conducted qualitative interviews with tāngata whaiora[1], their whānau and with mental health service providers. These were focused on three areas of interest:

1) **What and why Māori cultural elements were incorporated into therapeutic services?**

2) **How relevant were those Māori cultural elements for tāngata whaiora? and;**

3) **How relevant were those Māori cultural elements from the perspectives of whānau?**

Literature on Māori models of mental health service delivery was also sourced and reviewed. This information was used to complement the interviews and to explore the theoretical and operational underpinnings of kaupapa Māori models of service delivery. As with previous studies conducted by Wai-Research, this investigation has a translational focus and aims to contribute to service provision, in addition to the academic discourse. To this end, the findings of this study will help to inform the design of more culturally relevant and effective models of therapeutic care provision for Urban Māori in West Auckland and beyond, to ultimately improve health outcomes for the West Auckland Māori community.

[1]The term tāngata whaiora (seeking wellbeing) was initially coined by Professor Sir Mason Durie in the mid 1990's. Prior to this, words like client, service user, patient, or turoro (unwell) were used. By using tāngata whaiora instead, it was hoped that a more positive frame be created for those experiencing mental illness and to likewise encourage recovery.

BACKGROUND

This research has a focus on the West Auckland Community and aims to understand how the unique and diverse cultural experiences of Urban Māori might inform the design of more responsive mental health treatment and care services. The following section profiles the demographic features and characteristics of the West Auckland Community and offers additional detail on how this community, over time, has evolved and developed[2].

THE WEST AUCKLAND MĀORI COMMUNITY

The 'West Auckland Locality Population Snapshot' (2016)[3] highlights the key demographic features of West Auckland Māori. This data is based on the 2013 Census and reveals that:

- Approximately 30,654 people of Māori descent reside within West Auckland of which 27,395 identify as Māori.
- The five largest iwi affiliations of Māori residing in West Auckland are Ngāpuhi (34.5%), followed by Ngāti Porou (9.2%), Te Rarawa (6.2%), Ngāti Whatua (5.2%) and Waikato (5%).
- Over a third (35%) of West Auckland Māori are 14 years or younger with adults over 65 years old constituting about 4% of the total West Auckland Māori population.

URBAN MĀORI

The community of West Auckland is also unique in that it has one of the largest Urban Māori populations in New Zealand [4]. Urban Māori refers to whānau, or descendants of whānau, who have migrated to Auckland or other urban centres from their more rural homelands. Urban Māori are also often described as being 'pan-tribal' – a group comprised of different iwi (tribes) who in settings like West Auckland have subsequently gained recognition as a contemporary iwi group [5]. The experiences of the West Auckland Urban Māori community are in many ways similar to those in other urban environments. However, there are also a range of factors which are unique to this group.

DIVERSE CULTURAL REALITIES

Contemporary Māori are both culturally and ethnically diverse regarding the cultural impacts of migration from traditional homes to the establishment of Māori in urban settings. This has meant that while some Māori have maintained fluency and ability in Māori language and custom, others have not been so fortunate and have instead adopted largely Western lifestyles, with only a sense of identifying as Māori.

This diversity accounts for and includes Māori who have little understanding of Māori culture and language to those who are steeped in Te Reo Māori and tikanga. These groups may nevertheless both identify as "Urban Māori" and likewise benefit from the application of culture to a therapeutic setting. However, unless research is undertaken to determine how culture is applied in a meaningful and bespoke manner, it is unlikely that these opportunities will be maximised.

[2] Huakau, J. (2016). West Auckland Locality Population Snapshot. Te Pou Matakana: Waipareira Tuararo.
[3]Ibid.
[4]Huakau, J. (2016). West Auckland Locality Population Snapshot. Te Pou Matakana: Waipareira Tuararo.
[5]Waitangi Tribunal. (1998). Te Whānau o Waipareira report (Wai 414). Wellington, N.Z: GP Publications, c1998.

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MĀORI MENTAL HEALTH STATUS

Mental health is an aspect of Māori wellbeing which has been extensively researched. However, and due to a range of methodological and logistical reasons, prevalence studies have been infrequent. To this end, New Zealand's only psychiatric epidemiology study was undertaken in 2005. Data from this research reveals that over 50 percent of Māori are likely to experience a mental health disorder over their lifetime - the most common of which are anxiety disorders, followed by substance abuse and mood disorders[6]. The Ministry of Health also reported that in 2014/15, the rate of Māori utilising mental health services through District Health Boards (DHBs) was 4485.6 per 100,000 Māori population, an increase of 59.8 percent since 2001/02 [7]. Despite this, studies suggest that Māori are still less likely to access professional mental health support and that Māori typically tend to access services late and at an acute stage. This pattern has sometimes been seen to indicate poor provision of primary care and further implies that treatment will be more difficult and outcomes sub-optimal[8].

Given data and research limitations, there is also a lack of inquiry specifically detailing the mental health status and service experiences of Urban Māori in West Auckland, in particular studies which investigate the issues of cultural diversity and the implications for therapeutic interventions. In spite of this, a health needs assessment conducted by the Waitematā District Health Board (DHB) in 2015 found that (within the Waitematā DHB district) the prevalence of schizophrenia is more than double in Māori (723 per 100,000 population) compared with European/Other ethnicities (349 per 100,000 population)[9]. A separate health needs assessment conducted on behalf of Ngā Pou o te Whare o Waipareira reported that (within the Whānau Centre population, over an 18 month period) clients had over 500 internal referrals to mental health and addictions service[10].

KAUPAPA MĀORI RESEARCH APPROACH

The design and implementation of this research are guided by a kaupapa Māori approach. Kaupapa Māori has a number of definitions and perspectives, but essentially is a way of undertaking research in a manner which resonates with a Māori world view. It is an approach that is grounded in a Māori knowledge base and validates Māori worldviews that relate to ways of thinking, ways of engagement with others, relationships with the environment, language, and cultural identity [11 12].

[6] *Baxter, J., Kingi, T., Tapsell, R. & Durie, M. (2006). Māori. In: MA Oakley Browne, JE Wells, KM Scott (eds). Te Rau Hinengaro: The New Zealand Mental Health Survey. Wellington: Ministry of Health.*
[7] *Ministry of Health. (2016). Mental Health and Addiction: Service use 2014/15. Retrieved 9 August 2017 from http://www.health.govt.nz/publication/mental-health-and-addiction-service-use-2014-15#keytrends*
[8] *Eade, L. (2014). Te Tau Ihu Māori mental health outcomes and tāngata whaiora experiences in Te Wahi Oranga (Nelson Acute Mental Health Inpatient Unit): an exploratory study: a thesis submitted for the degree of Doctor of Philosophy at Te Kura Hinengaro Tangata-School of Psychology, Massey University, Turitea, Palmerston North (Doctoral dissertation, Massey University).*
[9] *Waitemata DHB. (2015). Waitemata DHB Health Needs Assessment 2015. Retrieved from WDHB2015HealthNeedsAssessment.pdf*
[10] *Ngā Pou o te Whare o Waipareira. (2017). Whānau Centre Needs Assessment. Retrieved from wai-research.html*
[11] *Smith, G. H. (1997). The development of kaupapa Māori: Theory and praxis (Doctoral dissertation, ResearchSpace@ Auckland).*
[12] *Smith, L. T. (2013). Decolonizing methodologies: Research and indigenous peoples. Zed Books Ltd.*

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A kaupapa Māori approach to research is one that is transformative for Māori, in that it places Māori at the centre of enquiry and challenges other approaches that are based on other world views[13]. It explores inequalities and power relationships. In that respect, the true value of kaupapa Māori can be seen across all fields in which dominant ideologies have marginalised the voice of Māori. This is particularly relevant to the field of psychology and mental health which has historically been heavily reliant on hegemonic discourses to drive theory and practice[14 15]. For example, Western models of psychological therapy, such as Cognitive Based Therapy (CBT), have become the most commonly adopted models in the country and while there has been some work done towards investigating the efficacy of CBT with Māori populations, there is still a lack of critical mass literature that explores the significant effect of many of these models for indigenous populations[16 17].

Kaupapa Māori offers a platform to develop frameworks, theories and practices in the field of mental health that are specifically catered to Māori and which explicitly seek to achieve outcomes for Māori[18 19]. While considerable progress has been made in the space of kaupapa Māori psychology - including rising numbers of Māori psychologists and the introduction of National Symposia for Māori and Pacific Psychologists to better understand their practice through a cultural worldview - there remains relatively little research about the effectiveness of kaupapa Māori to Māori service users.

RESEARCH AT THE INTERFACE

The current landscape of Te Ao Māori can be assessed as a culture influenced by both indigenous traditions and modern Western practices. Research at the interface examines the meeting points of indigenous and Western knowledge in the effort to promote innovation and the creation of new knowledge or fresh insight that can support the positive evolution of contemporary Māori society. Coined by Sir Mason Durie, *research at the interface*[20] should be differentiated from mātauranga Māori research and scientific research which employs only empirical scientific principles; rather, interface research attempts to utilise two sets of values and methods not to simply bridge the benefits that might arise from each, but to produce synthesised gains for indigenous people, most of whom are living at the interface - or along a spectrum of immersion. Encapsulating this sentiment, research at the interface is also the scoping ethos for this research project.

[13] *Smith, L. T. (2000). Kaupapa Māori research. Reclaiming indigenous voice and vision, 225-247.*
[14] *Levy, M. P. (2007). Indigenous psychology in Aotearoa: realising Māori aspirations (Doctoral dissertation, The University of Waikato).*
[15] *Nikora, L. (1989). Psychology – a time for change (30 June-1 July 1989): Summary of major themes. Hamilton: Department of Psychology, University of Waikato.*
[16] *Bennett, S. T. M. (2009). Te huanga o te ao Māori: Cognitive Behavioural Therapy for Māori clients with depression: development and evaluation of a culturally adapted treatment programme: a dissertation presented in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Psychology at Massey University, Wellington, New Zealand.*
[17] *Bennett, S. T., Flett, A. R., & Babbage, D. R. (2014). Culturally adapted cognitive behaviour therapy for Māori with major depression. The Cognitive Behaviour Therapist, 7(20e), 1-16. DOI: 10.1017/S1754470X14000233*
[18] *Nikora, L. (1989). Psychology – a time for change (30 June-1 July 1989): Summary of major themes. Hamilton: Department of Psychology, University of Waikato.*
[19] *Levy, M. P. (2007). Indigenous psychology in Aotearoa: realising Māori aspirations (Doctoral dissertation, The University of Waikato).*
[20] *Durie, M. (2004). Understanding health and illness: research at the interface between science and indigenous knowledge. International journal of epidemiology, 33(5), 1138-1143.*

METHODOLOGY

A range of research methods were employed to answer the research questions centring on a review of relevant literature, interviews with service providers, service users and whānau. This following section provides more detail on this process.

LITERATURE REVIEW

Prior to the commencement of this research project, Wai-Research undertook a literature review relating to kaupapa Māori models of psychological therapy and mental health services[21]. This literature review provided relevant contextual information on current kaupapa Māori models of psychological therapy – some of the main points of the review are summarised below:

As mentioned earlier, there have been a number of significant and seminal research programmes which have highlighted concerns around Māori mental health status and provision. We know, for example, that Māori are not genetically or physiologically predisposed to mental ill-health, with current trends being a relatively recent phenomenon[22]. At least to some extent, behavioural concerns are a major contributor and have continued to confound efforts to identify more sustainable solutions. Socio-economic factors are similarly destructive, as are lower rates of educational achievement, cultural alienation and the indirect effects of increased urbanisation, poor housing, social isolation and any number of indices that both trigger and sustain mental illness[23]. Many of these concerns are beyond the scope and ability of the mental health sector to address, and they highlight the need for comprehensive, integrated and multi-sectoral solutions. To this end, Māori mental health is unlikely to improve unless linked to broader strategies for Māori development[24].

This research, aimed with a particular interest in Urban Māori, is shaped within the context of significant increases in Māori admissions to psychiatric facilities over the past 40 years[25]. This data is compounded by similarly concerning increases in Māori suicide, and concerns over Māori ability to access timely treatment and care. Research has also suggested that the outcomes of care for Māori are likely to be compromised as a result, and that more is needed to develop services and interventions which better engage Māori and which build on cultural philosophies and practices[26].

[21] *Wratten-Stone, A. (2016). Kaupapa Māori Models of Psychological Therapy & Mental Health Services.*
[22] *Te Puni Kōkiri (1999). He Pou Tarawaho mo te Hauora Hinengaro Māori – A Framework for Māori Mental Health: Working Document. Wellington: Ministry of Māori Development, 1999, p. 28.*
[23] *Committee of Inquiry (1988). Psychiatric Report: Report of the Committee of Inquiry into Procedures Used in Certain Psychiatric Hospitals in Relation to Admission, Discharge or Release on Leave of Certain Classes of Patients. Wellington: Department of Health, p. 135.*
[24] *Durie, M. (1977). 'Māori Attitudes to Sickness, Doctors, and Hospitals'. New Zealand Medical Journal, vol. 86, no. 600, pp. 483–485.*
[25] *Mason, K. (1996). Inquiry Under Section 47 of the Health and Disability Services Act 1993 in Respect of Certain Mental Health Services. Report of the Ministerial Inquiry to the Minister of Health Hon Jenny Shipley. Wellington: Ministry of Health.*
[26] *Baker, R. (1988). 'Kia Koutou', in C. Walsh and S. Johnson (eds), Psych Nurses, vol. 88, p. 40.*

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Concerning though these issues are, and as noted previously, epidemiological evidence suggests that these high rates of admission are compounded by disproportionately high levels of prevalence, with more than 50% of all Māori likely to suffer from a mental health problem during their lifetime. Of equal concern is that service engagement is typically low, in spite of higher levels of acuity and need[27]. We also know that some research has been undertaken into the design of Māori mental health services and how cultural modes of therapy can be developed and applied. Few have focused on the specific needs of Urban Māori, none have explored to any great extent issues of cultural diversity and the contemporary realities of West Auckland Māori.

As a starting point however, it was important to review and examine what aligned work in this area has taken place to consider the implications for this study. As an illustration, and as early as 1995, *Guidelines for Purchasing Personal Mental Health Services for Māori*[28], described eight components or activities that would normally feature as part of a Māori mental health service. Included were cultural assessments, whānau participation, use of Māori language, incorporation of Māori tikanga and cultural practices, the therapeutic application of Māori arts and crafts, karakia, the use of Māori medicinal herbs/therapies and rongoā, and the involvement of tohunga and traditional healers.

The report outlined the manner in which activities could be applied, their significance and their purpose. It was further noted that cultural interventions would not constitute a mental health programme alone but that interventions related to clinical activity were also necessary. Before the construction of the guidelines, purchasing decisions for Māori mental health services often took place in an ad hoc and inconsistent manner[29]. The diversity of regional purchasing strategies tended to exaggerate these problems[30]. However, a far more significant issue was that cultural approaches to mental health care were relatively new and, to some extent, untested. While cultural therapy units such as Whaiora, Te Whare Paia and Te Whare Marie (at Porirua Hospital) had provided valuable practical guidance, many of the approaches had yet to be formalised, placed within a framework suited to regional purchasing plans or determined as capable of being modelled elsewhere.

[27] *Rankin, J. (1986). 'Whaiora: A Māori Health Cultural Therapy Unit'. Community Mental Health New Zealand, vol. 3, no. 2, pp. 38–47.*
[28] *Te Pūmanawa Hauora (1995). Guidelines for Purchasing Personal Mental Health Services for Māori. Palmerston North: Te Pūmanawa Hauora, Department of Māori Studies, Massey University.*
[29] *Tutara, T. (2000). Mental Health Promotion for Young Māori. Presentation speech at the Conference of the RANZCP Faculty of Child and Adolescent Psychiatry and the Child and Adolescent Mental Health Services, Auckland, 29 June 2000.*
[30] *The four regional health authorities developed a variety of approaches to meeting the needs of Māori. In the Northern region, Māori purchasing organisations (MAPO) were developed; in the Midland region, joint venture boards were established; in the Central region, direct contract negotiations were favoured; and in the Southern region, a less formalised approach was adopted.*

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Te Whare Manaaki[31] was a similar report, developed in 1998. It was based on three key principles: traditional Māori practice, Te Whare Tapa Whā/contemporary Māori health practice, and orthodox health practice. Each principle was designed to interact in a synergistic fashion and in a manner that promoted the best possible outcomes. Traditional Māori practice included tohunga, rongoā and mirimiri as well as karakia and the concept of whanaungatanga. Te Whare Tapa Whā/contemporary Māori practice described the importance of cultural assessment, whānau support, assessment and care programmes, while orthodox health practice highlighted the value of clinical activities and interventions, electroconvulsive therapy, pharmacology and/or behavioural therapy.

Although designed for a more specific purpose[32], *Te Whare Manaaki* described concepts and features consistent with the purchasing guidelines document and, in particular, emphasised the need to align cultural and clinical processes. In the end, both *Te Whare Manaaki* and the *Guidelines for Purchasing Personal Mental Health Services for Māori* were consistent in that they confirmed the focus of activity should be less on the types of interventions (cultural or clinical) offered and more on the manner in which these are applied to maximise health outcomes for tāngata whaiora/consumers.

Following these early reports, a number of hui also raised the challenge of identifying and describing the key characteristics, concepts and principles of a Māori health service:

"The extent of the debate around determining what is a kaupapa Māori service, provides some insights into why it has been difficult to determine what they look like, how one might operate and what the special characteristics might be. 'Kaupapa Māori' therefore has as many meanings as service providers. The principal reason behind this diversity is that tikanga belongs to iwi, it is not a set of principles that can be universally applied"[33].

Numerous others were to follow suit, which led to the design of various models, frameworks, structures, strategies and statements. They included those from the Health Funding Authority[34], Mental Health Commission[35], Māori Health Commission[36] and Ministry of Health[37] as well as those from a number of independent researchers[38] and academics[39].

[31] *Ryan, E. (1998). Māori Mental Health Services: A Proposal for Change. Wellington: Māori Health Commission.*
[32] *The model was specifically designed to describe how clinical practice could be considered as part of a proposed Māori mental health service development.*
[33] *Alcohol Advisory Council of New Zealand (2000). National Māori Alcohol and Drug Summit, 25–27 June 2000, Manu Ariki, Taumarunui Summit Report. Wellington: Alcohol Advisory Council of New Zealand, p. 11.*
[34] *Health Funding Authority (1998). Māori Mental Health Provider Hui – Christchurch. Wellington: Health Funding Authority.*
[35] *Mental Health Commission (1999). Blueprint for Mental Health Services in New Zealand. Wellington: Mental Health Commission.*
[36] *Māori Health Commission (1998). Tihei Mauri Ora. Wellington: Māori Health Commission.*
[37] *Ministry of Health (1995). Ngā Matatini.*
[38] *Health Services Research Centre (1994). Barriers to Mental Health Care in the Community: Towards an Economic Model. Wellington: Health Services Research Centre.*
[39] *Durie, M. (1994). Māori Cultural Identity and Its Implications for Mental Health Services.*

METHODOLOGY
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As noted, no study into mental health has been developed with West Auckland Māori – however, previous work and literature was nevertheless useful in informing this process. The review of international and indigenous discourse supplied context and better understanding of the potential implications of the place of this research. Based on the review of literature, we were able to capture current thinking and discourse on the integration of culture to a mental health treatment setting, and to obtain a clearer understanding on how suitable models and interventions - as well as the needs of West Auckland Māori - might be best represented.

In terms of treatment and care options for Māori, the literature also suggests that one of the main reasons Māori are disproportionately burdened by mental health problems is that there is an absence of therapies or services that cater to the cultural realities of Māori. Additionally, the fact that there are no kaupapa Māori models of psychological therapy that were specifically designed for Urban Māori, and which could be especially pertinent for West Auckland Urban Māori. However, the literature offers a number of common success factors that could provide a basis for the implementation of a kaupapa Māori approach for West Auckland. These factors include:

- the incorporation of Māori values and traditions - frameworks;
- synthesising Māori and Western models of health relevant for Urban Māori;
- including a culturally and clinically competent workforce;
- the involvement of elders in care planning;
- broadening therapy to include traditional healers or rongoā;
- ensuring easy access and low service cost;
- supporting holistic wellbeing.

In summary, while the basic principles of culturally aligned service delivery have been identified, there is inconsistent views in the literature on how these concepts are applied in practice or in ways which meet the specific needs of Urban Māori.

SERVICE PROVIDERS

Literature, while helpful, may not always capture contemporary views, or the perspective of key interest groups, consumers, service users, whānau and the community. As a complementary method, interviews with service providers were organised. Once provider involvement could be ascertained, the commencement of recruiting kaimahi (workers) from those providers began, who in turn, identified potential tāngata whaiora and whānau as participants. The criteria for inclusion of the providers were:

1. **Provider must be in West Auckland;**
2. **Provider must deliver mental health services;**
3. **Provider should be delivering mental health services for a number of years;**
4. **Provider should be delivering mental health services to Māori (though did not need to be a Māori specific service).**

A directory of mental health service providers in West Auckland was sourced through Raeburn House, an online directory of support services[40]. From this process, the following providers agreed to be included in the study:

MAN ALIVE – TANE ORA

Man Alive was founded in 1996 in Henderson, West Auckland, and aims to provide therapeutic care for males seeking to stop violent behaviours. After 21 years of service, the programme has grown to be the largest Living Without Violence (LWV) initiative in New Zealand, supporting males residing in South Auckland (Panmure), West Auckland (Henderson), North Auckland (Orewa), Whangārei and into the Far North.

Man Alive has an all-male counselling team that deliver an array of therapeutic interventions for violent behaviours and co-morbidity (i.e. predominantly anxiety, depression, trauma, Alcohol and Other Drug dependency (AOD)). The service is targeted toward boys aged 8-12, male youth 13-17 and male adults 18+. Interventions are facilitated in either a group or individual setting and vary in duration from 8 – 20 weeks.

The LWV adult group length is 20 weeks with a duration of 2.5 hours per group session and offered to mainstream and Māori cohorts. Reviewing the programme manual for the Māori LWV group programme – Te Ara Taumata Ora - the content is informed from Te Tikanga o Kauae Runga me Te Tikanga Kauae Raro; on drawing Māori metaphors and mātauranga Māori to expand understanding and uptake of content both culturally and clinically.

Adult referrals are sourced from the Ministry of Justice (specifically - Family and Family Violence Court), Corrections probation and community self-referrals. Along with delivering non-violence programmes,

[40] *http://www.raeburnhouse.org.nz/index.php/directory-of-support-services/itemlist/category/72-mental-health*

SERVICE PROVIDERS
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Man Alive's adult service offers general individual and couples counselling. The Men In Relationship Group programme explores breakdowns in intimate relationships and the Change Group supports men wanting to heal deeper predisposing issues that are interfering with normal life functioning. These groups are often attended post an LWV intervention.

For the purpose of this study, staff and participants from the Te Ara Taumata Ora programme in Henderson were included.

WHĪTIKI MAUREA

Whītiki Maurea is the Māori Clinical Service within the Waitematā District Health Board Specialist Mental Health and Addictions Group. Based in West Auckland, Whītiki Maurea provides clinical care in mental health and addictions with a Māori kaupapa (cultural values and concepts) approach. It consists of three teams - Moko Services: Māori Mental Health Team; Te Ātea Marino: Regional Māori Addictions Team and Te Pae Ahurea: the Māori Cultural Team. Whītiki Maurea originated in 1999, when Moko Services was launched as a cultural advisory service to the Waitematā District Mental Health Services.

Whītiki Maurea is committed to the kaupapa of healing for Māori by weaving together Māori cultural values and Western clinical practice, thereby aiming to provide Māori tāngata whaiora and their whānau with the best possible health outcomes. Whānau centred therapy is the driving force for Whītiki Maurea and a marae-focused, wairua-driven service is the ultimate objective. The cultural team is made up of two kaumātua, a team leader and eleven cultural advisors.

Access to Whītiki Maurea is via direct referral, other Waitematā DHB mental health services or Community Alcohol and Drug (CADS) teams. At assessment, a client's clinical and cultural needs will be formulated, then treatment planned for respective teams to commence. To begin their therapy journey, a client and whānau will be welcomed with a pōwhiri held by the Whītiki Maurea kaumātua and/or staff with support from the clinical team.

For the purposes of this study, staff and participants from Moko Services and Te Pae Ahurea were included.

FAMILY ACTION – WHĀNAU TOA

Family Action was newly formed in 2012 from the merger of Western Refuge and the Waitākere Abuse and Trauma Counselling Service. Based in Henderson, West Auckland, the agency offers an outreach and refuge service for women and children experiencing family violence and counselling for those affected by sexual abuse, trauma and family violence. The combined services enable Family Action to offer survivors of domestic violence advocacy support and therapeutic healing at 'crisis, intervention and prevention' stages of family violence.

Family Action's agency vision is 'Whānau Toa – Strong Flourishing Families'. A multi-disciplinary team of social workers, psychotherapists, counsellors and psychologists provide a refuge house, safety planning, court advocacy, telephone support and crisis counselling. Longer term therapy provisions include general

SERVICE PROVIDERS
CONTINUED

counselling, child and adult psychotherapy, family therapy, couples work and group therapy. Women in Action – Wāhine Toa, is a weekly group intervention for women seeking to move from the cycle of violence. Youth Action – Rangatahi Toa, is for youth who have experienced or witnessed abuse. Referrals are received from ACC, Ministry of Justice, Marinoto and community 'walk-ins'.

Family Action is a secular charitable trust open to all ethnicities. Specifically, Family Action do not have any Māori services. Tū Wāhine, located in Henderson, is an independent kaupapa Māori therapeutic service for wāhine, tamariki and whānau who have been involved in whānau and sexual violence. Additionally, they provide advocacy and primary prevention services. Māori clients who utilise Family Action services are offered at assessment the choice of Tū Wāhine's Kaupapa Māori service or Family Action's mainstream alternative.

For the purposes of this study, staff and clients from Family Action's refuge, individual and group services were included.

TE WHĀNAU O WAIPAREIRA TRUST

Te Whānau o Waipareira Trust (Waipareira) was established in 1984 in West Auckland. The Trust was a proactive response to many of the challenges encountered by Urban Māori at the time. Most significantly, the detrimental impacts of rapid and unmanaged urbanisation, decades of high unemployment, poor education and health. Waipareira created a collective voice to raise the profile of Urban Māori residing in West Auckland; advocating for rights and resources, and committing to protect future generations of Urban Māori.

Waipareira currently operate 60 services that cater for needs at five identified demographics: Whānau Pēpi, Whānau Tamariki, Whānau Rangatahi, Whānau Matua, and Whānau Kaumātua. Operating a synchronised, wrap around approach, whānau are able to access and incorporate several services to enable an achievement of Whānau Ora. Under their mental health provision there are 8 services for tāngata whaiora: child and adult advocacy; home based support; in-house support to Pacific, Iwi Māori and Mainstream; Alcohol, Drugs and Addictions Counselling; a kaupapa Māori day programme; and support for the West Auckland homeless community – Taniwha Tales.

Referrals are received from the Waitematā District Health Board, the community, primary health care services, Community Alcohol and Drug Service, and from other Waipareira internal services. Excluding the homeless service, all clients must have a mental health diagnosis prior to accessing Waipareira mental health services. Services are provided by a multidisciplinary team of social workers, mental health nurses and counsellors who are largely Māori. Kaumātua (elders) are accessible for cultural needs of tāngata whaiora, such as whakapapa reconnection, house blessings and other matters of tikanga.

For the purpose of this study, facilitators and participants from the Kaupapa Māori Day Programme, Iwi Support Services and Taniwha Tales were included.

INTERVIEWS

45 interviews, which included: 23 tāngata whaiora, 17 kaimahi and 5 whānau from the four mental health service providers were conducted.

The investigators of this project delivered a bespoke questionnaire[41] developed with the advice of experts in mental health and kaupapa Māori research.

KAIMAHI INTERVIEWS

Kaimahi (worker) in the context of this research refers to staff involved in the delivery of mental health services which includes (and is not limited to) social workers, mental health practitioners, nurses, practice leaders and managers. Kaimahi from the above four providers were interviewed to capture their professional perspectives of what therapies are delivered to Māori, what works or doesn't work for Māori and to gain some insight into the Māori cultural approaches that are used as part of service delivery.

Of the 17 kaimahi interviewed:

- 5 were employees of Family Action
- 2 were employees of Man Alive
- 7 were employees of Waipareira, and;
- 3 were employees of Whītiki Maurea.

TĀNGATA WHAIORA INTERVIEWS

Interviews were also conducted with tāngata whaiora[42]. Tāngata whaiora interviews were conducted to help create an impression of the mental health needs of the West Auckland Urban Māori community and to also determine whether the services were addressing those needs. These interviews were also helpful in ascertaining the mental health needs and seeing the relevance of services within specific Urban Māori experiences.

In total 23 tāngata whaiora participants were interviewed and included:

- 5 from Family Action
- 2 from Man Alive
- 6 from Waipareira
- 10 from Whītiki Maurea.

[41] *See Appendix*
[42] *See footnote 1*

INTERVIEWS
CONTINUED

The criteria for inclusion were:

- Identified as Māori;
- Over the age of 18;
- Currently utilising services with one of the four providers; and,
- Willing to participate in the study.

WHĀNAU INTERVIEWS

In total, 5 whānau (families) were interviewed. They had been identified by tāngata whaiora as 'family' even though they may not have had whakapapa links[43]. Because of this, the research team did not have any set criteria as to who could be considered for interviews in this group, other than that they were considered as whānau by the tāngata whaiora.

Whānau were interviewed in order to secure a more complete picture of the needs and experiences of tāngata whaiora. Within a kaupapa Māori framework it is important to not only acknowledge individual voices, but to also acknowledge the voices of whānau who travel alongside the tāngata whaiora on their journeys towards wellness.

ETHICS

Given the potentially sensitive nature of this study's focus, it was imperative for the research team to consider and address all ethical issues before commencing. This was to ensure that the safety of participants and researchers was maintained throughout and thereafter the research process.

As with all research conducted by Wai-Research, ethical issues were internally reviewed before the commencement of this study. This review was conducted by a research steering committee specifically assembled for this study and which consisted of: members of the investigation team, an external mental and research advisor, an internal mental health advisor, the director of mental health services at Waipareira, a community representative, and a member of the Waipareira Kaumātua Rōpū. Additionally, external ethical approval was sought and attained by the New Zealand Health and Disability Ethics Committee (HDEC) [44].

[43] *This concept of whānau has been described by Metge (1995) as a group who were not necessarily linked by whakapapa (genealogy), but by a kaupapa (purpose) such as a shared experience of urbanisation, adversity, mental health or homelessness.*

[44] *Ethics approval number 17/CEN/3*

INTERVIEWS
CONTINUED

DATA ANALYSIS

Transcripts of the interviews were grouped into the categories of 'tāngata whaiora', 'kaimahi' and 'whānau' and thematically reviewed (manually) by the research team. Each group was examined independently as each had been delivered specific questionnaires. This approach also assisted the process of triangulation and to compare and contrast the views of each group.

Members of the analysis team were also members of the interview team and as such could ensure that the themes extrapolated through analysis accurately reflected the intended views of participants. This information was then reviewed alongside the review of literature and in light of conversations with experts in the field. From this process, a draft research report was prepared, further reviewed by the research team, so that a final document could be constructed.

LIMITATIONS

As with all research investigations, a number of limitations have been identified. With more time and resource, it would have been optimal to have interviewed more tāngata whaiora, more whānau and also conducted a census of service providers throughout West Auckland. While this was ultimately not possible and also beyond the scope of this study, we are nevertheless confident in the validity of the research findings and the study's potential to contribute towards improving mental health outcomes

PROVIDER INTERVIEW RESULTS

This section describes the range of issues which were identified as part of the provider interviews. They are presented here in no particular order, but have emerged as part of the thematic analysis described previously.

WEST AUCKLAND APPROACHES TO THE APPLICATION OF A KAUPAPA MĀORI APPROACH

"There is no single route to kaupapa Māori psychologies in Aotearoa" [45] ***(Levy, 2016)***

While there are various sources of literature that explain kaupapa Māori as a theory, or a basis from which to validate and ground Māori knowledge within a colonised context, less is written on what happens when theory and practice merge within mental health provision. Within the West Auckland context of a high needs Māori population, and a provider base that is confronted with a multitude of barriers, the question of how to implement 'Māori-centric' thinking and philosophy within a practice was answered with some diversity, but also with some recurring themes.

The focus during the interviews around 'kaupapa Māori' had multiple tenets, in that providers spoke of their philosophical, non-tangible, approaches that they saw as being kaupapa Māori based, as well speaking about the actual 'doing' of kaupapa Māori, or the particular practices that were used by providers as part of their delivery of mental health services for Māori and their whānau.

MULTIPLE FRAMEWORKS AND MODELS

Most of the providers spoke of overarching and guiding Māori frameworks, most commonly the Tiriti o Waitangi principles, and Sir Mason Durie's ' Te Whare Tapa Whā. For the 'by Māori for Māori' providers, kaupapa Māori was more than an approach or tool, but was instead seen as an ethical philosophy, which was wrapped around the organisation's particular cultural and geographical whakapapa, such as for instance Waipareira's 'Te Kauhau Ora' framework:

"Te Kauhau Ora is part of order and practice. How do you transmit Te Kauhau Ora into practicing onsite? That is what makes us different."

The application of the frameworks to provider practice was seen as varying in some instances according to the interpretations of the kaimahi on the ground, yet also informed specific cultural interventions, such as 'tikanga' courses for tāngata whaiora, and training for kaimahi.

"In [our service] we all work slightly differently.
I think we all bring our iwi or our kaupapa, our Māori values differently."

The philosophical underpinnings of many of the services were – even if not outwardly labelled 'kaupapa Māori' – steeped in Māori values, such as manaakitanga, mana, tino rangatiratanga and the ethos of 'by Māori for Māori':

[45] *Levy, M. (2016) Kaupapa Maori Psychologies. In Waitoki W. and Levy M. (eds.) (2016) Te Manu Kai I Te Matauranga - Indigenous Psychology in Aotearoa/ New Zealand. The New Zealand Psychological Society: Wellington. P38.*

PROVIDER INTERVIEW RESULTS
CONTINUED

"I think a critical part of it is having Māori kanohi ki te kanohi, face to face, with the tāngata whai i te ora. If they see a Māori face I think that makes a real difference in terms of whether you are in the mainstream there is no guarantee that you will be seeing anyone who is Māori at all."

"But even though we have nothing we are always giving. I am teaching these guys here the importance of doing that, even if you are considered to be at the bottom of the barrel. Because what it will do for your insides is make you feel proud that you have been able to do that, and no one can take that away from you."

For some of the providers, a kaupapa Māori philosophy informed all aspects of their service design, to the point of using a 'cultural assessment' as part of the establishment of a baseline of what support is needed for tāngata whaiora entering the service:

"Our cultural assessment is based around the whare tapa whā concept or looking at the hinengaro or the tinana or the wairua and the whānau and pulling in different learnings or information that we gain from the family, and then producing a written whare tapa whā assessment that is then put on the patient's file. It is something that is discussed when it comes to clinical meetings, reviews."

KAUMĀTUA INCLUSION

The role of kaumātua was seen by some of the Māori providers as an essential part of a kaupapa Māori approach to mental health provision. Kaumātua provided leadership and guidance to both the organisation, the staff and the tāngata whaiora, and were active across the spectrum of pastoral care and tikanga governance:

"Kaumātua are often the ones to facilitate whānau hui because I think we tend to as Māori look to kaumātua for that kind of leadership. […] they are available to provide blessings of services, new buildings - inpatient units, there are times when there have been deaths. That is their role to go in and to do a cleansing for a process. They are like the senior advisory from a tikanga point of view."

Staff also spoke of how they worked together with kaumātua in recognising and addressing mental health within the context of Te Ao Māori, a Māori worldview:

"I walked into this house, and it was cold. It was freezing cold and it was sunny like this, all coming through here. I said 'mate what has gone on in here? What is happening?' We were sitting and I heard my grandmother's name. They let me have their house blessed."

KAUPAPA MĀORI PRACTICE

Specific kaupapa Māori practices that were mentioned during interviews included the use of pōwhiri/ whakatau (welcome), karakia and waiata (prayer and song), whakapapa/pepeha (ancestry), marae (noho), whakanoa (blessings/cleansing), whakairo (carving), and mahi toi (art).

PROVIDER INTERVIEW RESULTS
CONTINUED

At one of the providers, the welcoming of tāngata whaiora and their whānau through pōwhiri or whakatau was seen as an essentially 'tika' (proper) way of entering the service, as well as an opportunity for whānau to feel included in the healing journey of the tāngata whaiora:

"What is in place is, the tāngata whaiora is invited to the initial pōwhiri. They are encouraged to bring whānau with them which could be anyone they consider to be whānau; mum, dad, sisters, and brothers. So that is one point whānau is brought in at the early stage."

Karakia was talked about as being an important ritual to assure 'cultural safety' within the opening and closing of sessions with tāngata whaiora. This was articulated also by the mainstream services, who recognised this as an important acknowledgement of the tāngata whaiora's choices around their treatment:

"In my assessments I always ask along with culture their spirituality. […] And always asking about karakia, even though sometimes that doesn't go as planned."

Teaching karakia to the tāngata whaiora was also seen as important for some of the services, where knowledge of karakia was seen as an important part of claiming Māori identity:

"[Teaching them means that] they can be in a situation where they can step up and offer karakia somewhere."

Alongside karakia, teaching tāngata whaiora about their whakapapa, and how to mihi or recite pepeha was used by many of the services as another way to empower tāngata whaiora and strengthen their identity:

"But when we open up with our pepeha, we have had guys that had no idea and have gone out and tried to find their connections and they have been able to do that."

"They are slowly turning around and recognising who they are and where they are from. […] like one guy says, 'it is learning about whakapapa'. They took him back - so his ancestors brought him forward to where he is now."

The marae also plays an important role in connecting tāngata whaiora to Te Ao Māori, both within a 'cultural education' sense of taking tāngata whaiora onto noho marae (marae stay), as well as taking tāngata whaiora back to their own particular marae:

"I've had [staff] taking whānau back to marae. […] We've had them take them back to tangihanga. We've had the kuia take someone back to urupa."

Some of the services talked about using art and creativity within their approaches, in particular one of the services which was explicit about the connection between the ancient art form of whakairo (carving) and the connection this has to Māori 'therapy':

PROVIDER INTERVIEW RESULTS
CONTINUED

"Spiritually for Māori, carving was something that our ancestors did and those carvings are still present today. People look at them in awe. […] So the carving is a sense of spirituality and creative therapy. It is a beautiful thing. I mean if you look at each chisel mark, how many times did this fella hit this thing to make that, because you can see every chisel mark. So there is an awful lot of love and attention that has gone into it."

What the West Auckland providers are able to implement at the moment under a theory of 'kaupapa Māori', is based on the belief by the providers that Māori approaches can – and must - be implemented within the demands and conventions of a Pākehā dominated mental health system. The differences in how this is implemented stem from matters of resourcing, skill base, uncertainty about the core elements of kaupapa Māori, and other barriers, rather than from a lack of willingness by these providers – whether Māori or mainstream - to incorporate kaupapa Māori as part of their approach. This, in itself, can be seen as a perfect platform for further development around kaupapa Māori in West Auckland mental health provision to occur.

SERVICE BARRIERS

"Simply providing access to services will do little to effect sustainable change unless there are also changes in the way services are delivered so that they accord with indigenous world views." (Durie, 2011)[46]

The thematic analysis of the provider interviews identified a range of the commonalities in regards to the perception of the barriers affecting their ability to deliver the best outcomes for Māori clients. The underlying systemic causes of many of these barriers highlight the importance of looking strategically from a government level at what changes need to be made to provide a realistic and sustainable platform, from which kaupapa Māori services can be delivered. While these kaupapa Māori approaches provide the potential to lead to great things for tāngata whaiora it has to be given the adequate resourcing, time and political inclusion in order to flourish.

INSUFFICIENT FUNDING

"Well, we're battling for putea [funding]. We always are, and it's always going to be the edge, it always is. Because when it comes down to the dollar, that always happens. But you know, we get peanuts compared to what's offered to the other services. Feels a little bit tokenistic from our perspective."

One of the most common themes during the interviews was the issue of inadequate resourcing, funding struggles, and associated contract restrictions. All of the providers rely on government sources of funding for their mental health services – this was the same for the mainstream and the specific kaupapa Māori services. Funding was talked about in the sense that there is 'never enough' to cover the actual need of the West Auckland Māori community and that there is a sense of having to compete for resourcing within a context of low governmental funding priorities for mental health:

"Mental health is not the flash end of health – so there has always been that issue, we're always at the bottom of health in general. Always fight for the scraps at the table of the DHB."

[46] *Durie, M. (2011), Indigenizing Mental Health Services: New Zealand Experience. In Transcultural Psychiatry, 48 (1-2), P34.*

PROVIDER INTERVIEW RESULTS
CONTINUED

CLINICAL MANAGEMENT

The implications of inadequate funding for clinical services were discussed in respect of restrictive contracting frameworks, where the reality of need did not match the contract specifications, and which either resulted in not being able to provide necessary therapeutic interventions or staff taking on high caseloads that are outside of the scope of funding:

"If we had more resourcing, we might be able to pull together with other therapeutic type skills and put more energy and time into the area of DBT type work […] Whereas if we don't have that resource then it's just another area where we are not quite getting them to a point of being able to manage their un-wellness."

"There is [funding for] ten, that is it. No. It doesn't work like that. In the last six months I worked with over sixty guys, [and] about a dozen families."

Providers also spoke of budget constraints impeding clinical provision due to an inability to hire adequate staffing resources:

"It actually comes back to resource. In reality, we can't take everybody. If every Māori wanted this service, there is no way that we could handle it."

"Well funding always helps [...] We could have more staff to, I suppose, enhance our service for meeting Māori clients."

THE CULTURAL/CLINICAL INTERFACE

The lack of funding that was communicated by the research participants also highlighted a perceived gap around specific funding of Māori mental health, and the challenges that this presents to working in a truly effective whānau centred, kaupapa Māori way:

"We don't have family funding, whānau ora funding […] there is never enough money. Where we are scraping for little resources that we have to try and create these spaces for our whānau to go and be and feel comfortable and talk."

For the services that are delivering within a kaupapa Māori approach, the inclusion of whānau is seen as an important element of that approach. The barriers to the involvement of whānau in the healing process of tāngata whaiora relate back to the governance of Western paradigms over how the service has been allowed to be set up, and how it is funded:

"The funding is not necessarily on the whole whānau. It is just the single person that you are dealing with."

THE APPLICATION OF WESTERN FRAMEWORKS

While some of the services identified themselves as being 'by Māori for Māori', while others were mainstream services with or without Māori focused programmes, there was a clear shared theme around the effect of dominant Western frameworks.

PROVIDER INTERVIEW RESULTS
CONTINUED

Provider staff spoke about Western frameworks in the context of health care models and practices, as well as the overarching New Zealand socio-political system affecting the life circumstances of Māori whānau. All providers were in agreement that their overarching contextual point, whether they had specific kaupapa Māori services or not, were confronted by the interface of Western and Māori models of care and best practice:

"[…] we have to work within a particular construct, and it's a clinical model. It's a mental health model of care. And everyone talks about mental health being holistic, but the reality is…you know. It's just a term really, holistic."

For providers that offer a specific kaupapa Māori service within a larger mainstream provider, the Western clinical model was still operationalised as the 'norm' framing the kaupapa Māori services and influencing kaupapa Māori specific service delivery:

"I think at the moment, clinical drives everything. It would be really nice if we did actually sit side by side and we work together to drive these things together. But the medical model always wins out. Even here, I'm forever fighting."

WORKING AT THE INTERFACE

The interface between the Western medical model and Māori cultural model was also seen as a continued struggle of communication, as medical terminology remains the dominant language of treatment:

"I don't even like the word assessment per se, but you know, gotta use their language – but that's how it is all the time. And that's what I mean. Our way we see things, it's different from the clinical way."

For providers that are funded to deliver a 'Māori component' within a larger mainstream service, the overarching Western model was seen as determining service delivery, which was strongly regulated through the government funding body:

"This programme that has been set up it is sort of like, well there are bits and pieces that are Māori but it isn't really a Māori programme at all. Maybe 5%. […] But generally if you look at the programme itself it is actually a lot based on Western models."

For a mainstream provider where Māori elements are acknowledged as important and which are at times practiced by the staff within the organisation, the sense of these being an 'add-on' to the Western model of care was expressed by one interviewee as potentially tokenistic:

"I always find the difficult question really is about 'where is tokenism'? So we are quite good at singing waiata and we are good at karakia. We are particularly good at waiata when we have a Māori guest, and we are quite good at whakatau. Then you get the question of 'are we just paying lip service to it'? I don't know. I struggle with that. I really do."

PROVIDER INTERVIEW RESULTS
CONTINUED

TRANSLATING TIKANGA INTO PRACTICE

The challenge of translating kaupapa Māori practices into therapeutic action, was expressed in a myriad of ways throughout the interviews. For the services that had a kaupapa Māori ethos at the heart of their service design, it was often seen that the action of what happens 'on the ground' of supporting tāngata whaiora, could be very different to the theory of the overarching Māori principles of the service:

"I have been practicing with all the teams 'te kauhau ora'. How do you apply this in practice? It is all right knowing it over here, but actually the practice was not tikanga. So how do you apply it in practice as an intervention? Just having karakia and singing waiata is not a kaupapa Māori intervention. A kaupapa Māori intervention is more than that."

For the providers where clients have a choice between mainstream and Māori services, one of the barriers to implementing kaupapa Māori approaches was also around re-connecting or socialising tāngata whaiora to Māori culture:

"I think for me if clients are sort of detached from their Māori culture but you know it might be beneficial for them to get back in touch with that culture identity, I would like to know how to kind of challenge them and tie them in with their culture, but without coercing them."

Some of the interviewees commented that when Māori were reluctant to choose a specific Māori service pathway, the sense was that they felt culturally inadequate, or 'not Māori enough' to take the option, or alternatively did not see how that would help them:

"For whatever reason there is a block and they don't want to do it. They have no idea of their whakapapa. It can be quite challenging. There is a perception that you have to speak Te Reo Māori to be part of the programme."

Another aspect of this was the potential to inadvertently create 'tikanga' barriers:

"For example, a barrier could be they don't want to go through a pōwhiri. Because you have got your concept of what a pōwhiri is. I have noticed that we have had a lot of people who have said yes to pōwhiri as the first step, but on the day they don't turn up. What is the reason? Is it a barrier? We have got to make sure that we are not providing any barriers, even if it is a tikanga barrier."

WORKFORCE ISSUES

The relationship between service delivery and a qualified workforce was talked about throughout the provider interviews. Recruitment of Māori staff and work training for both Māori and non-Māori staff was seen as an ongoing challenge. While there has been some progress made within New Zealand over the past decade in attracting and training Māori students in the mental health field, there are still large gaps when it comes to finding Māori qualified in - and comfortable with - Māori approaches:

PROVIDER INTERVIEW RESULTS
CONTINUED

"We try to maintain at least 60 to 70% of our staff of Māori descent, but it is not always that way because if you don't have Māori staff who are trained or who are applying, or there are insufficient people out there to come in for jobs."

"That comes down to training too. It depends where they [kaimahi] are kind of trained and also getting back to those contracts and how the contracts were implemented. Really it is very, very hard as a kaupapa organisation to keep authentic when the powerful dynamics around it are not."

Another interviewee talked about the difficulty of recruiting trained Māori from mainstream mental health to work in a kaupapa Māori service:

"So recruiting their services is really difficult [...] I know a lot of Māori that work in the mainstream services – for all sorts of reasons they don't want to work in a Māori service. So recruitment is really difficult from the clinical side of things."

The lack of ongoing training for staff already working within kaupapa Māori oriented services was also articulated as an issue that created significant challenges to optimal service delivery:

"[There is] not even training working with Māori for my non-Māori colleagues. There is nothing there."

"So in order for us to keep up with the play and us to talk to Walsh Trust, Emerge, when do we ever? We never do. When is the last time we had a Hearing Voices workshop? I think it is important for our growth and for our whānau that we keep that going and we have regular training."

For non-Māori staff delivering within a mainstream framework to Māori clients, the lack of the right kind of training was seen as a major barrier to working with Māori in a culturally responsive way:

"There is no way that I could do a formal Māori kaupapa and be able to pull it off with any type of credibility. […] I do think that I am not trained well enough in what I do need to know. So that is something that is a barrier for me. So I have to go at it from a covert kind of Māori kaupapa."

"I think the main barrier for me is definitely and will always be I don't know enough, and I never will know enough. [...] sometimes I don't even realise that I have reached a barrier. 'Oh crap', I have tread on someone's toes. Sometimes I don't even realise that that is what I have been doing."

SOCIO-ECONOMIC FACTORS

Many of the providers felt encumbered in their ability to sustain positive impact on the mental health and wellbeing of tāngata whaiora in the face of the dire socio-economic circumstances of many of their clients:

"[We need to be] attending those physical needs, but one of the physical needs that we can't address, that we try really, really hard is housing. People can't get ready to deal with any other work if they don't have the food to eat and a place to stay. That is our biggest, biggest struggle I think at the moment."

PROVIDER INTERVIEW RESULTS
CONTINUED

"Money at a lot of the time is the problem, especially if they are not employed or anything. So you have to make little work around a lot of things for the family. […] The other thing, especially for our street whānau, because there are a lot of Māori who are on the streets, but like they haven't [been able to] check out their medical needs."

While wrap-around service providers are able to address some of these immediate needs, governmental social welfare systems were also seen as presenting a key barrier to supporting tāngata whaiora effectively:

"The other enemy [for whaiora] is WINZ [Work and Income New Zealand], as far as they see it. [WINZ] say 'Alright you are mental, blah, blah, blah, the doctor gave you a certificate, but, oh well, you can still go to work'. 'Oh okay.' So I go in and say 'good, they need to go to work, so give them the job; because I don't know of anyone that will take them like this.' "

Another interviewee commented on the link between the 'Work and Income' system set up to financially support tāngata whaiora, and the way in which this system encourages people to stay mentally unwell:

"So now let's say they progress. They would have to keep that [mental health] diagnosis to stay with us. So there is a vested interest [..] You get paid money to stay sick. You don't get a wellness benefit. You can't go down to WINZ and say 'well I would like to qualify for a wellness benefit'. You get a sickness benefit. [...]So there is a stigma associated with that. Because then they not only have a mental illness, now they are on the poverty scale."

OPERATIONAL SILOS

While some of the provider's spoke of being able to work across and with other service providers, for many the feeling was that interagency collaboration to work effectively towards the health of tāngata whaiora was still lacking:

"It is not working efficiently. I think that we have all got the same ambitions. We all want to achieve the same things, but we are still not pulling it together in a cohesive way. We are still doing our 'little silo what we are funded for' type of approach."

Cohesion of internal referrals, more robust connections in regards to external referrals, and connections across the wider community were seen as some of the solutions to avoid working within silos:

"Sometimes I think we do [work in silos]. […] We are not purposefully doing it, but forgetting about all the others. Because at the end of the day it is about us building a community for our whānau, and it includes the whole community."

It is important also to note here that many of the providers framed their experience of providing a kaupapa Māori service within the context of the perceived stigma associated with mental health, which influenced a range of factors. The stigma of mental health was described in relation to governmental decisions that affect funding allocations, contract scopes, and educational priorities. Stigma was also seen to influence

PROVIDER INTERVIEW RESULTS
CONTINUED

workforce decisions (mainstream versus kaupapa Māori provision), or whānau being unable or unwilling to be involved in tāngata whaiora mental health care:

"Again, it goes back to that stigma. Society says, 'stigma, mental health is this'. I'll tell people what I do and they're like 'oh that's gotta be hard, aye'…"

PROVISIONS FOR A "FIT-FOR-PURPOSE" MĀORI SERVICE

The interviews with provider staff revealed not just their current service provision and their concerns about perceived barriers, but also highlighted what providers thought of as essential elements that would need to be in place to build a "fit-for-purpose", kaupapa Māori mental health provision for West Auckland.

TINO RANGATIRATANGA

Tino rangatiratanga is recognisibly publicised in debates over the rights afforded to Māori set under Te Tiriti O Waitangi to exercise authority and self-determination over essential societal fabrics. At the heart of tino rangatiratanga is the ability to provide effective leadership to the governance of Māori partnership and participation in societal opportunity.

Equally, the uniqueness and effective visibility of Te Ao Māori within an ideal kaupapa Māori mental health service delivery was equated to the level of Māori decision-makers at the strategic governance level of an organisation. Acknowledged by Māori providers as essential (i.e. the presence of Māori senior managers, kaumātua), non-Māori organisations also included the importance of Māori leadership:

"I think we would have more Māori staff and at management level too, because you need to implement it. You don't mind different levels, but in all honesty for me it has got to start from the top and filter [down]."

"I think if it isn't led from the top then, excuse my French but you are pushing shit uphill."

Holding to a design of rangatiratanga (self-determination or self-governance), providers were unanimous, that to maintain the integrity of a kaupapa Māori therapeutic service it should include the presence of senior Māori leadership or rangatira Māori steering and maintaining the authenticity of the service design.

HE WAHI KOTAHITANGA

Kotahitanga is often used in health care services as a guiding principle that underlines service delivery. The conceptual understanding attributed to kotahitanga is of unity, togetherness or collective action and is recognised as a founding value to encourage staff to work equitably with colleagues and client. The underpinning of kotahitanga extends further to include community and environment. In this way, a wāhi or place was conceptualised by participants, that adopted an atmosphere of inclusion and openness to the wide diversity of culture within West Auckland, not only Māori, and was recognised as an opportunity for a uniquely West Auckland kaupapa Māori service:

PROVIDER INTERVIEW RESULTS
CONTINUED

"To be quite honest if it is really true kaupapa Māori then it should be universal. Otherwise to me it is not Māori. That is what I tell all my non-Māori [colleagues]. I say, look if it doesn't work for you then there is something wrong with that model that you are using because it should go right across."

The dissemination of knowledge and acquisition of diverse cultural understanding was widely shared as an important opportunity that could be provided within a kaupapa Māori service rather than a mainstream health care setting. Kaimahi interviews featured the idea of a communal space that could be sustained under a kaupapa Māori format and be accessed and shared openly by the whole community:

"I would see it as, if it's in West Auckland, it needs to be multi-iwi'd. So, being able to have education around the different whakaaro that come from the different iwi and the different korero that come from the different iwi."

"We called it [programme space] our whare […] Then when they get here we have our band and we have got our arts work, we have got our plants, our gardens."

HE WAHI MĀTAURANGA

The importance of cultural and clinical learning to inform holistic healing was described as a strong component of therapeutic provision and mental health well-being. A sustainable Māori service was seen as needing to embody an ongoing process of knowledge acquisition, not only for tāngata whaiora and whānau but for kaimahi also. Providers identified that tāngata whaiora and whānau would benefit from education on their specific mental health disorder, rather than having only a name and a course of medication to a diagnosis.

A non-Māori provider stated that an "ideal" kaupapa Māori service would have experts in Te Ao Māori who could be available to other agency staff in a new approach to Māori mental health needs in West Auckland, which would be a community of providers working for the whole community, versus individual providers working with individuals:

"I think if you were to design a kaupapa Māori service specifically for West Auckland, one of the components that it would have that would be so beneficial would be a specific arm that is learning to do training the trainers - the practical stuff of how to work with Māori; not just the protocols, not just the process and the rituals. [...]That kind of stuff would be immensely helpful for any agency here in West Auckland."

An equal marriage between clinical and cultural was offered as advantageous. A hope was shared for a service that embraced a symbiotic tuakana-teina (equal mentoring) approach where a Māori lens of health held an equal footing with Western best practice:

"So there are lots of people that will say 'it needs to be cultural it needs to be cultural', but we're living in the year 2000. [...] I do have a full belief that clinical and cultural can work together and should work together. But then again, it's very hard to find those clinical counterparts that will actually let it be equal. Because their world, everything about their world is superior and inferior. Whereas. I'd love it to be a tuakana-teina, synergy."

PROVIDER INTERVIEW RESULTS
CONTINUED

Employing an equal relationship that is open to shared learning ultimately serves the needs of tāngata whaiora as they emerge. Clinical and cultural practice should be working synergistically and be ideally located in-house together, to form a one-stop-shop approach to lessen the impact of a fragmented mental health system.

PŪRĀKAU MĀORI

The need for consistency in effective practice delivery for working with Māori was evident. All providers demonstrated either an overt or covert approach to delivering kaupapa Māori services to tāngata whaiora and whānau. The type of approach centred on the organisation's operation being intentionally kaupapa Māori versus mainstream working with Māori clients. However, providers collectively demonstrated an emphasis on the experience of kaupapa Māori values over a generalised requirement to exact tikanga (procedure) or kawa (protocol) Māori. Equally this importance was expressed as a base line in an 'ideal' setting:

"Some people say we are not really kaupapa Māori because kaupapa Māori initially is within the context of driven by Māori for Māori. Māori funded, iwi funded by Māori for Māori etc. Referring to kaupapa as being whanaungatanga, manaakitanga, aroha and all the concepts around what being Māori is all about. So that is the kaupapa that you deliver. You deliver those values to the people. […] So for me kaupapa Māori is really just about values."

"I am Canadian, there is no way that I could do a formal Māori kaupapa and be able to pull it off with any type of credibility. So being able to look at the Treaty and what are the underpins for it, and meeting it at that level so my sense of connection at meet and greet is around where do I come from, where do you come from? We are both mothers who have done this [mother behaviours]."

WHAKAMANA NGA WHAIORA

A sustainable Māori approach to mental health delivery was also seen as rooted in a natural emphasis on the way that people are seen, treated and invited to experience service:

"That is the root of it all really, is how we show that respect to the individual through that whole process and make them feel welcomed."

"Well, it is walking alongside people so that you give them the courage and the strength to be able to resolve their own issues without you stepping in and having to do it all for them. That is Whānau Ora."

Providers practiced the essence of kaupapa Māori through the adoption and practice of pūrākau Māori or relational values that enable engagement at a humanistic and holistic level. The idea here is to demonstrate that respectful stewardship of self, others, and place, opens new positive awareness, which enables access to experiencing and practicing innate values.

TĀNGATA WHAIORA FINDINGS

As with the previous section, the findings from the tāngata whaiora interviews are described below and likewise have emerged as part of a thematic analysis of interviews. These are presented under specific categories but in no particular order of importance.

CLAIMING IDENTITY & SENSE OF BELONGING

The post 1940s Urban Māori drift created a large disconnect from rural marae life, a source of Māori cultural identity, language and normality [47]. Conversations with participants as to the importance of providing Māori culture within their therapeutic experience were varied, and indicated either familiarity or an inability to access Māori culture.

MANA MOTUHAKE

Discussions with tāngata whaiora as to the importance of incorporating Māori culture into therapy could be viewed on a spectrum of immersion of those steeped in Te Ao Māori, to those disenfranchised from traditional Māori culture, choosing a neutral 'take it or leave it' approach:

"I felt when I follow the world of Māori I am complete. The minute I step out of that I fall apart. I don't know what it is but I feel like I am more in myself with the world of Māori."

"I can appreciate the concepts of the Māori culture, the perspective and interpretation. So I am just neutral in the middle. If it was there, sweet. If it wasn't, sweet."

Those who felt neutral were however open to Māori culture in therapy, such as the use of Te Reo Māori, so long as it was presented in a digestible manner that would not compound feelings of inadequacy:

"When I come across Māoris and they can speak Te Reo Māori, I value that and I appreciate that. Some of them got the opportunity when they were young, so that is what they are used to. I didn't get that. If it was there I would appreciate it and I would slowly chip away in regards to like learning a bit more."

MĀORI FOR MĀORI

At some of the services that provided a specific Māori intervention, a choice was offered to tāngata whaiora whether a Māori or mainstream therapeutic service would support their treatment journey. This was discussed either at a triage stage or during an assessment phase of therapy. Those who chose a Māori service shared an assumption that they would be able to relate more easily with Māori staff or other group members:

"I was brought up by my grandmother on the marae quite a bit, with waiata and karakia and stuff like that. So I just thought that would be quite good for myself. Like Māori relating to Māori, if that makes sense. Going through the same issues. So that is why I chose the Māori side."

Trauma at the hands of Māori whānau and a perceived lack of privacy due to closeness of Māori community were reasons for preferring mainstream treatment:

[47] *Moon, P. (2013). Turning Points: Events that changed the course of New Zealand history. Auckland; New Zealand: New Holland Publishers (NZ).*

TĀNGATA WHAIORA FINDINGS
CONTINUED

"So because I went through trauma when I was so young, now being an adult I have to kind of slowly find an effective, positive and passive way to re-programme part of my sub-conscious mind because for a lot of my early childhood I hated being Māori, because of what she did to me."

"The Māori community in West Auckland is pretty small and everyone knows everyone, in some way they know someone. I suppose that is what put me off."

For Māori using a non-Māori service there were concerns around mis-interpretation of spiritual experiences commonplace and accepted in Maōri culture. Fears included being wrongly judged and misdiagnosed under a medical model of assessment:

"Because I am working with a Pākehā/European organisation, I am really frightened of what I say. Am I going to really be safe or are you going to judge something and then take my kids away?"

"Being Māori and Samoan as well, we have a 'seeing' aspect, we have that gift of tohunga which is in my family and in my line. So me and my sons are big seers, so I see a lot like spiritually. Then someone that doesn't understand that… to understand that without thinking that we are crazy and we are totally going off the loop. You know you should be medicating under that. That has been really hard."

WHANAUNGATANGA

During the interviews with tāngata whaiora, one of the strong narratives that came through was around finding a sense of connection with others as part of a group service experience. The notion of 'connection' was talked about in clearly positive terms, to the extent that some interviewees referred to it as a 'whānau' experience. Relationship building here referred to connections beyond those one-on-one bonds of a 'client' and a mental health worker, and towards a group of like-minded others that support each other:

"It's just the people you meet - it's just good to meet nice people. I reckon that's the best part I think I like about it. And all the support you get if you get stuck with something. Like the guys are here to help you out in the best way that they can help you out."

"I always come in here and I talk to everybody, but they always mingle in with me. When I am down they always come and pick me up and help me and all that."

The ability to re-create a sense of whānau is here built on support and understanding, learning from each other, and the realisation that others in the group have had similar experiences:

"Plus, most of the guys here have been through a similar situation so they can like relate to what I'm saying."

For many of the tāngata whaiora, the important factor around their feeling of belonging is that the group was seen as fulfilling a 'family', or 'whānau' function, although unlike a traditional whānau this is one that they themselves chose to belong to as a part of their journey towards wellness:

"But yeah, definitely it's a whānau feel. That's the magic we've got here. And I wouldn't be here otherwise."

"When we walk in here bro, we've learnt to be one big happy family. If we're not here we're talking to each other on Facebook. If we're not on here, we're living out there with each other."

TĀNGATA WHAIORA FINDINGS
CONTINUED

WHAKAPAPA EXPLORATION AND KAUMĀTUA SUPPORT

A sense of belonging for Māori is also experienced through knowledge of genealogy, intricately linked with ancestral land. The majority of tāngata whaiora shared a knowledge disconnect regarding their own idenity as a Māori, and an openess to be supported by a kaumātua in piecing together their whakapapa.

Some services actively provided a support through in-house kaumātua to help piece together whakapapa.

"It was a good idea (for me) to try and learn pepeha, waiata and mihi, and to get sort of a knowledge on where my roots are. (...) That is what our main Talk Therapy has been about in the last month here (ie. with a kaumātua)."

The provision of whakapapa exploration was in itself an effective mode of therapy for providers to consider. Tāngata whaiora shared how whakapapa knowledge created a sense of balance or feeling more centred.

SYSTEM NAVIGATION

Tāngata whaiora within this study were clear in how they perceived the mental health services operating as a small part in a bigger and very complex system. Tāngata whaiora spoke of providers lacking the ability to work together in a way that benefited Māori and of the stresses involved with having to engage with a number different agencies:

"I am tired of being everywhere. I have been pulled left, right and centre for the last 10 years virtually. I was coming to the point where I was fighting the system. I thought they were meant to be there to help you and guide you and MOE and CYFS and that, and I am fighting them. Or I am doing their job for them."

The experiences of many of the tāngata whaiora navigating the mental health system were described as being difficult and time consuming. Much of this time and effort required to deal with different agencies in order to access mental health services and resources left tāngata whaiora tired and stressed, potentially worsening their mental wellbeing or intensifying the depressive symptoms and anxiety that were already experienced. Accordingly, this issue indicates a strong need for more support to be given to whānau who are navigating this system. At times they felt they were fighting the system, or there was a need for more collaboration by mental health providers and other agencies so that tāngata whaiora were not experiencing undue anguish when seeking help.

SYSTEM INTEGRATION

Another issue that tāngata whaiora experienced in navigating the mental health system was the lack of a 'one stop shop' that could provide a range of different health and social services. While providers were giving support for tāngata whaiora in other areas such as housing or budgeting training, these were usually provided outside the parameters of what they were funded to deliver. Subsequently, tāngata whaiora needed to navigate between a number of agencies in order to access all the support they required:

"How do we do it? All this stuff. Then you have got to go and see this person and they put you into this service. I said I am tired of going between all the different services. Why can't we just do this? One person, one person. Because it is breaking me down mentally."

WHĀNAU PERSPECTIVE

The following section summarises the themes which have emerged from the whānau interviews. Again, these are in no particular order.

WHĀNAU SUPPORTING WHĀNAU

When looking at Māori mental health service provision, the role of whānau is an important consideration. Excluding whānau from decision making around care approaches, and a failure to transfer knowledge around mental illness were seen as serious barriers to informed participation.

Whānau members who were interviewed as part of this project had experienced both mainstream and kaupapa Māori approaches, and spoke frankly about the wide range of complex issues they continued to face. The whānau spoke of feelings of frustration, bewilderment and helplessness, and saw a range of barriers that affected their ability to support the tāngata whaiora in their whānau, regardless of whether they were in a kaupapa Māori service or not. It is important to note that these interviews were held with whānau who had chosen to, or been able to, walk the path of mental health care alongside their loved ones, unlike some of the interviewed tāngata whaiora who were totally estranged from their whānau:

"The other thing is most other people in my sister's situation they don't have bloody family. The family have walked. They have said 'sayonara, I have had a guts full.' It is challenging."

For these whānau who wanted to be involved in the care of their whānau member, an ability to be supportive and to advocate for what they believed to be best care, was often undermined by systemic issues within the healthcare system, and in this sense mirrors some of the concerns of providers and tāngata whaiora.

WHĀNAU INVOLVEMENT: THE CHALLENGES

Whānau experiences of navigating the mental health system revealed significant dissatisfaction around the communication between themselves and the mental health service, as well as the communication between the service and the tāngata whaiora. The wish to be included in decision making around care was often not integrated into the way that services worked with tāngata whaiora, and was talked about as a high friction point:

"We also lodged a complaint against mental health services for not listening to family. So whānau input they say is important, but it is not given a lot of credence."

"I think they don't like me very much because I stomp my feet. But they do sometimes realise that they have to contact me and let me know certain things. I mean we don't really get to attend anything… it has always been me pushing for anything, to have meetings."

WHĀNAU PERSPECTIVE
CONTINUED

Whānau also reported that there was often a conflict between what they as a whānau knew about their whānau members, versus what the provider saw as the best way forward:

"Because I know that she's not well and she is getting worse and [they] aren't doing anything about it. […] I felt like I am paranoid quite often with her key worker, because I know within days if she is unwell and that is when I start saying 'can you keep a better eye on her, check her meds ra de ra', and I just feel like they think that there is nothing wrong with her."

A sense of powerlessness was also talked about from the point of view that whānau felt undereducated around the issues that affected their tāngata whaiora, and that the sharing of knowledge only happened when whānau were prepared to push the issue with service providers:

"There is not a lot of information. There is like a wall of pamphlets but that is all. If I have received that information it is because I have asked the questions. It has not come to me freely."

"[We need] more understanding I think of whānau around the mental health, because there are a lot of people out there that have to deal with family members with very bad cases of mental health."

Another barrier that whānau saw as impacting on the care of tāngata whaiora was the lack of resourcing of the mental health system. Whānau spoke of this being an impediment at times of crisis, as well as at the ongoing support end of the care spectrum:

"She had been into [service]. She had texted. She had rung. They assured her it would get sorted. She rung Crisis. They said they couldn't do anything whereas I know they can, they have got a doctor on call."

"I can see where a bit of the issue is, is that people take priority. So if they have got a caseload of twenty people and [whānau member] is on the list to be seen at 10 o'clock for a visit for a cup of tea and one of their other people is suicidal, well the cup of tea gets… you know. But it doesn't get rescheduled. It is just gone."

This means that lack of resourcing was seen as something that the whānau, their tāngata whaiora and even providers were unable to address:

"I can understand everything is stretched. You know, the most important person to me is my sister but there are so many other people out there that need help. They this time let her go pretty much because they needed the bed. They pretty much admitted that."

MEDICATION

Medication was a strong recurring theme throughout the whānau interviews, with all interviewed whānau commenting on the complexities around the role that medication played in the care of their tāngata whaiora. Concerns that were discussed by whānau were over the efficacy of medication, the lack of education around the effects of medication, as well as the exasperation felt by whānau when they had been excluded from being part of decision making around medication issues.

WHĀNAU PERSPECTIVE
CONTINUED

For some whānau, the over-reliance on medication services was seen as a serious issue, especially when other approaches were being side-lined:

"Medication should be your last resort, not a first resort that you go to and then be totally reliant on it. Well, I think turning people into zombies isn't curing them […] I get angry. I have been with [service] and told them that to me there should be more counselling and more group therapy and things like that."

"I find it very hard when people say they might have ADHD and then they throw tablets at them and it is just like actually they probably just need some counselling and some love and support."

"You think your drugs are getting rid of the voices; they are not. My kids have always got them. It is how they handle those voices. That is what I mean. It is about how you handle them, not whether you have got them."

Other whānau commented that for them it was not ideal for their whānau member to come off the medication, as past experiences of negative consequences meant that medication was essential to the care plan:

"So they were trying a component of cultural health and part of that component was to see if they could take the whaiora off their medication all together. We weren't impressed when we heard, because [whānau member] went down really fast and got really sick and we had to build her back up."

Changing a medication routine was seen as a perilous time for whānau, who were often uninformed of decisions made to change medication, and felt in the dark around side-effects and the knowledge they needed to support their tāngata whaiora:

"I think as a family we have gotten so [annoyed] to be honest that people don't listen to us. Too many times they have tried changing her meds without consulting us, and she just smashes down."

"I think I do need more education around medication wise really, because I know [whānau member] doesn't like taking medication."

WHĀNAU PERSPECTIVE
CONTINUED

WHĀNAU AND KAUPAPA MĀORI SERVICE PROVISION

When asked about the effect or benefits of having a kaupapa Māori service focus, whānau articulated the benefit of this approach for their tāngata whaiora, but were also cognisant of the need for balance between cultural and clinical elements. The elements that were identified as helpful were around the support structures of the kaupapa Māori service, and also how whānau themselves felt more included and understood:

"He [Māori service staff] was one of the best, I have to say, because he actively listened. He would look like he was off on his own little waka and then he would go 'so what you are saying is that from a whānau perspective it is ….' I was just like 'wow.' He was listening to what we were actually saying. The clinical were like what, 'ah, what?' He is like, 'no you are not listening. The family are saying this.'"

"I think it [kaupapa Māori service] is more giving us hope. We have got more hope that there are services out there that can help and support us as a family. There are a lot of services out there that just push families apart and go separate ways instead of working in with the family and working those models properly."

The ability to listen and be more in-tune with whānau views was as important as the small acts of support that a kaupapa Māori service was able to offer to the whānau:

"Because even if I was sitting in the waiting room and [whānau member] was in with [therapist], there was always a kaumātua that was walking around and he would always sit down and talk to me. It didn't have to be about what was going on. It just had to be about normal life."

Whānau also noted that cultural understanding and priorities should not come at the expense of clinical priorities, and that the ideal scenario is for both sides to work together:

"I think the good thing about it is when the cultural and the clinical actually listen to what the family contribute. So what I have noticed is that when you have the cultural aspect in there they listen more to what the whānau are saying and they comprehend it more."

"But the clinical cultural stuff needs to be met together and the clinical needs to be lifted to another level, which was a bit hard to say to them at that stage. I did say it though. I said 'clinical needs to sort their stuff out, because we are not coming back."

The whānau interviews revealed a nexus of concerns that highlighted the at-times vulnerable position that frequently confronted whānau. Working with the whole whānau, rather than an individual alone makes sense, although this can also be challenging. It is nonetheless a foundation for a kaupapa Māori mental health practice.

DISCUSSION

The last three decades has seen the increasing use of Māori culture as a therapeutic intervention within the mental health sector. Moving from a space of Western models of psychological care being the sole primary intervention, a catalyst of change occurred to address continued high representation and readmission rates of Māori in the mental health system. There has been greater sensitivity to Māori cultural worldview as an important part of therapeutic care planning and provision. The literature review established that mental health services throughout Aotearoa are moving to incorporate cultural care for Māori; a movement from identifying need and reason has gradually translated into actual cultural care provision for Māori within therapeutic settings. The result of this is an interface, where Western and Māori models of health are considered and practiced.

In spite of these gains, and notwithstanding the increasing number of Māori mental health service providers, the mental health status of Māori (as measured by prevalence, acuity, access, and outcomes) has not measurably improved. The reasons for this are both unclear and complex. To some extent, environmental and socio-economic factors are likely to blame, as are issues such as alcohol and drug use. Educational underachievement, poverty, poor housing, and unemployment are also known catalysts of mental ill-health and are again areas where Māori tend to be clustered.

Researchers have, for some time, also identified cultural decay and alienation as potential issues, as cultural constructs (traditionally used to promote wellbeing) have been eroded alongside increased levels of urbanisation and whānau dislocation.

To some extent, and given the wide range of factors which precipitate mental ill-health, it would be unreasonable to expect services alone to impact prevalence or Māori rates of mental ill-health. However, services nevertheless play a key role in facilitating access to timely treatment and care, the provision of culturally inspired interventions, and in the promotion of outcomes which better match the expectations of tāngata whaiora.

Insofar as this research has reinforced the need to further develop mental health services for Māori, it has likewise revealed that there is no single approach to the delivery of mental health. Models of service delivery are typically dynamic and are often shaped by factors such as funding arrangements, access to cultural and clinical staff, setting, environment, and wider theories on how culture might best contribute to mental health outcomes.

The issue of urbanisation, cultural diversity, and pan-tribalism has however received very little attention – at least from a mental health perspective, and other than to acknowledge the fact that Urban Māori are most likely to be dislocated from their traditional culture and tribal institutions. Given the increasing level of urbanisation amongst the Māori population and the correspondingly high prevalence of mental ill-health, this report provides a timely insight into how mental health services for Urban Māori might best be framed. A number of key issues and recommendations have therefore been identified. These have emerged through an additional analysis of the issues identified previously, further conversations with experts, as well as follow-up discussions with researchers and academics.

DISCUSSION
CONTINUED

A TĀNGATA WHAIORA FOCUS

The interviews with staff, whānau, and tāngata whaiora (in particular) were consistent on a number of levels, but none more so than when considering the need to focus service delivery on the needs of tāngata whaiora. While this seems like an obvious and reasonable proposition - it was sometimes felt that services were constrained by what they were able to deliver rather than maintaining a more considered focus on what the actual needs of the tāngata whaiora might be. This issue was compounded by the fact that not all services were in a position to offer the type of comprehensive support needed. However, and as a general principle for service delivery within an urban setting, a focus on the individual needs of tāngata whaiora was seen to be critical.

THE CULTURAL CLINICAL INTERFACE

Many of those spoken to highlighted the value of both cultural and clinical interventions and processes. Moreover - and for these to have maximum effect - they needed to operate alongside each other and in concert. It was generally agreed that these could in theory be applied without conflict or compromise and as part of a more holistic and comprehensive care plan. It was likely that for some Māori mental health services, access to both cultural and clinical skills would vary. However, and as a broad principle, mental health services for Māori should at least provide appropriate access to both.

CULTURALLY INSPIRED INTERVENTIONS

Leading on from the previous point, the research has also revealed the fact that the application of culture to a mental health setting is neither consistent nor well understood. Oftentimes the level of cultural input and the range of cultural activities provided would depend on the services access to cultural skills and expertise. While models of Māori health, such as Te Whare Tapa Whā, were used to guide service delivery, the manner in which these were interpreted or applied was inconsistent.

In spite of this, a number of features of a Māori mental health service were identified. Kaumātua input, for example, was often referred to, as was Te Reo Māori and tikanga, whakapapa, waiata and whaikorero. While not all services were able to access these types of skills, they were all nevertheless considered important characteristics. A key finding however, was the proposition that the application of culture to a mental health setting should not be viewed as cultural enhancement per-se, but rather an opportunity to improve mental health treatment and care as well as outcomes. To this end, it was agreed that culture should be applied in a way which was therapeutic and lead to positive health outcomes.

DISCUSSION
CONTINUED

CULTURE AND DIVERSITY

The notion of cultural and ethnic diversity is not new and has become increasingly relevant to contemporary Māori society. It can no longer be assumed that all Māori experience a single cultural reality and for most they will sit along a wide and diverse cultural continuum. Added to this, and arguably more recently, ethnic diversity has become more apparent as immigration from more diverse parts of the world has occurred. These changes have added to the richness of our society, but have also created challenges to the way in which "culture" is applied to therapeutic and health settings. It cannot be assumed that all Māori will embrace the same level of cultural therapy or that their Māori culture will take prominence over other cultures they may be exposed to.

The point here is that a considered rather than blanket approach to the application of culture to a mental health service setting is required. As with the previous point, this should align with the cultural needs and expectations of the tāngata whaiora rather than the aspirations of the service or staff.

ENVIRONMENTAL DRIVERS

It was noted that mental health services alone were unlikely to improve the mental health status of Māori, and that without broader societal change and support that these issues were unlikely to improve. This was not to say that Māori mental health service did not have a key role to play, but rather that they must work in concert with broader health promotion and public health initiatives and more broadly to support and highlight the role of socioeconomic, educational, and behavioural factors.

RESOURCING

A lack of resource was also a common theme to emerge. This had a range of implications – from an inability of services to provide the type of care needed, to contractual arrangements which were too narrow or brief. The implications were that services often found it difficult to maintain care or retain staff, moreover to provide the care needed. As a general outcome from the research it was suggested that in order for services to operate efficiently and to maximise health outcomes, that an adequate and sustainable level of resource was required.

INTEGRATION

Given the size and diversity of urban environments as well as the complex needs of tāngata whaiora, it was noted that integration with other social support services were required. This co-ordination and integration was again seen as necessary in order to maximise health outcomes, and importantly ensure that health gains and social supports were maintained. Within the current environment, silos were seen to have formed, which in many ways did not promote this type of integration or cooperative approach. Too often, the responsibilities for care were seen to be the role of other agencies and it was sometimes unclear as to who should take a lead role. Nevertheless, and in spite of this, greater cross-agency coordination was seen as imperative to effective mental health service delivery for Māori and to improving health outcomes.

DISCUSSION
CONTINUED

URBAN REALITIES

This report has previously highlighted the challenge of delivering treatment and care to a culturally and ethnically diverse population. It has also highlighted the cultural and ethnic realities of tāngata whaiora, which will often be bespoke and unique to their particular situation and circumstance, such as their unique history, whakapapa, engagements, and associations with others.

While many of these issues are well known, the implications of the urban environment on cultural identity has received far less attention, especially within the context of Māori mental health service delivery. To this end, urbanicity – like culture and ethnicity, must be acknowledged as playing a key role in shaping individual and collective identity. Moreover, and by extension, it must be a critical factor in determining how mental health services for Māori (within West Auckland) are designed.

The implication of urbanicity for service delivery are complex but have been clearly articulated as an outcome of this research. It suggests that the culture of being Urban Māori may be of more relevance to the identity of tāngata whaiora than would the culture of ethnicity. In practice, this may mean that culturally inspired interventions are less aligned to tradition and more focused on the realities and integrations experienced by modern Urban Māori. Whanaungatanga, for example, has been shown to help support engagement with tāngata whaiora. However, for Urban Māori, this concept may need to be viewed through a broader lens and where whakapapa is of less relevance than social connections and interactions. Associations with particular suburbs might hold greater meaning than would a hapū or iwi, likewise traditional activities such as kapa haka or wānanga could be enhanced through more contemporary cultural activities such as waka ama or touch rugby. The point here, is that culture can play a powerful role in promoting and sustaining mental health outcomes for Māori. Moreover, that for Urban Māori, the manner in which culture is applied or integrated into service delivery will need to take into account notions of urbanicity, and how this is linked to improved mental health outcomes for Māori.

DISCUSSION
CONTINUED

The Framework below is used to highlights key points and opportunities:

Item	Description	Opportunity
Tāngata Whaiora Focus	Ensuring that services focus on the needs and expectations of tāngata whaiora	Health outcomes meet the expectations of tāngata whaiora
Cultural/Clinical Interface	Ensuring that both cultural and clinical options are available	Comprehensive care is provided
Culturally Inspired Interventions	Appreciating that cultural modes of care will vary	Innovative and bespoke cultural models are developed
Cultural and Ethnic Diversity	Increasing cultural and ethnic diversity will impact on the mode and method of service delivery to Māori	Cultural and ethnic diversity is considered as part of treatment and care plans
Environmental Drivers	Services alone are unlikely to impact rates of disease	Consideration as to the broader drivers of mental ill health
Resourcing	Adequate and sustainable resourcing is required	Resourcing to maximise health outcomes
Integration	Integration with social services providers is imperative	Addressing broader social issues as a means of promoting mental health outcomes
Urban Māori Realities	Urban realities are drivers of Urban Māori culture	Using urban culture as a driver of mental health outcomes

APPENDICES: GLOSSARY

Aroha	To love, feel compassion, empathy
Hapū	Kinship group, clan
Hinengaro	Mind
Iwi	Extended kinship group, tribe
Kaimahi	Worker, employee
Kapa Haka	Māori performing arts
Karakia	Prayer
Kaumātua	Elder
Kaupapa Māori	A philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society
Kawa	Marae protocol
Koroua	Elderly man
Kotahitanga	Unity
Kuia	Elderly woman
Mahi	Work
Mana	Prestige, authority, control, power, influence, status, spiritual power
Manaakitanga	Hospitality
Marae	The open area in front of the wharenui, where formal greetings and discussions take place
Mātauranga	Knowledge
Mihi	To greet
Mirimiri	Massage
Noho	To sit or stay
Pepeha	Formulaic expression, saying of the ancestors,
Pēpi	Infant
Pōwhiri	Invitation, rituals of encounter, welcome ceremony on a marae, welcome
Pūrākau	Legend or myth
Pūtea	Money
Rangatahi	Youth
Rongoā	Medicines
Roopū	Group
Tamariki	Children
Tapu	Prohibited
Tāngata whaiora	Seeking wellbeing
Tangihanga	Funeral
Te Ao Māori	The Māori world
Te Reo Māori	The Māori language
Teina	Younger sibling of the same gender
Tikanga	Correct procedure or custom
Tinana	Body

APPENDICES: GLOSSARY
CONTINUED

Tino rangatiratanga	Self-determination, sovereignty, autonomy
Toanga	Bravery, courage
Tohunga	Skilled person, chosen expert, priest, healer
Tuakana	Elder sibling of the same gender
Urupa	Cemetery
Wahi	Place
Wāhine	Female, women
Waiata	Song
Wairua	Spirit, soul
Waka	Canoe, vehicle
Waka ama	Outrigger canoe
Wānanga	Educational seminar
Whaikorero	Oration
Whakaaro	To think, plan, decide
Whakapapa	Genealogy, descent
Whakatau	To welcome officially, formally
Whakairo	To carve
Whakanoa	To remove tapu
Whānau	Extended family, friends
Whanaungatanga	Relationship, kinship, sense of family connection

KAIMAHI / PROVIDER QUESTIONNAIRE

1. What is your service type?
2. What is the number of years involved in the mental health sector?

Service specific questions:

What is it about [service] that makes them different from other mental health providers?

- Do you think tāngata whaiora prefer [service] to other providers?
- If yes, why?
- If no, why?

3. Do you identify as a Māori service for Māori or a Service that works with Māori?
4. How does the organisation integrate 'kaupapa Māori' into your service?

Details of your kaupapa Māori approach:

(Taha Tinana)

5. How do you qualify a Māori client for your service?
6. Is there a choice to be in your service?
7. Are there any overt / common stigma, whakama that you have to work with urban tāngata whaiora?
8. How are the physical needs of tāngata whaiora addressed within your service

(Taha Wairua)

9. How do you support the spiritual health of tāngata whaiora?

(Taha Hinengaroa)

10. How is the mental health of tāngata whaiora supported within your service?

KAIMAHI / PROVIDER QUESTIONNAIRE
CONTINUED

(Taha Whānau)

11. How are the whānau needs of tāngata whaiora supported within your service?
12. Are there any barriers to using kaupapa Māori or Māori Culture in your service?
13. What is the best aspect of your service that works for Urban Māori?
14. Does a kaupapa Māori approach create conflict with your funder / external stakeholder requirements?
15. How could your approach be applied to the general population?
16. Do you think that West Auckland has specific needs for our Māori population?
17. If you were to think of a kaupapa Māori service that works really well, what kind of things would it incorporate?

Training

18. Training
    - Do you feel adequately trained by the service to work with Māori?
    - What specific training do you think is necessary to work with tāngata whaiora?
    - Can you access Māori cultural experts in your work place – koroua, kuia, other?

Other

19. What would help you to improve the mahi you are doing with tāngata whaiora?
20. Is there anything else you would like to add?

TĀNGATA WHAIORA QUESTIONNAIRE

TĀNGATA WHAIORA QUESTIONNAIRE

- What services are you using at (Provider)?
- How long have you been using this service?

REFERRAL

- How were you referred into the service?
- Was the referral process supportive?
  - If not/how? What could improve?
  - If so/how?
- Were you able to have any say about who you would see?
- Were you able to relate easily to the person you saw?

ASSESSMENT

- What was the process of assessment? Did you feel supported to safely discuss your needs and concerns?
- If not, what could have been done differently during your assessement?
- Did the assessment include an assessment of your participation in Te Ao Māori?

TREATMENT

(Taha Hinengaro)

- How does this service combine Māori culture with clincal care?

For instance:

- Does the service use observation of tikanga Māori?
- Does the service include provision in Te Reo?
- Does the service include Māori art, carving, weaving etc?
- Does the service include waiata, kapa haka?

TĀNGATA WHAIORA QUESTIONNAIRE
CONTINUED

(Taha Wairua)

- How does the service support your spiritual wellbeing in treament?
- Is karakia an important part of your treatment?
- Has the service included kaumātua?
- Has the service used traditional Māori healing in your journey?
- Do you get to spend time with your Māori side, including your own marae?
- Do you learn aspects of culture that are new to you?
- Do you use Te Reo Māori during treatment and care?

(Taha Tinana)

- Did you have a physical examination to exclude any physical ailments?
- Were questions asked about your physical health?
- Were there any suggestions about how you might improve your physical wellbeing?
  E.g. What physical activities were included as part of your treatment/recovery? How?

(Taha Whānau)

- Does your whānau participate with you in this service?
- What [additional] services do you think your whānau would benefit from?
- Are you now able to relate better to your whānau?
- Do you receive any advice about how you could contribute to your whānau wellbeing?
- Is there a link between your problem and the whānau?
- If so, are you being helped to manage that?

TĀNGATA WHAIORA QUESTIONNAIRE
CONTINUED

SERVICE EXIT /OUTCOME

- Overall, how important was the cultural dimension to your treatment or care?
- Was it helpful?
- Was it a bit 'weird', or a bit hard to follow?
- Was it over-done?
- Did it inspire you?
- Did it work in with your clinical treatments in a positive way?
- Or did it create some confusion between the two approaches?
- Are you better in yourself now?
- If so, how much of that improvement do you think is due to the cultural things?
- What is the best aspect of this service for you? What benefits have you gained?

Workforce

- Is it important to you to have Māori staff working with you?
- Do you feel that the staff in this service are able to meet both your cultural and your therapy needs?

Improvements

- How could the service be improved?

WHĀNAU QUESTIONNAIRE

- What service is (tāngata whaiora) using at (provider)?
- How long has s/he been using the service?

Referral

- How was (tāngata whaiora) referred to the service?
- Was whānau involved in any way in the referral process?

Assessment

- Did the service allow you to discuss your experience of supporting your whānau member's mental health during the assessment process?

Treatment

- How has this service benefited your whānau member?
- How were your whānau's cultural practices incorporated in the treatment?
- How were you educated about your whānau member's mental health?
- What [additional] services do you think whānau would benefit from?

Workforce

- Do you feel that the staff are able to support your whānau member culturally and clinically? How?
- How have the kaimahi/clinicians maintained your trust?

Exit – Outcome

- What is the best aspect of this service for your whānau?
- What mental health benefits has your whānau gained from this provider?

Improvements

- How could the service be improved?

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TE WHĀNAU O WAIPAREIRA

KOKIRITIA I ROTO I TE KOTAHITANGA

Progressively Act in Unity

Whānau Centre: Reception level 2, 6-8 Pioneer Street, Henderson
Postal: PO Box 21 081, Henderson, Auckland 0650
Phone +64 9 836 6683 0800 924 942 Facsimile +64 9 837 5378
www.waiwhanau.com