MĀ TŌ TĀTOU WHANAUNGATANGA E WHAKATAKI I TE RITENGA TIKA

Māori Mental Health Service Engagement – A Narrative Woven by Tāngata Whaiora, Whānau Members, and Māori Kaimahi

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ABSTRACT

Uplifting Māori mental wellbeing is a priority in Aotearoa with major national studies revealing Māori experience persistent and growing disparities in mental health outcomes. Notably, the mental health sector lacks explanations for the significant finding that Māori seek less help from mental health services despite the prevalence of psychological problems.

Following a Kaupapa Māori Research approach, this research sought to understand why service engagement was incommensurate with mental wellbeing needs among pakeke Māori and offer recommendations for how mental health practice could evolve to address this outcome. Semi-structured interviews were carried out with five tāngata whaiora, three whānau members, and four Māori kaimahi. The perspectives of these three rōpū were privileged as they reflected those with lived experience of engaging with, or carrying out mahi in, mental health services. Interview kōrero was analysed and developed into themes using thematic analysis. The collective perspectives of tāngata whaiora, whānau members, and Māori kaimahi were integrated within a narrative about how mental health care experiences influenced Māori service engagement.

Findings spoke to the importance of practicing within Te Ao Māori which involved upholding tikanga and mātauranga Māori, acknowledging cultural identity, facilitating reconnection with Māoritanga, and being whānau-centred in mental health care; developing genuine and meaningful relationships with tāngata whaiora and whānau; encouraging openness, support, and literacy around mental wellbeing; empowering Māori voices in assessment and intervention; and appropriate mental health sector resourcing. This research can help the mental health sector begin to understand why Māori seek less help from services and provide culturally and clinically responsive solutions for how

mental health practice can support and improve service engagement to uplift Māori mental wellbeing.

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GLOSSARY

Aotearoa	New Zealand
Aroha	Love, compassion
Ātua	Māori gods
Atua	Māori god
Awa	River
Awhi	Embrace
Haka	Traditional song and dance
Harakeke weaving	Flax weaving
Harirū	Greeting, hand shake
Hauora	Wellbeing, health
Hongi	Way of greeting which involves pressing noses
Hui	Meeting, gathering
Hūmarietanga	Humility
Iwi	Tribe
Ka kite	Farewell
Kai	Food
Kaiāwhina	Role in health and disability sector of kaimahi who helps, supports, and counsels
Kaimahi	Clinician, worker
Kaitiaki	Guardians
Kaitiakitanga	Guardianship, involves ensuring the mauri of people and natural elements is nurtured and healthy
Kanohi ki te kanohi	Face to face
Kapa haka	Group performance of the haka

Karakia	Prayer
Karanga	Call, to call out
Kaumatua	Male elder
Kaumātua	Māori elder
Kaupapa	Purpose, topic
Kaupapa Māori Mental Health Service	Mental health services which provide mental health care where Māori culture, knowledge, values, practices, and beliefs are privileged
Kaupapa Whānau	Group who shares a common purpose, identity, and responsibilities
Kawa	Marae protocol
Kete	Basket
Kia ora	Māori greeting, be well
Koha	Gift, offering
Kōhanga reo	Māori language preschool
Kōrero	Talk, conversation, speak
Kuia	Female elder
Mahi	Work
Mamae	Hurt, pain
Mana	Spiritual power, authority, prestige, based in the spiritual realm mana is inherently connected with tapu
Manaaki	To take care of, look out for, protect, support
Manaakitanga	Kindness, generosity, and respect for people
Manuhiri	Visitors, guests
Māori kaimahi	Māori clinician, worker

Māori kairangahau	Māori researcher
Māoritanga	Māori culture, practices, beliefs, ways of life
Marae	Focal point of Māori culture. Term used to describe the enclosed space in front of the wharenui but often refers to the whole complex
Mataku	Fear
Mātauranga Māori	Māori knowledge
Mauri	Life force, life principle, the essential quality and vitality of a being or entity
Mihi	Acknowledge, thank
Mihimihi	Greeting
Mihi-whakatau	Speech of greeting and welcome, cultural process observed within mental health services to welcome tangata whaiora and whānau
Mirimiri	Māori massage
Mokopuna	Grandchild, descendent
Noa	To be safe, ordinary, unrestricted, free from tapu
Pākehā	New Zealanders of European descent
Pakeke	Adult
Papatūānuku (Papa)	Earth mother and partner of Ranginui from whose union all life is born
Pēpē	Baby
Pepeha	Traditional speech expressing how Māori locate themselves within their whakapapa

Poi	Light ball attached to a string that is rhythmically moved to accompany waiata
Pono	Truth, honesty
Poroporoaki	To farewell, process to conclude an encounter
Pōwhiri	Traditional welcome ceremony, ritual of encounter
Pūrākau	Māori narratives of creation and custom passed down by tūpuna
Rangahau	Research
Rangatahi	Youth
Rangatira	Leader, chief (male or female), person of mana who can lead by uniting people together, esteemed
Ranginui (Rangi)	God of the sky and partner of Papatūānuku from whose union all life is born
Reo	Language
Rongoā Māori	Traditional Māori healing, Māori medicine
Rōpū	Group
Ta moko	Traditional Māori tattoo
Tamariki	Children
Tāne	Male
Tāne Mahuta	God of forests and birds who separated Ranginui and Papatūānuku and ascended the twelve realms to receive the three baskets of knowledge for humankind
Tangaroa	God of the ocean
Tāngata	People
Tangata whenua	Indigenous people

Tangihanga	Māori funeral ritual
Taonga	Gift, treasure
Tapu	Sacred, blessed, to set apart things, places, or people
Tauira	Student, pupil
Tautoko	Support
Tāwhirimātea	God of wind
Te Ao Māori	The Māori world
Te reo Māori	The Māori language
Te Tiriti o Waitangi	Founding document of Aotearoa, version of the Treaty of Waitangi signed by the majority of Māori rangatira whereby sovereignty was not ceded to the Crown.
Tika	Right, correct, appropriate
Tikanga Māori	Māori values and customs
Tino rangatiratanga	Self-determination, sovereignty
Tohu mātauranga	University degree, academic qualification
Tohunga	Māori healer, expert, scholar, authority
Tūpuna/ Tīpuna	Ancestors
Tūrangawaewae	Place of belonging, place to stand through whakapapa
Utu	Reciprocity, maintaining balance and harmony
Wahine	Woman, female
Wāhine	Women
Waiata	Song
Wairua	Spiritual energy, soul, spirituality defined by Māori worldviews
Wairuatanga	Spirituality

Wānanga	Discuss, conference, educational forum
Waka	Canoe
Whaea	Mother, aunt
Whaikōrero	Practice of oratory
Whakaaro	Thought, idea, understanding, opinion
Whakamā	Shame
Whakapapa	Genealogy
Whakataukī	Māori proverb
Whakawhanaungatanga	Process of making connections and building relationships
Whānau	Family or friends
Whanaunga	Relative, family member, kin
Whanaungatanga	Relationship, kinship, sense of familial connection
Whāngai	Cultural custom of adoption or fostering
Whare	House
Wharekai	Dinning hall
Wharenui	Meeting house
Whatumanawa	Seat of emotions
Whenua	Land

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Preface

Ko wai ahau?

Ko Maungakiekie te maunga

Ko Waitematā te moana

Ko Māhuhu ki te Rangi te waka

Ko Ngāti Whātua te iwi i te taha o tōku matua

Ko Ngāti Pākehā te iwi i te taha o tōku whaea

Ko Amelia Backhouse-Smith ahau

The inspiration and hopes which shaped this thesis are captured in the whakataukī that opens this rangahau: Mā tō tātou whanaungatanga e whakataki i te ritenga tika - *By our kinship we strive to meet our present and future needs.* Entering the Clinical Psychology Training Programme as a Māori candidate I aspired to be involved in a piece of rangahau that could be of value for my people. Given my future mahi lay within the mental health sector as a Māori clinical psychologist I was concerned by the outcome that we, as Māori, engaged less with services despite the unequal experience of mental health problems. This disconnect led me to question how I could reach my people and help nurture wellbeing, and motivated me to try and begin to make a positive, culturally responsive difference in the area of mental health service engagement for Māori. In my search to better understand this unmet need of my people there was much personal reflection and kōrero with different individuals. Towards the end, I felt working alongside tāngata whaiora, whānau members, and Māori kaimahi - the people with lived experience of service engagement and mahi within the mental health sector - to explore why Māori use services less and how mental health practice could evolve to support engagement may be a valuable way forward. On a personal level, I sought to learn what I could do in my own mahi to be most helpful for whānau Māori.

Throughout this journey, I have been privileged to collaborate with Māori tāngata whaiora, whānau members, and kaimahi as a Māori kairangahau and kaimahi who walks between the worlds of Te Ao Māori and Te Ao Pākehā. I believe each position not only facilitated the development of meaningful connections and a richer empathy and insight into the experiences shared, but rounded my understanding of Māori mental health service engagement. I have faith that as Māori we have the potential to create a renewed narrative of wellbeing and empowerment in mental health. We have already begun the journey.

Chapter One: Māori Vitality and Resilience

Tawhiti rawa atu to tātou haerenga te kore haere tonu, maha rawa atu o tātou mahi te kore mahi tonu.

We have come too far not to go further, we have done too much not to do more.

Māori, the tangata whenua of Aotearoa, possess a strong and vibrant cultural heritage which contributes towards mental, and holistic, wellbeing (Durie, 2001). Over one thousand years ago, Māori arrived in Aotearoa having voyaged in waka across the Pacific Ocean from Hawaiki. Aboard these waka were our tūpuna, custodians of mātauranga Māori and Māoritanga: Māori knowledge, culture, practices, values, and beliefs. With these ways of life Māori flourished in Aotearoa (Harris & Matutina Williams, 2014).

Centuries later, Māori and the Crown intended to form a partnership through the signing of Te Tiriti o Waitangi in 1840. If honoured, Te Tiriti o Waitangi could have provided mutual advancement for Māori and Pākehā in health, education, technology, and trade whilst preserving Māori culture and the sovereignty Māori had over their lives and land (Matiu & Mutu, 2003). However, the outcome of Te Tiriti o Waitangi was colonisation, which detrimentally affected Māori wellbeing through the loss of whenua, reo, mātauranga, tikanga, and whānau structures (Durie, 1998; Jones, 2000).

Nevertheless, Māori have demonstrated endurance and resilience amidst the negative outcomes of colonisation (Durie, 2011). In the area of mental health, Māori have initiated movements to reclaim spaces that value Māori approaches towards understanding and treating psychological problems (Waitoki & Levy, 2016). Examples of these accomplishments include the creation and increasing application of Māori models of holistic wellbeing such as Te Whare Tapa Whā (Durie, 1984) and Te Wheke (Pere, 1991); the development of Māori centred assessment paradigms such as the Meihana Model (Pitama et al., 2017; Pitama, Huria & Lacey, 2014;) and assessment measures like Hua Oranga (Kingi, 2002); the cultural adaptation of evidence-based interventions for Māori (Bennett, Flett & Babbage, 2016); the provision of Kaupapa Māori mental health services; the establishment of Māori workforce development programmes including Te Rau Matatini and Te Rau Puawai; and the progressive integration of Māori knowledge and practices into national mental health strategies and training programmes (Durie, 2011; Macfarlane, Blampied & Macfarlane, 2011; Waitoki & Levy, 2016).

However, these positive discourses about Māori mental health can be masked by the tendency to use deficit-focused frameworks in research and clinical practice with Māori (Baxter, 2008; Bishop, 1998). Māori authors have articulated that dominant research approaches were developed according to Pākehā values which do not legitimate Māori knowledge, processes, or ways of being and implicitly position Māori as incapable of managing difficult lived experiences (Bishop, 1998; Smith, 2012). This influence is evident in clinical practice where Johnstone and Read (2000) reported psychiatrists perceived Māori were biologically predisposed towards mental health problems and that mātauranga Māori and Māoritanga were not important. In comparison a strengths-based approach empowers Māori by recognising the culture of wellbeing Māori are descended from, situating Te Ao Māori as valid and normal and, importantly, that Māori are competent in developing solutions to address problems they experience. As such, this thesis will adopt a strengths-based position to achieve its aim of enhancing the mental wellbeing of tāngata whaiora and whānau by offering useful insights and recommendations towards understanding and improving Māori engagement with mental health services. The whakataukī at the beginning of this chapter captures this position; it can be understood as collectively recognising the significant accomplishments Māori have made in mental health, along with the need to continue our mahi in this area to facilitate the ability of present and future generations of Māori to flourish as our tūpuna did before us.

Thesis Structure

This thesis is divided into ten chapters. Chapter One provides an overview of this thesis, introduces the strengths-based position it will adopt, and defines terminology used in the current research. Chapter Two outlines the early status of Māori mental health, followed by how Māori mental health outcomes have been measured, and why Māori mental health service engagement is an important issue. Chapter Three reviews the literature regarding the relationship between mental health care experiences and service engagement among other Indigenous peoples. Chapter Four discusses the modest body of New Zealand research about the nature of Māori mental health care experiences. Chapter Five outlines the rationale for the current research in consideration to the previous four chapters, along with the research aims and questions. Chapter Six details the methodology used for the current research and the subjective positioning of the researcher. Chapters Seven, Eight, and Nine present the research findings with tāngata whaiora, whānau members, and Māori kaimahi, respectively. Chapter Ten discusses the significance and meaning of the findings and offers culturally and clinically responsive recommendations to support Māori mental health service engagement. It will also consider the strengths and limitations of the study, future research directions, and final conclusions.

Terminology

Engagement. In the context of this thesis engagement refers to the initial, ongoing, and/or future intentions to access mental health services among Māori. This particular definition was chosen for two principal reasons. Firstly, it aligns with the objectives of New Zealand mental health strategies and findings from major national studies about Māori service use patterns (Baxter, Kingi, Tapsell & Durie, 2006; Ministry of Health, 2002, 2008; Oakley Browne & Wells, 2006a). Secondly, this definition can capture the different positions Māori may occupy in relation to mental health service use (Pomare, 2015). Engagement has been similarly defined in research with Indigenous populations that seek to improve the use of, and experiences with, mental health services (Berry & Crowe, 2009).

Mental health services. Within this thesis, this term refers to specialist mental health services that work with Māori who experience mental health problems, ranging from community mental health services for adults or children and adolescents to acute and inpatient mental health services.

Tangata whaiora. The term tangata whaiora is used to describe someone who has lived experience of mental health difficulties and has engaged with mental health services, either in the past or present.

Whānau member. This term refers to someone who is the relative of a past or present tangata whaiora and who can speak to her or his experience of supporting their whanaunga with mental health service engagement.

Māori kaimahi. The term Māori kaimahi is used to describe the types of Māori mental health professionals' that tāngata whaiora and whānau members may interact with in mental health services. This can include, but is not limited to, psychologists, psychiatrists, counsellors, social workers, mental health nurses, support workers, or Māori cultural workers.

Use of Māori Kupu

Throughout this thesis Māori kupu (Māori words) are used without the English translations being given. Instead, a glossary of Māori kupu is provided at the beginning of this thesis. The reasoning behind this decision is that frequently English translations do not fully capture the essence and perspectives of Te Ao Māori that Māori kupu can (Matiu & Mutu, 2003). Furthermore, a school of thought exists that the use of Māori kupu can help engage individuals towards understanding, and perhaps even using, a Māori worldview. It is the author's hope this decision to use Māori kupu may encourage the reader to embark on such a journey in the spirit of our bicultural nation.

Chapter Two: Māori Mental Health and Service Engagement

Improving Māori mental wellbeing is a significant priority for the New Zealand mental health sector (Baxter, 2008; Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2002, 2008). Research indicates Māori disproportionately experience psychological problems and have lower engagement rates with mental health services (Baxter et al., 2006; Government Inquiry into Mental Health and Addiction, 2018; Oakley Browne & Wells, 2006a). In order for strategies and studies to effectively address these negative mental health outcomes, it is important to examine Māori mental health from historical and contemporary perspectives (Durie, 2001; Wratten-Stone, 2016). As such, this chapter briefly outlines the early and historically dominant status of Māori mental health. An overview of how Māori mental health outcomes have been measured and the current position of Māori mental health are then provided. To conclude, the importance of addressing Māori mental health service engagement to improve Māori mental wellbeing is considered.

Historical Perspectives of Māori Mental Health

The disproportionate representation of Māori in negative mental health outcomes is a recent development in Māori history, emerging only during the mid-1970's (Durie, 2001; Kingi, 2005). Traditionally the status of Māori mental health has been positive (Kingi, 2005). For instance, early research regarding Māori mental health by Beaglehole and Beaglehole (1946) sought to understand the relative absence, opposed to prevalence, of psychological problems among Māori. The authors proposed that Māori culture, in particular whānau structures, served as a protective factor against Māori developing psychological problems or experiencing a reduced quality of life if they occurred. In comparison, the study reported a high rate of psychological problems among Pākehā.

However, Beaglehole and Beaglehole (1946) suggested that similar to other Indigenous peoples, the detrimental effects of colonisation could cause the positions between Māori and Pākehā in mental health to be reversed in future.

Approximately three decades later this prescient conclusion became apparent in official New Zealand mental health statistics. Between the period 1970 and 1974, the mental health status of Māori and Pākehā converged for the first time (Durie, 2001). The disparities in Māori and Pākehā mental health, which subsequently developed in 1975, have grown significantly such that Māori mental health is now a pertinent issue. The changing status of Māori mental health can be reflected in the objectives of contemporary research that focus on understanding and reducing these disparities (Baxter, Kokaua, Wells, McGee & Oakley Browne, 2006; Bushnell, 2005).

Measuring Māori Mental Health Outcomes

Māori mental health outcomes were previously documented using indices such as hospital admission, suicide, and incarceration rates (Durie, 2001). According to these statistical records there was a high prevalence of psychological problems among Māori. Although these indices provided the most extensive information available at the time, they could not accurately measure the state of Māori mental health as they were not based on a representative New Zealand community population. Consequently, these statistical records could alternatively have reflected greater use of psychiatric facilities by Māori; the change in how the Māori population was measured from blood-quantum to self-identification; or low use of community health services (Durie, 2001).

Recently, Māori mental health outcomes have been more accurately measured in research with increasingly representative populations. The initial study was conducted by the Mental Health and General Practice Investigation (MaGPIe) research group at the

University of Otago. The study examined the prevalence of psychological problems among individuals who attended general practices (Bushnell et al., 2003). Māori were observed to present to primary health care with higher rates of psychological problems, independent of socioeconomic disadvantage, compared to non-Māori (Bushnell, 2005). Despite this, treatment for psychological problems was offered to Māori and non-Māori by general practitioners at similar rates. The MaGPIe research group suggested the findings supported the need for a greater understanding of culture-specific factors in Māori mental health problems, and the development and facilitation of access to culturally appropriate mental health services (Bushnell, 2005). However, as Māori participants were selectively drawn from a population of general practice attendees, the pattern of psychological problems and engagement with health services representative of the Māori community population could not be determined (Bushnell, 2005). This limited the applicability of the MaGPIe study findings in Māori mental health outcome initiatives.

Te Rau Hinengaro: The New Zealand Mental Health Survey[1] is one of the most recent studies which has provided greater certainty regarding the mental health status of Māori. Te Rau Hinengaro was a large-scale study conducted to elucidate the epidemiology of major psychological problems and service use patterns within a representative New Zealand community population (Oakley Browne & Wells, 2006b). Findings confirmed the high prevalence of mental health problems among Māori. Approximately one in three Māori (29.5%) experienced a psychological problem within a 12-month period (Baxter et al., 2006), while lifetime prevalence rates indicated one in two Māori (50.7%) would meet diagnostic criteria for a psychological problem within their lifespan. One of the most noteworthy findings of Te Rau Hinengaro was that Māori who experienced psychological problems used mental health services less and delayed

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[1] Hereafter referred to as Te Rau Hinengaro

seeking help until wellbeing was significantly affected (Baxter, et al., 2006; Oakley Browne & Wells, 2006a). Specifically, over a 12-month period, two thirds of Māori (67.5%) with a psychological problem did not engage with services. Based on these findings, a greater understanding about the use of these services among Māori and the ability of services to effectively respond to Māori mental wellbeing needs was deemed necessary (Baxter, 2008).

The Government Inquiry into Mental Health and Addiction: He Ara Oranga[2] was commissioned in 2018 amidst growing concerns about the ability of mental health services to meet the mental wellbeing needs of communities within Aotearoa. He Ara Oranga sought the perspectives of people with lived experience of mental health problems, whānau, and practitioners and service providers about the current state of the mental health sector and changes that were required moving forward. Notably, findings reported that in the decade following Te Rau Hinengaro, Māori continued to experience disparities in mental health outcomes including service engagement rates that were disproportionate to mental wellbeing needs. Recommendations identified that improving Māori mental wellbeing and ability to access services for culturally and clinically responsive support was a priority (Government Inquiry into Mental Health and Addiction, 2018).

Addressing Māori Mental Health Service Engagement

Findings from these national studies indicate Māori mental health service engagement is incommensurate with the prevalence of psychological problems (Baxter et al., 2006; Baxter, 2008; Government Inquiry into Mental Health and Addiction, 2018). Although improving Māori mental wellbeing is a priority of the New Zealand mental

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[2] Hereafter referred to as He Ara Oranga

health sector, an understanding about what contributes towards low service engagement rates and how services can respond to needs in a culturally and clinically responsive manner is absent (Baxter, 2008; Government Inquiry into Mental Health and Addiction, 2018). As such, research is needed to explore why Māori engage less with mental health services. This will enable solutions to be offered for how mental health practice could evolve to improve service engagement and uplift Māori wellbeing.

Chapter Three: Indigenous Mental Health Care Experiences and Service Engagement

The prevalence of psychological problems and underutilisation of mental health services has been widely reported among Indigenous populations, including Australian Aboriginal and Torres Strait Islander, Native American/American Indian, Alaskan Native, First Nations, Métis, and Inuit (McIntyre et al., 2017). Colonisation is recognised as a key factor in the poor mental health status of Indigenous people whereby cultural knowledge, practices, kinship ties, spirituality, and connection with the land were lost (George, Morton Ninomiya, Graham, Bernards & Wells, 2019; Isaacs, Maybery & Gruis, 2013). To redress the issue of unmet mental wellbeing needs experienced among Indigenous populations, research has evaluated how mental health care experiences may influence service engagement from the perspectives of clients, families, and clinicians (Berry & Crowe, 2009). Similar to this thesis, these studies adopted a strengths-based approach which recognised Indigenous populations are capable of developing solutions to uplift the wellbeing of their people (Goodkind, Gorman, Hess, Parker & Hough, 2015; Heart et al., 2016).

It is important to acknowledge the literature considered within this chapter was predominantly drawn from research with Australian Aboriginal and Torres Strait Islander populations. While disparities in mental health service engagement have been identified among other Indigenous peoples, studies are yet to explore why these outcomes are present and how they could be addressed. Notwithstanding this, the available literature suggests mental health service engagement is shaped by experiences of culturally appropriate mental health care, meaningful relationships, communication, flexible practice, and shame, mental health literacy, and mistrust. This chapter will discuss these findings and consider how they can inform the current research.

Culture in Mental Health Care

Mental health care experiences and service engagement intentions among Indigenous peoples are strongly connected to the provision of culturally appropriate assessment and intervention. Indigenous clients, families, and clinicians have articulated this involves using traditional knowledge and customs alongside clinical competencies, facilitating cultural reconnection, working with family in mental health care, and embedding organisational standards of practice in an Indigenous worldview (Berry & Crowe, 2009; Gone & Trimble, 2012; Hepworth et al., 2015; Isaacs et al., 2012; Isaacs et al. 2010; Vicary, 2002; Vicary & Bishop, 2005; Vukic et al., 2009; Westerman 2004).

Wellbeing is conceptualised holistically within Indigenous cultures where the health of a person is inherently tied to kinship, environment, spirituality, and traditional knowledge and practices (Young & Koopsen, 2010). As holism shapes client and familial lived experiences of mental health problems, case formulations and interventions should be informed by a cultural perspective to ensure the care provided is helpful and supportive of service engagement (Berry & Crowe, 2009; Mehl-Medrona, 2009; Westerman, 2004). Furthermore, Indigenous peoples have expressed a preference to engage with mental health services that integrate traditional practices within clinical interventions. As an example, American Indian, Alaskan Native, and First Nations clients related the opportunity to participate in customs that promoted healing such as smudging, drumming circles, or sweat lodges alongside Western therapies improved their wellbeing and built confidence to use mental health services (George et al., 2019; Gone & Trimble, 2012). This privileging of cultural practices also created space for clients to reconnect with and strengthen their cultural identity as part of recovery.

Culturally appropriate care also recognises kinship is central to the mental wellbeing journey of Indigenous clients, both during and beyond service engagement. When an individual experiences unwellness their family and community provide support through nurture, guidance, advocacy, or traditional healing (Berry & Crowe, 2009; Vicary & Bishop, 2005; Westerman, 2004). Families initiate mental health service contact only when they feel unable to uphold the wellbeing of their kin as a support system. Therefore, given the collective orientation to wellbeing, clinicians are advised to collaborate with family in mental health care such as seeking their perspective during assessment and utilising interventions which situate the client within their familial context.

Notably, to improve service engagement, organisational standards of practice need to be informed by an Indigenous worldview to ensure culturally appropriate care is prioritised and delivered across the mental health sector (Coffin, 2007; Westerman, 2004). Services can support this change by adopting guidelines which outline culturally competent practice such as attending to relationality, holistic wellbeing, and empowerment in mental health care with Indigenous clients and families (Mehl-Medrona, 2009). Although such systemic change is long-term, implementing these initiatives is integral to ensure Indigenous service engagement becomes commensurate with mental wellbeing needs (Hinton et al., 2015).

Looking ahead, suggestions by Indigenous clients, families, and clinicians on how to facilitate culturally appropriate mental health care have included clinicians involving themselves within Indigenous communities to develop an authentic appreciation of traditional customs, language, and relationship structures (Berry & Crowe, 2009; Vicary, 2002). Likewise, when non-Indigenous clinicians demonstrate an openness to listen and learn from clients and families about culture and integrate these understandings in practice, positive outcomes such as reclamation of mental wellbeing and improved service engagement can be conferred (Vicary & Westerman, 2004). Furthermore, making space for Indigenous communities to contribute their resources in the provision of mental health care, for instance having elders present in support and mentoring roles, was a solution put forward by clients and families (Hinton et al., 2015).

Relationships

Relationality is essential to Indigenous peoples' understanding of the world and way of living (Westerman, 2004). Accordingly, studies indicate that relationships in mental health care shape the confidence and willingness of Indigenous clients and families to engage with services (Berry & Crowe, 2009; Hepworth et al., 2015; Hinton et al., 2015; Isaacs et al., 2012; Jobling et al., 2016; Vicary & Bishop, 2005; Vicary & Westerman, 2004; Vukic et al., 2009; Westerman, 2004).

At the beginning of the mental health care journey, meaningful relationships between clients, families, and clinicians can be nurtured by taking the time and effort to make connections and understand one another prior to starting clinical intervention work. This relationality process is characterised by reciprocity where each person present shares cultural or familial affiliations, occupational background, and interests (Sheldon, 2001). Indigenous people have articulated this culturally appropriate integration of personal and professional identities by clinicians builds trust in the therapeutic relationship, placing them at ease within service environments and sustaining engagement during less positive care experiences (Hepworth et al., 2015; Jobling et al., 2016; Vicary & Westerman, 2004). Similarly, Indigenous and culturally competent clinicians described prioritising relationality as a fundamental part of responsive practice that uplifted wellbeing and promoted service use (Hinton et al., 2015).

A unique cultural connection is present among Indigenous clients, kinship groups, and clinicians that influences mental health service engagement. For example, the opportunity to work with an Indigenous clinician supported the decision by some clients and families to access services (Berry & Crowe, 2009; Hepworth et al., 2015; Isaacs et al., 2012; Vicary & Bishop, 2005; Vukic et al., 2009). A shared cultural identity was perceived to offer a deeper understanding and empathy of Indigenous peoples lived experiences, worldview, and cultural processes which subsequently contributed towards progress in recovery. Alternatively, other Indigenous people have indicated the provision of mental health care by a clinician with the same cultural identity was a deterrent of service engagement (Hepworth et al., 2015; Vicary & Westerman, 2004). Given the extensive familial connections within Indigenous communities, clients expressed uncertainty about the confidentiality of care and concerns their mental health difficulties would become known if the clinician belonged to the same kinship group (Lee, Harrison & Conigrave, 2014).

Within these studies, the perspectives of clients, families, and clinicians were sought regarding how services could better reach Indigenous people who experienced mental health problems. It was recommended clinicians and service providers place effort into developing meaningful relationships, as these connections were the foundation for responsive assessment and intervention experiences that facilitated engagement. Additionally, the suggestion was given that non-Indigenous clinicians develop genuine relationships with the wider cultural community by spending time with Indigenous people in a social context. These bonds would create a pathway for accessing mental health services that clients and families trusted (Isaacs et al., 2012). Furthermore, although experiences varied, the majority of clients and families proposed expanding the

Indigenous mental health workforce as the opportunity to work with an Indigenous clinician ultimately encouraged service engagement (Hepworth et al., 2015).

Relationality in mental health care also applied to the dynamics among professions, teams, and services involved in supporting wellbeing. Indigenous clients and families indicated the process of navigating various uncoordinated mental health services was a barrier to engagement (Hinton et al., 2015). This issue was affirmed by clinicians and mental health providers who suggested improved relationships between services and disciplines such as greater information sharing and understanding about the type of treatment offered could lead to a more integrated care pathway that facilitated Indigenous engagement (Hinton et al., 2015; Kowanko et al., 2009).

Communication: Active Listening and Reciprocal Conversations

Communication enables a foundation of trust and understanding to be built among Indigenous peoples and clinicians in mental health care, making it influential in shaping the nature of care experiences and service engagement (Berry & Crowe, 2009; Eley et al., 2006; Westerman, 2004). Studies suggest effective and culturally appropriate communication is underpinned by active listening and reciprocity in conversations (Vicary & Bishop, 2005). In mental health practice with Aboriginal and Torres Strait Islanders this positive care experience is enacted through yarning, the traditional approach to communication where important issues are safely discussed in a relaxed, conversational manner (Bessarab & Ng'andu, 2010). For example, therapeutic interactions open with social yarning, a process of forming trust and relationships whereby clinicians express regard for who the client and their family are as people by attentively listening and talking about shared life experiences, personal interests, family, or ties to the local country (Lin, Green & Bessarab, 2016; Sheldon, 2001). The development of rapport enables the transition to clinical yarning where information relating to social and emotional wellbeing can be gathered in conversation. By using open ended, non-directive questions and comfortable, non-judgemental silence Indigenous people are supported to share their lived experience of unwellness. During clinical yarning, stories, metaphors, and visual aids can also be used to help clients and families understand mental health problems and develop a plan for wellbeing in a culturally and clinically meaningful way (Lin et al., 2016, Westerman, 2004). Given miscommunication and misunderstanding often lead to unhelpful care experiences, adopting Indigenous communication approaches in practice can facilitate service engagement (Eley et al., 2006).

Indigenous kinship structures inform who represents the client and family in service interactions alongside whose perspective is considered in mental health care planning, decision-making, and interventions. Within Aboriginal and Torres Strait Islander cultures community elders, grandparents, parents, or aunts and uncles may act as a family spokesperson and contribute to conversations and choices about mental health care for the client. Consequently, to ensure mental wellbeing needs are appropriately met in care and service engagement is encouraged, it is recommended time and space be provided for Indigenous communication processes to take place.

Flexible Practice

Belonging to a collectivist culture informs how Indigenous people relate with and support one another during times of wellness and unwellness. With regard to mental health practice and service engagement, research suggests this translates to flexibility in the time and location that care is provided (Berry & Crowe, 2009; Eley et al., 2007; Hinton et al., 2015; Isaacs et al., 2012; Vicary & Westerman, 2004). For instance, clinicians indicated allowing appointment times to be adjusted and working with clients and families outside of standard service hours increased the ability of Indigenous people to access mental health care (Vicary & Westerman, 2004). Correspondingly, clients and families spoke to how carrying out assessments and interventions within an environment that was culturally suitable and geographically accessible positively contributed towards service engagement intentions. As Indigenous people can present with greater distress in service settings compared to their daily cultural environment, clinicians are advised to explore whether differences exist in the degree of unwellness between the two contexts (Berry & Crowe, 2009). However, studies suggest experiences and willingness to engage with services could be most effectively enhanced by providing mental health care within the local Indigenous community, such as at the school or by the riverside (Isaacs et al., 2012). In a familiar and comfortable environment clients and families would be inclined towards greater honesty about their lived experiences of unwellness, enabling an accurate formulation and responsive intervention approach to be developed. To enact this flexibility in practice for the benefit of Indigenous people, clinicians indicated greater resourcing and reduced caseloads in the mental health sector would be necessary (Isaacs et al., 2012).

Shame, Literacy, and Mistrust

Indigenous engagement with mental health services is detrimentally affected by the interconnected experiences of shame, mistrust, and literacy associated with psychological problems and help-seeking behaviour (Hepworth et al., 2015; Hinton et al., 2015; Isaacs et al., 2012; Isaacs et al., 2010; Lee et al., 2014; McKendrick, 2007; Vukic et al., 2009). Shame is considered a particularly challenging emotion to navigate in mental health as it originates internally and externally according to a person’s worldview and societal norms (Corrigan, 2004). Indigenous clients have described experiences of shame regarding their kin group learning they received mental health care or their unwellness being negatively re-interpreted by the cultural community if a formal psychiatric diagnosis was given (Hepworth et al., 2015; Hinton et al., 2015; Isaacs et al., 2013). Therefore, to protect themselves and their family from shame, clients reported delaying or avoiding using mental health services despite compromised wellbeing (Corrigan, 2004; Isaacs et al., 2013).

Among Indigenous people shame is compounded by low mental health literacy: the ability to recognise when Western understandings of mental unwellness may be relevant and knowledge of interventions and services which can help manage these difficulties (Hinton et al., 2015; Mental Health Foundation, 2019). In example, family members relayed they did not encourage their kin to use services as they were unaware organisations that provided specialised support to live well with mental health problems existed (Lee et al., 2014). Similarly, Indigenous people described being fearful about engaging with mental health services because of inaccurate and unhelpful discourses such as being indefinitely admitted to an inpatient ward if help was sought (Eley et al., 2007). Clients also articulated they were mistrustful of services whereby they did not expect to be treated respectfully (Fielke, Cord-Udy, Buckskin & Lattanzio, 2009; Isaacs et al., 2012; McKendrick, 2007). Past experiences of receiving inequitable care because of their cultural identity cultivated this mistrust and led to the disinclination to use mental health services.

Indigenous people proposed initiatives to de-stigmatise mental health problems and help-seeking behaviour were a potential solution to address shame, literacy, and mistrust and promote willingness to reach out to services. This included delivering mental health care in a safe space where Indigenous people were present in a staff capacity and privacy was clearly explained as a priority to reduce shame (Hinton et al., 2015).

Likewise, the provision of culturally appropriate education programmes and readings materials with information on psychological problems and available services was suggested to improve mental health literacy among the Indigenous community (Eley et al., 2006; Vukic et al., 2009).

Summary

In seeking to understand and provide solutions for unmet mental wellbeing needs among Indigenous peoples, research has evaluated the influence of care experiences on service engagement. Findings indicated the provision of culturally appropriate care whereby Indigenous knowledge and customs were integrated into clinical practice, collaboration with kinship groups took place, and organisational standards of practice were grounded in an Indigenous worldview promoted service engagement. The dedication of time and effort by clinicians into developing genuine relationships with clients and families fostered trust to use services, while positive relational dynamics between professions and services created an integrated, accessible pathway to mental health care. Likewise, mental health service engagement intentions and the ability to take part in care were enhanced through privileging Indigenous communication approaches that created opportunities for clients to share their narrative of unwellness and for kinship groups to contribute towards decision-making and planning; flexibility in practice regarding the time and environment assessment and intervention were offered; and improving mental health literacy to reduce shame and mistrust associated with help-seeking behaviour.

Taken together, the aims and outcomes of the literature reviewed here can guide the current research to understand why Māori engage with service less and importantly how mental health practice could evolve to uplift Māori mental wellbeing in Aotearoa.

Chapter Four: Māori Mental Health Care Experiences

New Zealand research has not directly examined how mental health care experiences can influence service engagement among pakeke Māori. To date, studies have only investigated what constitutes helpful or unhelpful mental health care experiences for pakeke Māori. This modest body of research has considered the perspectives of tāngata whaiora, whānau members, or Māori kaimahi across different levels of mental health services. This chapter will discuss the findings from these studies and how they inform the aims of the current research. Māori concepts relevant to understanding this literature will also be explained.

Supporting Relationships

Relationships are central to Māori culture, influencing social processes and individual and collective mental wellbeing (Durie, 2001). Notably, research suggests meaningful relationships between tāngata whaiora, whānau, and kaimahi in mental health care can influence Māori service experiences (Brannelly, Boulton & te Hiini, 2013; Eade, 2014; Elder, 2008; McClintock, Moeke-Maxwell & Mellsop, 2011; McClintock, Tauroa & Mellsop, 2013; Mooney, 2012; Pomare, 2015; Tricklebank, 2017; Wharewera-Mika, 2012). Consistent with Te Ao Māori, relationality can be privileged in mental health care through whakawhanaungatanga: the process of making connections and forming whānau relationships with people using culturally appropriate practices. Whakawhanaungatanga communicates a sense of connectedness between individuals and an implicit commitment to the relationship being established (Bishop, 1998). As such, upholding tikanga in assessment and intervention can facilitate meaningful relationships and create helpful care experiences for Māori.

Research has explored how Māori kaimahi approach relationality in mental health practice with tāngata whaiora and whānau (Brannelly et al., 2013; Elder, 2008; Mooney, 2012; Wilson & Baker, 2012). Collectively, Māori social workers, nurses, and psychiatrists described that their knowledge and experience of Te Ao Māori enabled them to feel comfortable developing deeper, meaningful relationships with tāngata whaiora and whānau. This included expressing aroha, awhi, and manaakitanga within interactions and engaging in whakawhanaungatanga by sharing whakapapa connections and similar lived experiences (Brannelly et al., 2013; Elder, 2008; Mooney, 2012; Wilson & Baker, 2012). Māori kaimahi focused on nurturing relationships with the awareness they supported tangata whaiora and whānau to fully participate in mental health care and experience services as helpful (Wilson, McKinney & Rapata-Hanning, 2011). Furthermore, in line with tikanga and Māori perspectives in mental health disciplines this relationality in practice was also ethical and tika (Waitoki & Levy, 2016). Māori kaimahi acknowledged following tikanga carried the potential of increasing tangata whaiora and whānau expectations of the service along with the likelihood of kaimahi burnout (Mooney, 2012). In recognition of this, Māori kaimahi mentioned the importance of clearly outlining boundaries in roles, responsibilities, tikanga processes, and whanaungatanga principles with tāngata whaiora and whānau from the outset of engagement (Mooney, 2012). As such, from the position of Māori kaimahi, creating beneficial experiences for Māori with mental health services may involve a balance between honouring Māori values of relationality and self-care.

A separate body of literature that explored tāngata whaiora experiences with mental health services suggested this approach to relationality in mental health care was appreciated (Eade, 2014; Pomare, 2015; Tricklebank, 2017; Wharewera-Mika, 2012; Wharewera-Mika et al., 2016). Tāngata whaiora articulated they had a sense kaimahi genuinely cared for their wellbeing and that they deserved to be taken care of when empathetic, respectful, trusting, and collaborative relationships were present (Tricklebank, 2017; Wharewera-Mika, 2012). Likewise, being able to laugh with kaimahi helped to create a valued relationship and alleviate any anxiety tāngata whaiora felt in using services (Pomare, 2015). In comparison, tāngata whaiora have indicated the development of meaningful relationships was prevented by the reluctance of kaimahi to interact with them and their whānau (Eade, 2014; Wharewera-Mika, 2012). For example, rather than getting to know tāngata whaiora on the inpatient mental health ward, nurses reportedly concentrated on the computers at the nursing station thereby appearing distracted and unapproachable. An absence of continuity of care also hindered relationships (Eade, 2014; Wharewera-Mika, 2012). The continual rotation in shift rosters made it difficult for tāngata whaiora to establish rapport with any particular kaimahi and oftentimes left them confused about their mental health care plan. Collectively, these findings support the value of relationality where the presence or absence of meaningful relationships respectively encouraged helpful or unhelpful mental health service experiences for tāngata whaiora (Eade, 2014; Wharewera-Mika, 2012).

These Māori values of engagement and relationality are epitomised in the approach used to manage the power imbalances inherent in relationships between kaimahi, tāngata whaiora, and whānau (Elder, 2008; Mitchell, 2014). Research has identified the benefits of reducing relational power imbalances from the perspectives of these three groups (Eade, 2014; Elder, 2008; Wharewera-Mika, 2012). Sharing whakapapa during whakawhanaungatanga was highlighted as an effective tikanga process to equalise and strengthen the relationship. One Māori psychiatrist reported that after sharing her whānau, tūpuna, and whenua connections, the whānau she was working with exclaimed: "Ah, she's one of us!" (Elder, 2008, p.201). Subsequently, this led to the delineation of power inequalities which built rapport and created the space for the tangata whaiora and whānau to participate in mental health care.

Given wellbeing is collectively determined for many Māori, whānau are often an essential support for tāngata whaiora in the experience of unwellness and journey through mental health care (Durie, 2001; Pitama et al., 2014; Te Pou o te Whakaaro Nui, 2010). The definition of whānau is diverse and varied; whānau can refer to biological relations, friends, neighbours, households, or a group who shares a common purpose, identity, and responsibilities which is also known as a kaupapa whānau (Durie, 2001; Lawson-Te Aho, 2010). In this respect, rangatahi tāngata whaiora and whānau articulated helpful experiences and access of Child and Adolescent Mental Health Services (CAMHS) was supported by whānau-centred practice where whānau were actively included in the development and implementation of mental health care plans (McClintock et al., 2011; McClintock et al., 2013; Pomare, 2015).

Tāngata whaiora and whānau considered the relational dynamics between organisations that supported wellbeing an important part of the relationships they had with mental health services. Collaboration between these organisations made the mental health system easier to navigate for Māori (McClintock et al., 2011; Tricklebank, 2017). This involved services working together to provide on-going mental health care, accommodation, transportation, and social support following referral to other mental health agencies or discharge from inpatient services (Wharewera-Mika, 2012; Wharewera-Mika, 2016).

Communication and Language

Communication in mental health services facilitates the sharing of experiences, values, worldviews, and information between tāngata whaiora, whānau, and kaimahi.

Guidelines for effective communication and language with Māori in mental health care are provided by Te Pou o te Whakaaro Nui (2010). Several studies explain how these suggested communication and language practices could influence mental health care experiences for Māori (Eade, 2014; McClintock et al., 2011; McClintock et al., 2013; Pomare, 2015; Wharewera-Mika, 2012; Wharewera-Mika et al., 2016).

During the initial meeting with tāngata whaiora and whānau, it is valuable to clearly outline the purpose and processes of the intervention approach that will be used to build an understanding of the 'why' and 'how' of mental health care (Te Pou o te Whakaaro Nui, 2010; Wharewera-Mika et al., 2016). This explanatory practice also offers an opportunity to clarify preferences and expectations of care between kaimahi, tāngata whaiora, and whānau. Research supports the importance of having a workforce that is capable of providing mental health education when working with Māori. Findings revealed tāngata whaiora and whānau described helpful care experiences when information about the clinical and cultural supports available within the service or mental health system were shared with them (McClintock et al., 2011). Another feature of good communication that influenced care experiences was active listening by kaimahi (McClintock et al., 2011; McClintock et al., 2013). Active listening involved kaimahi asking tāngata whaiora how they were feeling in a genuine manner and privileging their perspectives regarding their needs, concerns, understandings, or aspirations in mental health care (McClintock et al., 2011; Pomare, 2015). Within the context of these discussions, tāngata whaiora appreciated the use of an open, non-directive conversational style where kaimahi waited until tāngata whaiora felt ready to open up instead of pressuring them to talk (Pomare, 2015).

Collaborative decision-making and treatment planning among tāngata whaiora, whānau, and kaimahi has been described as an integral part of effective communication

(Eade, 2014; McClintock et al., 2013; Wharewera-Mika, 2012). Tāngata whaiora said they felt their voices were respected in mental health care during these shared conversations. Similarly, whānau of rangatahi tāngata whaiora indicated that services were experienced as responsive when kaimahi acknowledged and considered their input during assessment and treatment planning (McClintock et al., 2013). In contrast a lack of communication with whānau during significant phases of mental health care, such as discharge, constituted negative service encounters (Gibbs, Dawson, Forsyth, Mullen & Te Oranga Tonu Tanga, 2004).

Another approach to collaborative engagement which was positively received by tāngata whaiora and whānau were whānau hui (Wharewera-Mika, 2012). At these hui whānau were invited to attend the inpatient service by the Kaupapa Māori mental health team. During a conversation with kaimahi and tangata whaiora, whānau were updated about the progress of their whanaunga in treatment (Wharewera-Mika, 2012). Efforts to ensure there was appropriate time and space to work with whānau to help them support tāngata whaiora also included maintaining ongoing communication in between visits to the service. For example, follow-up calls to check that steps in the mental health care plan were being taken, such as visiting the general practitioner, conveyed to whānau a sense kaimahi and services cared (Pomare, 2015).

The importance of using clear, culturally appropriate language during communication with Māori in mental health care has been strongly emphasised in guidelines and research (Mauri Ora Associates, 2006; Pomare, 2015). Tāngata whaiora service experiences have been shaped by the use of language that provides them with the opportunity to comprehend the psychological problem they experience and the rationale or techniques for an intervention. In example, tāngata whaiora have related the use of clinical terminology by kaimahi made it difficult to understand the message being communicated (Pomare, 2015). While tāngata whaiora acknowledged clinical terminology had relevance in mental health services, they would have appreciated if this information could be explained using simple language as well. Consequently, tāngata whaiora revealed they ceased listening to kaimahi during treatment or became hesitant to continue attending the mental health service (Pomare, 2015).

Alternately, an appreciation for the cultural nuances in the language Māori use has been noted to inform the nature of mental health care experiences. The style of language tāngata whaiora or whānau converse in, whether this be te reo Māori, English intermingled with Māori, or English, conveys Māori values, beliefs, and a sense of identity (Mauri Ora Associates, 2006; Pomare, 2015). In turn, this understanding guides responsive engagement and development of assessment and treatment plans. While studies suggest the ability of kaimahi to detect the cultural nuances in language is variable, it is an important skill which may influence service use choices for rangatahi tāngata whaiora and whānau (Pomare, 2015).

Flexible Support Boundaries and Service Environment

Māori provide and receive care differently to Pākehā in mental health services. Often this scope of care is attributed to 'being Māori', where tikanga is followed and Te Ao Māori is respected (Brannelly et al., 2013; Boulton, 2006). This approach is expressed in the flexible time and location boundaries for mental health support offered by Māori kaimahi (Abel, Marshall, Riki & Luscombe, 2012; Boulton, 2006; Brannelly et al., 2013; Elder, 2008; Mooney, 2012). For instance, a Māori kaimahi relayed that upon receiving a phone call at 10 o'clock one night she immediately went out to help the tangata whaiora and whānau with the problem they were experiencing (Elder, 2008). Similarly, if particular whānau members of tāngata whaiora were not present for a home visit during the day, Māori kaimahi would return in the evening to engage with those whanaunga (Boulton, 2006). Māori kaimahi also supported tāngata whaiora by transporting or accompanying them to events such as tangihanga. Research by McClintock et al. (2011) affirms how these flexible time and location boundaries in mental health care are valued from the perspectives of tāngata whaiora. The availability of support outside of service hours and willingness of kaimahi to arrange transport to the mental health service or organise an assessment or intervention in a community setting created positive care experiences.

The provision of mental health care in an environment that fosters connections to Te Ao Māori influences the nature of service experiences among Māori. This includes the presence of Māori artwork and photography and having room to accommodate whānau who attend the service in support of tāngata whaiora (McClintock et al., 2012; Pitama et al., 2014; Te Pou o te Whakaaro Nui, 2010). Kaimahi have also mentioned the importance of working in spaces that are sufficiently large for the mana and wairua of all people in the mental health care interaction to be present (A. Allen, personal communication, June 24, 2016). In addition, incorporating structures on the service grounds that represent focal points of Māori culture such as the wharenui or wharekai can work to create a culturally responsive environment. The wharenui and wharekai facilitate space for whakawhanaungatanga and a sense of safety, inner peace, and empowerment for tāngata whaiora and whānau (Taitimu, 2008; Wharewera-Mika, 2012).

Research and guidelines have also solicited the perspectives of tāngata whaiora and Māori kaimahi about the delivery of mental health care in environments outside of the service building (Kingi, Russell, Ashby & The Youth Wellbeing Study Team, 2017; Love, 1999; Te Pou o te Whakaaro Nui, 2010; Wharewera-Mika, 2012). Tāngata whaiora value the opportunity to connect with Papatūānuku, the natural environment, and

Māoritanga in mental health care such as returning to their tūrangawaewae or cleansing themselves within their awa (Kingi et al., 2017; Wharewera-Mika, 2012). This allows for a psychological healing process that uses wairua and mauri to foster whanaungatanga with ātua, tūpuna, and whenua (Love, 1999; N. Ormsby, personal communication, February 24, 2016).

Culturally Responsive Practices

Research with tāngata whaiora, whānau, and Māori kaimahi unequivocally suggests that culturally responsive practices help develop positive mental health care experiences (Abel et al., 2012; Bennett et al., 2016; Eade, 2014; Elder, 2008; McLachlan, Wirihana & Huriwai, 2017; Mitchell, 2014; Mooney, 2012; Pomare, 2015; Tricklebank, 2017; Wharewera-Mika, 2012; Wharewera-Mika et al., 2016). Hirini (1997) emphasises that cultural practices used in mental health care should not only be sensitive but useful for Māori, helping to improve their mental wellbeing. Examples of such culturally responsive practices identified in the literature include following tikanga during engagement, approaching wellbeing from a Te Ao Māori perspective, and strengthening cultural identity. These will be discussed in the following section.

Whakawhanaungatanga and whakapapa sharing. The practice of whakawhanaungatanga embodies how relationships form part of the essence of Māori culture (Bishop, 1998). Expressions of whakawhanaungatanga within mental health service settings can include adapted pōwhiri, karakia, the sharing of kai, and hongi (Mitchell, 2014). Research and anecdotal accounts also suggest that whakapapa sharing is a valuable and effective way of engaging in whakawhanaungatanga (Bennett et al., 2016; Elder, 2008; Mitchell, 2014). Whakapapa sharing communicates the origins of a person’s identity through the ties they share with whānau, tūpuna, ātua, and whenua

(Durie, 2001). In the context of mental health care provision, whakapapa sharing can involve the disclosure of personal information such as iwi and hapū connections, whānau background, and employment history by kaimahi (Bennett et al., 2016). For non-Māori kaimahi this self-disclosure can be challenging; it requires working outside the scope of care taught in Western oriented training programmes where clear boundaries between professional and personal are encouraged (Te Pou o te Whakaaro Nui, 2010). However, engaging in whakawhanaungatanga and sharing whakapapa can have beneficial outcomes when working with Māori.

Mitchell (2014) examined the effect of whakapapa sharing in psychological therapy with wāhine tāngata whaiora and concluded it fostered positive service experiences by facilitating meaningful participation in treatment. By reducing the power imbalances inherent within the therapeutic relationship, tangata whaiora felt more comfortable and able to share their problems. Mitchell (2014) suggested that utu was a significant element of whakapapa sharing. Utu is an important concept in Māori culture concerned with reciprocity and maintaining balance and harmony. Self-disclosure through whakapapa sharing positioned kaimahi in a space of openness that placed trust in tāngata whaiora to receive this information. This generated reciprocity where tāngata whaiora communicated their whakapapa and enjoyed a more equitable relationship (Mitchell, 2014).

In relation to utu, findings from other authors suggest whakapapa sharing also facilitates engagement at a personal level. Māori kaimahi commonly utilise whakapapa sharing as part of whakawhanaungatanga when interacting with tāngata whaiora and whānau to develop rapport in mental health care (Bennett et al., 2016; Mooney, 2012). It serves to acknowledge who Māori are as a whole person, including whānau and tūpuna, and that they are more than the mental health problem they experience. Māori kaimahi stressed this tikanga process was integral for working effectively with Māori (Bennett et al., 2016) and creating positive and useful care experiences which may affect future decisions about mental health service use (Mooney, 2012). Whakawhanaungatanga was also proposed to help Māori kaimahi better understand the needs of tāngata whaiora and whānau and manage unhelpful misperceptions or whakamā associated with accessing care. Overall, upholding tikanga during engagement conveyed respect for tāngata whaiora and whānau as Māori and helped make present Te Ao Māori within mental health care (Mitchell, 2014).

Mātauranga Māori. A growing body of research supports the efficacy of integrating cultural and clinical knowledge and practices in mental health care. Engagement, assessment, and intervention approaches which are congruent with Te Ao Māori provide helpful, responsive care experiences for tāngata whaiora and whānau. A foundation of this practice is drawing on mātauranga Māori to appreciate that Māori understand wellbeing is holistic (Durie, 2001). A widely recognised Māori model of health which captures this worldview is Te Whare Tapa Whā. Developed by Durie (1984), Te Whare Tapa Whā proposes wellbeing is determined by four interconnected dimensions: taha hinengaro (mental/emotional wellbeing), taha tinana (physical wellbeing), taha whānau (relational wellbeing), and taha wairua (spiritual wellbeing). The metaphor of a whare is used to illustrate the model where each dimension of wellbeing makes up the four walls of the whare. When one wall (dimension of wellbeing) becomes unbalanced, the integrity of the whare (one's holistic wellbeing) is compromised (Durie, 1984).

Studies with, or conducted by, Māori kaimahi reveal they often seek to blend cultural and clinical approaches in their practice (Abel et al., 2012; Bennett, Flett & Babbage, 2014; Brannelly et al., 2013; Elder, 2008; Elder et al., 2009; McLachlan et al., 2017; Wilson & Baker, 2012). For example, Bennett et al. (2014) developed a culturally adapted manual of Cognitive Behaviour Therapy (CBT) for Māori with depression where engagement, assessment, and treatment processes aligned with tikanga Māori and holistic approaches to wellbeing. Following CBT tāngata whaiora were observed to experience a decrease in depressive symptomatology where change in one domain of wellbeing, such as taha hinengaro, produced change in the other three domains of wellbeing outlined in Te Whare Tapa Whā (Bennett et al., 2014). Alternatively, McLachlan et al. (2017) evaluated the utility of the Whai Tikanga Values - Card Sort (WTV-CS), an intervention which integrates Māori values and an Acceptance and Commitment Therapy (ACT) approach. When using the WTV-CS in session, kaimahi support tāngata whaiora and whānau to work through a series of cards that align with the four dimensions of Te Whare Tapa Whā. Each card represents a value and is inscribed with a whakataukī, a Māori proverb that imparts knowledge, values, and actions of tūpuna. Feedback from nationwide workshops with Māori kaimahi suggested the WTV-CS helped tāngata whaiora and whānau explore feelings, thoughts, and behaviours in a culturally relevant way which facilitated treatment engagement and empowerment through reconnection with Māori culture (McLachlan et al., 2017).

Complementary to the research findings with Māori kaimahi, tāngata whaiora and whānau have described the value of mental health care when mātauranga Māori is integrated within practice. A compelling example is the use of pūrākau: Māori narratives of creation and custom passed down by tūpuna which offer guidance in navigating difficult life experiences (Cherrington, 2016; Rangihuna, Tipene-Leach, Kopua, 2018). Kingi et al. (2017) explored the role of pūrākau with rangatahi Māori who engaged in self-harm and their whānau. Pūrākau were reported to help rangatahi and whānau understand why self-harming behaviour occurred, remove whakamā associated with seeking help, and begin the healing journey. Similarly, in the approach known as Mahi a Atua, kaimahi, tāngata whaiora, and whānau wānanga how the difficulties and responses of ātua in pūrākau bear resemblance to their lived experiences and strengths (Rangihuna et al., 2018). This suggests sharing pūrākau facilitates mana enhancing interactions by creating a culturally safe space to explore mental health problems and develop a pathway towards wellbeing. Taken together, research supports the grounding of mental health practice within Te Ao Māori where tāngata whaiora, whānau, and Māori kaimahi are provided with a culturally meaningful way of understanding and addressing psychological problems.

Strengthening Māori cultural identity. Māori mental wellbeing is linked to a secure cultural identity (Bennett & Flett, 2001; Durie, 2001; Reid, Varona, Fisher & Smith, 2016). Cultural identity refers to how individuals connect with and understand themselves and their place of belonging within Te Ao Māori (Durie, 2001; Reid et al., 2016). Cultural identity also depends on the opportunity Māori have to express, and have endorsed within social institutions such as mental health services, their identity as Māori. Within the literature there is growing recognition about the value of using tikanga in mental health care to help tāngata whaiora nurture or strengthen their cultural identity (Eade, 2014; Hollands, Sutton, Wright-St. Clair & Hall, 2015; Kingi et al., 2017; McClintock et al., 2011; Mooney, 2012; Reid et al., 2016; Wharewera-Mika, 2012). In practice this includes supporting tāngata whaiora to learn about or reconnect with Māoritanga through whakapapa, te reo Māori, whenua, whānau or marae activities, karakia, iwi or hapū tikanga, waiata, kapa haka, poi, massage, or ta moko using a kanohi ki te kanohi approach.

Research has also explored how cultural identity strengthening practices are experienced in mental health care. For tāngata whaiora the sense of connection to ātua, tūpuna, and whenua that whakapapa sharing provided also created space to have conversations that were innately tied to being Māori such as those about cultural identity (Mitchell, 2014). Similarly, intervention approaches which included kapa haka performance and taught tāngata whaiora about the whakapapa, history, and contemporary messages communicated in the waiata and actions of haka supported them to connect with their place of belonging in Te Ao Māori (Hollands et al., 2015; Smith, 2003). From the perspective of Māori kaimahi, the simple action of greeting tāngata whaiora and whānau with 'kia ora' and bidding farewell with 'ka kite' can enhance cultural identity in care as the wairua of Māori inherently responds to te reo Māori (Mooney, 2012). Complementary to this, whānau described the validation that was experienced when the Māori identity of their whanaunga was positioned as a strength within mental health care by kaimahi commenting that Māoritanga and cultural identity was something to be valued (Pomare, 2015). In line with this positive experience, whānau of rangatahi tāngata whaiora expressed the aspiration that cultural identity would continue to be privileged within mental health practice at CAMHS (McClintock et al., 2013).

Collectively, tāngata whaiora, whānau, and Māori kaimahi have articulated how strengthening cultural identity can enhance and restore mana and enable wairua to heal so mental wellbeing is uplifted (Eade, 2014; Kingi et al., 2017; Wharewera-Mika et al., 2016). To facilitate this positive mental health care experience, it is integral kaimahi appreciate the diversity in cultural identity among Māori where tāngata whaiora and whānau may present to services at different stages in their journey, and adjust their practice accordingly (Durie, 2001; Hirini, 1997; Huriwai et al., 2001).

Summary

National research has explored and identified helpful and unhelpful mental health care experiences from the perspectives of tāngata whaiora, whānau, and Māori kaimahi. These experiences centred on developing genuine relationships which balanced tikanga and professional practice as well as relationality between services and disciplines; reciprocity in communication that helped tāngata whaiora and whānau understand the mental health problems experienced, service supports available, and collaborate in decision-making and treatment planning; flexibility in the time and location mental health care was provided; and culturally responsive service practices which privileged tikanga and mātauranga Māori during engagement, assessment, and intervention. Taken together, the literature reviewed suggests Māori mental health care experiences have the potential to influence service engagement. This supports the aims of the current research which seeks to better understand why Māori mental health service engagement is incommensurate with mental wellbeing needs by directly exploring the relationship between care experiences and service use.

Chapter Five: The Current Research

Presented in this chapter are the rationale, aims, and questions of the current research with consideration to the reviewed literature.

Research Rationale

Improving Māori mental wellbeing is a priority of the New Zealand mental health sector (Government Inquiry in Mental Health and Addiction, 2018). Findings from major studies in Aotearoa indicate Māori mental health service engagement is incommensurate with the prevalence of psychological problems (Baxter et al., 2006; Government Inquiry into Mental Health and Addiction, 2018; Oakley Browne & Wells, 2006a). Similar outcomes have been reported among other Indigenous populations leading to research that seeks to understand and offer solutions to address Indigenous mental wellbeing needs. This body of literature was informed by the perspectives of clients, families, and clinicians, and suggested a relationship was present between mental health care experiences and service engagement. Specifically, culturally appropriate assessment and intervention, meaningful relationships, communication, flexible practice, and shame, mental health literacy were indicated to influence service engagement. Based on these findings, culturally and clinically responsive recommendations for how mental health practice could be adapted to facilitate service engagement among Indigenous people were provided (Berry & Crowe, 2009; Gone & Trimble, 2012; Hepworth et al., 2015; Hinton et al., 2015; Isaacs et al., 2013; Isaacs et al., 2010; Mehl-Medrona, 2009; Vicary & Westerman, 2004; Vukic et al., 2009; Westerman, 2004).

Research in Aotearoa has not directly explored how mental health care experiences can influence service engagement among pakeke Māori. Presently, studies have only examined whether mental health care experiences were helpful or unhelpful.

Therefore, little is known about why Māori seek less help from services and what could be done in mental health practice to improve engagement and uplift wellbeing. Furthermore, the perspectives of pakeke tāngata whaiora, whānau members, and Māori kaimahi have not been collectively considered in one study. This is significant as research that explored CAMHS engagement with rangatahi tāngata whaiora, whānau, and Māori kaimahi offered valuable insights into service engagement patterns and recommendations for mental health practice (Pomare, 2015). Similarly, Mason et al. (2004) suggested integrating the perspectives of those involved in mental health care could help provide coordinated best practice guidelines for services working with Māori. This represents a methodological weakness and gap in understanding as the New Zealand mental health sector seeks explanations for why Māori service engagement is incommensurate with mental wellbeing needs.

The current research will seek to address these limitations by exploring how mental health care experiences may influence Māori service engagement from the perspectives of pakeke tāngata whaiora, whānau members, and Māori kaimahi. Integrating these perspectives, coordinated recommendations for how mental health practice could evolve to support and improve service engagement among Māori in a culturally and clinically responsive manner will be provided.

It is important to acknowledge the voice of Māori who experience mental health problems and do not seek help from services is inherently absent within this research. Akin to other studies that recognised the value kōrero with this rōpū could offer in addressing Māori service engagement and mental wellbeing needs (Pomare, 2015), attaining their perspectives posed significant recruitment challenges. As such, this research considered the perspectives of tāngata whaiora: people with lived experience of mental health problems that have engaged with services. The rationale for this decision was tāngata whaiora were perceived as being able to offer insight, although of a different nature, into why Māori engage less with mental health services based on their own experiences. This methodological decision is discussed as a limitation within Chapter Ten.

In light of these considerations, the aims and questions of the current research are presented as follows.

Research Aims

1. Develop an understanding of why Māori mental health service engagement is incommensurate with mental wellbeing needs.
2. Describe how mental health care experiences contribute towards Māori service engagement outcomes by integrating the perspectives of tāngata whaiora, whānau members, and Māori kaimahi.
3. Provide coordinated recommendations for culturally and clinically responsive mental health practice that supports and improves Māori service engagement and mental wellbeing.

Research Questions

1. What are helpful mental health care experiences that tāngata whaiora, whānau members, and Māori kaimahi perceive facilitate engagement with mental health services?
2. What are unhelpful mental health care experiences that tāngata whaiora, whānau members, and Māori kaimahi perceive contribute towards uncertainty, delay or unwillingness to engage with mental health services?
3. How could mental health practice evolve to improve Māori service engagement and uplift mental wellbeing?

Chapter Six: Methodology

Kaupapa Māori Research Approach

The spirit of Kaupapa Māori Research is captured by the orientation towards improving Māori wellbeing through exploring and developing solutions to issues that Māori experience as relevant and important (Smith, 2012; Walker, Eketone & Gibbs, 2006). Kaupapa Māori Research is a unique and distinctly Māori approach to working *with* and *alongside* Māori in research, where Māori worldviews, tikanga, and ways of being in the world are privileged (Smith, 2012; Walker et al., 2006).

Kaupapa Māori refers to being, thinking, and living life as Māori (Smith, 1997). When Kaupapa Māori is applied as a research approach, it seeks to resolve the displacement of authentic Māori voices by non-Māori researchers that sought to understand and construct Māori lived experiences and realities using Pākehā research frameworks (Bishop, 1998). This stance is evident in the ontology and epistemology of Kaupapa Māori Research, which complement and inform one another (Crotty, 1998). Traditional Māori ontology, or beliefs about the nature of reality and human existence, is founded on collectivity (whanaungatanga) among people (kotahitanga), relationships to ātua and the cosmos (wairuatanga), and an appreciation of the role humans have in protecting and nurturing the environment (kaitiakitanga). Taken together, these reflect the connection between the mind, body, and spirit (Henry & Pene, 2001). Kaupapa Māori Research epistemology, or views about what is considered valid and appropriate knowledge, affirms that to be Māori and follow a Māori worldview and practices is normal. As such, Māori philosophies, language, culture, and customs are positioned as legitimate and natural when constructing and understanding Māori knowledge within Kaupapa Māori Research (Henry & Pene, 2001; Pihama, Cram & Walker, 2002).

By its very nature, Kaupapa Māori Research is strengths-based. The approach upholds the mana of Māori communities (Cram, 2001) and offers the potential for positive change in outcomes important to Māori such as mental health (Moewaka Barnes, 2000). These qualities are reflected in the fundamental principle of tino rangatiratanga which relates to self-determination and empowerment (Pihama et al., 2002). The enactment of tino rangatiratanga by Māori within research is captured in the principle of social justice that is concerned with challenging and resolving pervasive inequalities experienced by Māori. Within this research, tino rangatiratanga and social justice were present in the opportunity participants had to develop knowledge and provide solutions to address low Māori mental health service engagement and uplifting wellbeing.

Kaupapa Māori Research is not a prescriptive research approach; it is dynamic and tikanga is fluid depending on the Māori community engaged and the research aims. This research followed Māori principles of engagement articulated by Smith (2012) and elaborated on by Cram (2001) that guide research processes and outcomes:

- Aroha ki te tangata (respect for people)
- Kanohi ki te kanohi (the seen face; appreciating the value of connecting with people face-to-face)
- Titiro, whakarongo, … kōrero (look and listen first, then speak when you have a place of understanding to talk from)
- Manaaki ki te tangata (share, host, and be generous to people; recognise that interactions are collaborative where participants and researchers learn from another and develop shared understandings; reciprocate participants sharing their stories by communicating with them about the research findings)

- Kia tupato (be cautious; be culturally safe; remain reflexive about the insider/outsider status as a researcher)
- Kaua e takahia te mana o te tangata (do not trample over the mana or dignity of people; engage in a genuine and meaningful manner)
- Kia māhaki (do not flaunt your knowledge; be humble in your approach; recognise people are the experts of their lived experiences and aspirations)

Underpinned by these values, Kaupapa Māori Research was considered the most appropriate approach for this research. Through positioning and affirming Māori worldviews, tikanga, and ways of being as normal, the voices of tāngata whaiora, whānau members, and Māori kaimahi created a narrative about how to improve Māori mental health service engagement and uplift wellbeing.

Qualitative Research

Qualitative research provides rich, deep, and meaningful insights into the lived experiences of individuals, whānau, and communities (Braun & Clarke, 2013) and allows for collaboration and relationality between participants and the researcher (Willig, 2008). As such, qualitative research is considered appropriate when engaging in research with and alongside Māori (Moewaka Barnes, 2000). In addition, qualitative research can honour the perspectives of tāngata whaiora, whānau members, and Māori kaimahi by grounding the narrative of meaning within their accounts and holding tensions within the data that capture the complexity of life (Yardley, 2008).

Thematic analysis was selected as the qualitative method of data analysis as it was appropriately suited to addressing the research aims and questions. The theoretical flexibility of thematic analysis enabled a Māori worldview to be applied during data analysis and interpretation (Braun & Clarke, 2006; Elder, 2008; McClintock et al., 2011;

McClintock et al., 2013). An inductive approach was used whereby the codes, themes, and overall narrative were developed from participant interview kōrero. Reflective of the spirit of Kaupapa Māori Research where Māori have the ability to self-determine, an experiential approach was followed. This assumed participants held, and could share, an understanding into an authentic reality of Māori mental health service engagement and care experiences.

Overall the attributes of relationality and empowerment and the rich, meaningful insights into the complexity of participant lived experiences that qualitative research offered made it compatible with a Kaupapa Māori Research approach and the aims and questions of the current research.

Myself as a Researcher

Qualitative research acknowledges and values the presence of subjectivity where the personal experiences, values, and perspectives of the researcher influence how knowledge is created (Willig, 2008; Braun & Clarke, 2013). Reflexivity is the process of self-reflection by the researcher to account for subjectivity and uphold the quality of the research. Therefore it is important I consider how who I am, as a Māori who walks between Te Ao Māori and Te Ao Pākehā, an intern psychologist and past tangata whaiora, and a researcher may have shaped the process and findings of this research.

My positioning as a researcher was partially alluded to in the preface of this thesis. Being Māori I was deemed an ‘insider’ and therefore given a level of trust by participants as a kaitiaki in the safe keeping of the findings. Likewise, I could have been considered to possess a deeper or innate understanding of the culture and lived experiences shared by participants. My whakapapa and upbringing place me as walking between the two worlds of Te Ao Māori and Te Ao Pākehā. This positioning enabled me to develop meaningful connections and relate to tāngata whaiora, whānau members, and kaimahi who expressed the same. Conversely, while engaging with participants who grounded themselves more strongly within Te Ao Māori, I acknowledged my position of unknowing as an ‘outsider’ and sought guidance from participants through the kōrero.

This thesis was completed after working as an intern psychologist in District Health Board (DHB) mental health services. Alternatively, I myself have been a tangata whaiora who has engaged with mental health services. I reflected this influenced data analysis where I felt I could relate to the roles, processes, language, and experiences in the mental health system described by participants. At the same time, I recognised my experiences as an intern psychologist and tangata whaiora did not perfectly reflect those of participants and was mindful of heavily applying this lens while interpreting the findings.

As a researcher, I appreciate I held a relative position of power which could influence participant responses during interviews. Alternately, as a young wahine researcher, I found participants expressed manaakitanga towards me, and a willingness to openly share their experiences and whakaaro. Finally, in discussing challenging and at times sombre perspectives, I brought my own lens of hope that I view the world through which is interwoven in the strengths-based approach of this research.

Ethical Approval

Ethical approval for this study was granted by the Northern B Health and Disability Ethics Committee, application reference 16/NTB/165.

Participant Recruitment

Eligible participants were individuals who identified as Māori, were aged 18 years and over, and were past or present tāngata whaiora, whānau members of tāngata whaiora, or Māori kaimahi working in mental health services. Participants were recruited from around Aotearoa using snowball sampling by advertising among Māori networks of the researcher and primary supervisor. Interested potential participants contacted the researcher and were emailed or posted the relevant participant information sheet (see Appendix A) and informed consent form (see Appendix B). Ethically, this recruitment approach minimised undue influence to take part, as potential participants were unknown to the researcher until they expressed an interest to participate. Furthermore, this procedure enabled the invitation to take part to be declined without affecting tāngata whaiora or whānau member mental health care and personal or professional relationships. Participant recruitment ceased when data saturation occurred. Depending on the interview kōrero this differed between tāngata whaiora, whānau members, and Māori kaimahi participant groups.

Participants

Given the small size of the Māori mental health community, protecting the identity of participants was paramount. To facilitate a safe and constructive space for kōrero, descriptive attributes of participants were limited to engagement or employment in Kaupapa Māori or mainstream mental health services, professional scope of practice, and nature of the whānau relationship to tāngata whaiora.

In addition, although recruitment procedures removed the researcher from direct contact with potential participants, the researcher had whanaungatanga with several participants which is not uncommon for Māori in a research context. Three participants were friends of the researcher and three were part of a kaupapa whānau the researcher belonged to.

Tāngata whaiora. Five current and past tāngata whaiora took part in the research. Tāngata whaiora reported engagement with Kaupapa Māori and/or mainstream mental health services.

Whānau members. Three whānau members of tāngata whaiora were interviewed. Whānau had relationships with tāngata whaiora as parents, aunties, and children.

Māori kaimahi. Four Māori kaimahi who were employed in Māori and mainstream mental health services participated. Māori kaimahi practiced as mental health nurses, psychologists, and community support workers. This research did not aim to evaluate similarities and differences in the perspectives that mental health professionals from various disciplines held about the relationship between Māori mental health care experiences and service use. Rather, the perspectives of Māori kaimahi were explored using a collective lens that upheld the integrity of the kōrero.

Interview Schedules

Separate semi-structured interview schedules were developed for tāngata whaiora and whānau members (Appendix C) and Māori kaimahi (Appendix D). The interview schedules were designed to guide the kōrero alongside the research aims while remaining responsive to the narratives of participants. Based on experiences and knowledge of participants, this involved exploring the journey towards engaging with mental health services or background working in mental health, what mental health services were currently doing well for Māori, how mental health services could do things differently to improve Māori service use and uplift wellbeing, and future aspirations for how mental health services could help Māori.

Questions were phrased to be congruent with Māori ways of communication (H. Valentine, personal communication, September 2016). For instance, to enable participants to meaningfully share their story with ease, questions were leveraged based on the kōrero that took place or included a gentle transition where the types of questions asked were phrased in relation to the experience participants had described.

Interviews

Interviews were carried out after informed consent was given by participants. To manaaki participants and ensure each had equal opportunity to share their stories and lived experiences, interviews took place in settings accessible for participants including homes, the Massey University Wellington Psychology Clinic, and over video-calling applications or the phone. Interviews lasted between thirty minutes to two and a half hours. During interviews, the researcher positioned herself as manuhiri and the participants as tangata whenua (Moyle, 2014). Although the researcher hosted the interviews, this positioning acknowledged and respected the mana and mātauranga of participants and their lived experiences. Tangata whenua and manuhiri positions were implicitly communicated by emphasising the collaborative nature of this research and the privilege the researcher felt to share in participants' stories and whakaaro.

Tikanga Māori guided the nature of engagement with participants and emphasised this research took place within a Māori space. Interviews were arranged at a time and place which was suitable for participants. For interviews that took place in person, mihi involved a kiss on the cheek and/or a hug. Prior to beginning the interviews, the researcher's appreciation for participants' sharing their time was communicated and whakawhanaungatanga took place. Whakawhanaungatanga was fluid and matched the nature of the relationship between the researcher and participants and involved a combination of whakapapa sharing, including iwi and hapū affiliations, and whānau and educational background. Whakapapa sharing allowed participants and the researcher to locate one another in their whakapapa, connections to Papatūānuku, and establish or recognise relationships with each other (Durie, 2001). Whakawhanaungatanga also involved kōrero about how life was going, how whānau were, and whakaaro about current events. Prioritising relationships helped build rapport and participant comfort within the research space. The option of opening the interview with a karakia was offered to facilitate a safe space for kōrero and prepare the wairua of participants and the researcher. Karakia was led by the researcher or the participant according to participant preferences.

The researcher hosted the interviews by explaining the research kaupapa and aspirations, providing an overview of areas the kōrero may cover, and emphasising the co-creation of a narrative to improve Māori mental health service engagement and uplift wellbeing. Interview kōrero was guided by the interview schedule and was responsive to participant stories. Whakawhanaungatanga was also woven throughout the interviews. The majority of participants accepted the offer to close the interview with a karakia and restore the wairua. Informal kōrero followed and for interviews where the researcher and participants met in person, kai was provided for an appropriate time. To mihi participants the researcher expressed gratitude to participants for sharing their time and experiences. Furthermore, koha was offered as a tangible expression of manaakitanga. For Māori, the offer of koha has whakapapa in the pōwhiri process where manuhiri lay down a koha before the tangata whenua as a contribution to facilitating the hui (Bishop, 1998). When koha was offered, the researcher stepped away to allow space for participants to consider this koha. This ensured the mana and tapu of participants and the researcher were recognised and upheld (Bishop, 1998). Koha was accepted by most participants, while as is tika the researcher accepted the decision of some participants to take part in this research whakahirahira.

Data Analysis

Interview data was analysed following the six phases of thematic analysis outlined by Braun and Clarke (2006; 2013). A Te Ao Māori lens was applied in each phase where Māori ways of being, thinking, and values were present in analysis and interpretation. Recordings were transcribed by the researcher as part of familiarisation with the data. To ensure the accuracy of interview transcripts the researcher checked them against the recordings. During the transcription process initial ideas about what the data conveyed were noted down. Following this, data relevant to the research questions was coded by reviewing the interview transcripts. This process was thorough, inclusive, and guided by how the codes 'fitted' with participant kōrero. Codes were collated into a word document with supporting interview excerpts and systematically reviewed and revised.

Candidate themes were developed by analysing codes and organising these into potential themes and sub-themes. In addition to using a word document, a thematic map was developed to support this early phase of data analysis. The value of themes was determined according to whether they captured meaningful and important information that upheld the integrity of the interview kōrero and the overarching narrative of understanding Māori mental health service engagement, opposed to prevalence within the data (Braun and Clarke, 2006; 2013). Candidate themes were refined using Patton's (1990) criteria of internal homogeneity and external heterogeneity. This process involved reviewing coded extracts and evaluating whether coherent, meaningful patterns were present within a theme and if themes were sufficiently distinct from another. Themes were also considered in relation to the overall data set. Subsequently, candidate themes were clearly defined by concisely describing the story each theme held and how it contributed towards answering the research aims and questions. Candidate themes were discussed and evaluated in hui with supervisors and further refined according to feedback, in line with thematic analysis as a recursive process. A revised thematic map was created to support the analysis.

Lastly, themes and sub-themes were developed into an analytic narrative interwoven with compelling extracts from interview kōrero that addressed the research aims and questions. This narrative was presented in the three findings chapters which respectively conveyed the perspectives of tāngata whaiora, whānau members, and Māori kamahi participants. This phase represented a final opportunity to ensure the interview extracts, themes, and narrative were meaningful, coherent and upheld the integrity of the interview data and research intentions. These were again reviewed in hui with supervisors. The overarching narrative that integrated the collective perspectives of the three rōpū was provided in the proceeding discussion chapter.

Sharing the Findings

Findings were shared with participants as part of manaaki ki te tangata. Participants could elect to receive a small summary of the findings via post or email in the informed consent form. The opportunity to discuss the findings further in person or over video-calling applications was also offered and whānau or a support person was welcome to attend.

In summary, a qualitative Kaupapa Māori Research approach discussed within this chapter was deemed responsive and appropriate for the aims of the current research, the community who took part, and the subjective positioning of the researcher.

Chapter Seven: Findings – Tāngata Whaiora Perspectives on Māori Mental Health Service Engagement

This chapter presents the research findings based on interviews with past and present tāngata whaiora who shared their perspectives about Māori mental health service engagement. Research findings are organised into seven themes and three sub-themes, as outlined in Table 1, and discussed in line with how the journey through mental health care unfolded for tāngata whaiora in their kōrero.

Table 1. Tāngata Whaiora Themes and Sub-themes

Theme	Sub-Theme
Whakamā, Mataku, and Opening Up about Mental Health	
Connection with Te Ao Māori	He Māori Ahau: Cultural Identity and Tikanga in Practice Holistic Wellbeing Whānau Involvement
Charting the Course Towards Hauora: Tangata Whaiora Voice in Mental Health Care	
Relationships	
Flexible Mental Health Practice	
Mental Health Literacy	
Mental Health Sector Resourcing	

Whakamā, Mataku, and Opening Up about Mental Health

Tāngata whaiora indicated the tension between wanting support for mental health problems and feeling whakamā or mataku about seeking help contributed towards low Māori service engagement. Underlying these difficult emotional experiences was the relative absence of everyday conversations about mental health which created the perception that being unwell was not okay. As one tangata whaiora expressed, an open attitude towards mental wellbeing could be encouraged through kōrero, where people with lived experience of mental health problems and service use supported others to realise they were not alone and that help was available.

> *People don't talk about it [mental health]. People don't talk about what it's like, about their difficult times, and about what worked for them until someone else says 'Look I'm having these real problems, I can't do this anymore.' Then somebody might say 'Hey, I've got a good idea. I saw this cool person, maybe you'd like to see them?' It's not until then, otherwise we don't necessarily have conversations about mental health... it's like admitting a fault. It's like admitting that you're less than okay is not okay (TW1)*

The following tangata whaiora affirmed a stoic mentality prevented open conversations about mental wellbeing with whānau and friends, and therefore the potential to receive support to seek help. Māori women were thought to be particularly affected by this outlook given the role talking had in their daily life and relationships.

> *Māori don't talk about using practitioners. We still have that whole mentality like 'Oh, she'll be fine' 'Oh it's just a hard day'. Especially as women, I think we do that a lot. Men definitely do but I think we [women] are really used to talking, so in this really individualistic world a lot of us women are really finding it a lot harder... women are tough but we need our community, we need to talk to each other, we're*

> *the ones that sit around with our cups of teas and it's just ingrained in our souls (TW5)*

Conversely, another tangata whaiora reflected discourses about Māori as warriors dissuaded tāne from talking about the mental health difficulties they experienced. This perceived inability to appear emotionally vulnerable often culminated in feelings of isolation and completed suicide. Promisingly, this tangata whaiora perceived a transition towards a more human, compassionate way of being for Māori men was occurring and that continued support for this movement could enhance the likelihood Māori would reach out to whānau and mental health services for assistance.

> *There's an intergenerational masculinity role modelling of being tough. I feel like I've lost a lot of friends through suicide who have been Māori and the common thread amongst all of their deaths has been not saying anything or talking. Putting on this brave face and never crying and never being looked at as weak. But I do feel like that model is changing. I feel like the more we progress and the more we're losing people, the more that wall's hopefully being cut down (TW3)*

Notably, although tāngata whaiora understood that participating in mental health care could nurture wellbeing, they indicated the whakamā attached to psychological problems and help-seeking behaviour discouraged service engagement.

> *It's still very much a Māori concept of 'What is mental health?' It's a very stigmatised thing and so even within our own communities, while we have these services that are wonderful for us and can provide for us, we are not willing to participate in them because we're still very whakamā... it's not because we don't want the help (TW2)*

Likewise, mataku deterred tāngata whaiora from reaching out to services although they recognised engagement was beneficial for their wellbeing. As an example, one tangata whaiora explained she did not contact her care team or the Crisis Response Service (CRS) for support when early warning signs of unwellness were present. This decision was made from fear Oranga Tamariki would be notified and access to her children would be amended.

> *When I get real bad, I can't really reach out to the crisis line because I'm worried that it will get used against me for seeking help. In the past when I've sought help it's been used against me with concern to my children, that's Oranga Tamariki's leverage. So even when I'm going downhill it's like I'm too scared to reach out, so I try to deal with it on my own (TW4)*

The same tangata whaiora articulated how the judgement that surrounded mental health alongside the discrimination towards Māori in Aotearoa created an environment of whakamā and mataku in being open about unwellness. This contributed towards service engagement rates that were incommensurate with mental wellbeing needs among Māori.

> *I think low service use is to do with the labels eh... Because being realistic, with Māori, a lot of people look down at them no matter what their situation is. And because there's so much judgement, that's why a lot of people hide whatever they're going through or are too scared to seek help (TW4)*

Recommendations for how service engagement could be supported involved encouraging Māori, and indeed Aotearoa society, to begin having everyday conversations about personal experiences of mental unwellness and service use. Tāngata whaiora explained these open conversations would progressively lessen the whakamā and mataku tied to psychological problems and seeking care, and enable manaakitanga to be expressed in their place where people know it is okay not to be okay and to ask for help.

> *I think now having had a positive experience I would most definitely talk about it quite freely with anybody. I'm not whakamā about saying that I've been to see a clinical psychologist and a counsellor and that it has been hugely beneficial for me (TW1)*

> *Educate us to make us understand that, you know, we are doing a disservice to ourselves by making those amongst us who are like that feel they are less of, or less than, for feeling the way that they do (TW2)*

Tāngata whaiora also suggested that actively involving kaumātua within mental health care settings represented a solution to addressing low Māori service engagement. As kaumātua hold mātauranga and guide whānau, hapū, and iwi through life experiences in Māori culture, their presence in services and initiation of conversations about mental health could create a new narrative around seeking help for current and future generations.

> *One of the things the service does quite well is... they open up their conference rooms to the kaumātua groups, so they're surrounded by these [mental health] services all the time. And so I think in doing that it's a really subtle way of de-stigmatising that these things [mental health difficulties] happen to us, they happen to all of us. Because it's the kaumātua that are involved, they sort of begin the conversation, and it's coming from the top down that 'It's okay, it's not you, nothing's wrong with you' and hoping that the next generation will learn there's nothing wrong with seeking help, that if you need help you need to do something about it. I do hope that other services take on that idea that you need more kui and kaumatua... to participate in services as much as possible through conversations (TW2)*

In summary, tāngata whaiora expressed open conversations about mental health were not part of daily life in Aotearoa leading to whakamā and mataku being associated with unwellness and accessing mental health care. Subsequently, Māori were disinclined to engage with services although they understood the value of seeking help to live well. Nevertheless, tāngata whaiora indicated encouraging everyday conversations about mental wellbeing and experiences of care could create an open, accepting perspective towards mental health in Aotearoa that supports service engagement.

Connection with Te Ao Māori

This theme speaks to how adopting a Te Ao Māori approach to mental health practice could improve service engagement and provide care experiences that attend to the cultural and clinical needs of Māori. In their kōrero, tāngata whaiora articulated this involved validating Māori identity and integrating tikanga within assessment and intervention, approaching wellbeing holistically, and involving whānau in the recovery journey.

He Māori ahau: Cultural identity and tikanga in practice. Mental health service engagement and helpful care experiences were supported when the identity, values, and worldview tāngata whaiora connected with as Māori were recognised and considered in care. For instance, these tāngata whaiora described the manaakitanga they felt when services and kaimahi showed commitment to culturally responsive practice by privileging Māori identity within the approach to care.

> *I felt really supported and acknowledged for being Māori. Not just the 'It's a token thing or something that might be a consideration' but more that 'You're Māori; right, so what can we do for you that's going to help you?' (TW1)*

> *It's always been I was seen as a Māori client, there's always that acknowledgment (TW3)*

The narrative that Māoritanga nurtures wellbeing and confidence to engage was echoed by another tangata whaiora who expressed the importance of Māori being able to be as Māori within mental health services. This was made possible by following tikanga in assessment and intervention, which assured tāngata whaiora a Māori perspective was privileged and that they would be guided through care with kindness and respect.

> *Having the opportunity just to be ourselves as Māori, it broke down a lot of barriers for me. So that was probably the biggest help for me, having somebody that understands how we work, you know, without even really knowing it... Doing karakia at the start just puts a Māori person at rest. That recognition that this person knows about manaakitanga, knows about kaitiakitanga, wairuatanga and all that sort of stuff. You don't need to explain it and I think you automatically just feel relaxed... those values are just handed down through our blood (TW5)*

Integrating tikanga into mental health care provided tāngata whaiora the opportunity to deepen their ties to Te Ao Māori and imparted humility to the therapeutic relationship where tangata whaiora and kaimahi could connect as fellow humans. One tangata whaiora relayed how tautoko and encouragement from his cultural therapist to learn about his whakapapa was an uplifting, meaningful experience that positively shaped his journey through services and motivation to engage.

> *The cultural therapist I've been working with is amazing. The first thing he said was 'Do you know your whakapapa bro? Do we need to work on that?' It was like 'This is awesome!' Being brought into the world of Te Ao Māori in that way, on that humility and that human level is super awesome (TW3)*

Under the banner of Kaupapa Māori mental health, tāngata whaiora described feeling optimistic about engaging with services in anticipation Te Ao Māori would be authentically integrated within practice. However, in some circumstances the assessment and intervention approach used by services continued to unequally privilege a clinical perspective over a cultural one, leading some tāngata whaiora to disengage from care.

> *When I first went to Māori mental health I thought it would be beneficial being with a Māori service. But their kaupapa, I didn't really like it, to me it felt fake... for me nothing was really done in the cultural way, it just felt like it was all by the books, it just didn't feel real (TW4)*

Taken together, tāngata whaiora articulated cultural identity is an integral part of who a person is and therefore cannot be placed aside when seeking mental health care. To support Māori to engage with services, it was suggested kaimahi could consciously reflect on how culture shapes the experience of unwellness and how it can guide treatment.

> *When we're talking about being culturally aware, we need to consider 'What does it mean to be Māori? What does it mean for that individual and their current situation?'*

Holistic wellbeing. The use of holistic interventions in mental health practice which recognised cultural understandings of wellbeing created care experiences that supported Māori service engagement. Kaupapa Māori services in particular were noted to attend to physical, spiritual, and relational health in their approach to care alongside psychological health. For example, the following tāngata whaiora described their wellbeing was nurtured holistically by the opportunity to receive nutritional advice, mirimiri massage, or join social and cultural activities as part of a kaupapa whānau. This access to cultural pathways of healing often complimented tangata whaiora wellbeing plans and was indicated to be an approach to mental health care that was beneficial for Māori and facilitated service engagement.

> *I feel like the resources that Māori mental health offer are really good... at the marae every Friday they have mirimiri massage and nutritionists where you can talk about what you're eating and exercise and things like that. And part of my wellbeing plan, which I think fits in well with this, is that I became sober... I got into fitness... and meditation practice (TW3)*

> *As part of a Kaupapa Māori mental health group we all gather every fortnight and do an activity day. It's for everyone that's using the service and we go out and learn te reo Māori, play sports, things like that. It's like a big family group that we all join together and where we all get treated equally (TW4)*

Openness to the spiritual realm in mental health practice allowed kaimahi to provide care which was responsive to the dynamic needs of tāngata whaiora. As one tangata whaiora recounted, the relationship she and her counsellor had with wairua enabled tūpuna to guide treatment towards what would nurture her wellbeing in that moment. This connection with wairua and holistic understanding of health helped maintain her engagement in care, particularly when she felt reluctant to attend therapy sessions.

> *One time I didn't really wanna talk and I was going to cancel on my counsellor but I thought I'd better go. And when I walked in she was like 'Oh I've already laid out the mirimiri table for you because your tīpuna have already told me you're coming and you don't wanna talk today'. And it was so what I needed. And I said to her 'Did you actually know that I didn't need to talk?' and then she was like 'I don't know what it was, I just felt it, I felt like your tīpuna came to me, I just went with it' (TW5)*

The value of cultural resources and healing approaches in mental health care such working with a tohunga and receiving rongoā Māori were identified by another tangata whaiora.

> *The fact that you can have a tohunga come and see you is just awesome (TW3)*

Consequently, tāngata whaiora suggested a holistic approach to mental health practice that aligned with mātauranga Māori was a solution to improving Māori service engagement. This adaptation to care would also place Māori people and Māori culture in an empowering position and begin to generate new discourses about Māori mental wellbeing in Aotearoa.

> *Take ideas from Māori culture... attending to a person holistically is an idea that appeals to many people... and I think that if we were more explicit about 'This is how Māori see health, this is actually beneficial for everybody, this way of thinking about your life, because you don't exist in isolation'... we'd see that is actually quite a strong place to be and a strong place to come from and that's part of what it is to be Māori (TW1)*

Whānau involvement. For tāngata whaiora the ability to engage with mental health services and the value of care received was enhanced by the opportunity to involve whānau in the journey towards wellbeing. For instance, as the following tangata whaiora explained, each care interaction whānau attended represented progress as they assisted their whanaunga to process information and apply therapeutic strategies.

> *I believe me being able to have a good experience within mental health services is because I've had such wonderful external support, I feel like that's such a huge part of it. My time with each person working within that field was utilised really well because I was there with people, with friends and family. All the things that I needed to be doing outside of my appointments I had the support around that as well, so*

> *each visit felt like a bit of progress... my friends would come and they'd take notes. So I might not have remembered what happened or I might have been sitting there trying to make sense of what the kaimahi was talking about instead, but later I was able to have that information (TW3)*

Correspondingly, tāngata whaiora perceived the absence of whānau involvement made engaging with mental health services a solitary and anxiety-provoking experience where the potential benefits to wellbeing that care held were unable to be realised. As this tangata whaiora articulated, being unable to share the journey with a support system that could provide validation, reassurance, and guidance may reduce intentions among Māori to seek help.

> *People I've met within mental health services, other whaiora that have had a terrible time, I feel like they don't have any family or friends. And I feel like that's the critical piece, to have that support. So yeah, they really struggle. It's like feeling alone, not being able to talk to somebody else and go 'I was really scared at the doctor's today and I don't know what to do'. And they go 'No, it's all good, you should do this and do this'. Not having the person to bounce off, I can imagine would be really hard and actually maybe taint the mental health service experience (TW3)*

As such, tāngata whaiora proposed a whānau-centred approach to mental health care could facilitate greater Māori service engagement. In practice this would involve working alongside both tāngata whaiora and whānau in assessment and intervention where a collective understanding about mental health problems and the care plan could be developed.

> *Better providing for the wellbeing of us tāngata whaiora and our whānau. Because even though you're dealing with the one client, it's not just the client; you're dealing*

> *with the whole whānau. Help the whānau understand and acknowledge what's going on for the whaiora (TW4)*

To conclude, tāngata whaiora reflected connecting with Te Ao Māori in assessment and intervention facilitated culturally and clinically responsive care experiences that supported Māori engagement with services. This approach to practice involved privileging cultural identity and tikanga in mental health care, utilising holistic interventions, and involving whānau in recovery. To further improve service engagement moving forward, tāngata whaiora recommended mental health practice be increasingly grounded within Te Ao Māori.

Charting the Course Towards Hauora: Tangata Whaiora Voice in Mental Health Care

Māori engagement with mental health services was a journey shaped by the empowerment of tāngata whaiora to have their voice heard and respected in mental health care. In practice this involved supporting tino rangatiratanga with shared conversations and active listening so Māori could self-determine and fully participate in assessment and intervention. This approach to care was experienced by the following tangata whaiora who gave an account of genuine collaboration in therapy which encouraged her to continue engaging with services.

> *The Māori clinician was very flexible in his approach. He gave me options. If I said it didn't work, we talked about why... he kinda collaborated with me and involved me in the process. And then when I said 'I'm not too sure about this' he asked me 'Would you just persevere? Because I believe that you're almost coming through something at the moment. Could we try it for one more week?' and that was really quite cool (TW1)*

Another tangata whaiora articulated when care teams supported Māori to have an authentic voice in decisions about their mental health care, this potentially anxiety-provoking experience was transformed into a positive one that facilitated service engagement. For example, this tangata whaiora felt able to make an informed choice about medication because his psychiatrist provided him with information and time to reflect on the possible treatment options and outcomes.

> *Moving from talking therapy to actual medication, I was sort of on the fence about it. I guess it's the unknown... I was given material to do my own reading on the medication before the script was written. I thought that was really good, like the doctors encouraged that. They said we can start medication at anytime, this is what we recommend, this is what we think may help. And they were also really clear about we might get it wrong and it might make you worse coz we're not sure, you know, but all in all it's really effective. Yeah, so the consultation around it and the sensitivity around it were great (TW3)*

Likewise, the opportunity for tāngata whaiora to express what wellbeing looked like for their whānau as well as themselves was identified as a helpful service experience.

> *The kaiāwhina would sit there and discuss with me an overall plan of what I really wanted for not only myself, but what I wanted for myself and my family, and what that would look like for me (TW2)*

Tāngata whaiora felt empowered to engage in conversations about their mental health care when they were acknowledged as experts of their lived experiences. This involved kaimahi actively listening to tāngata whaiora and waiting until they had a place of greater understanding to use their professional competencies to help create awareness and offer advice from. As the following tangata whaiora related, this collaborative approach to practice facilitated helpful care experiences that supported service engagement.

> *What I really liked about counselling, and what I found through my ongoing therapy, is the way they sort of sift through what you're saying and find things that you don't really realise that you keep touching on and how they sort of question you on those things. I've heard of some counsellors that ask ongoing questions and nothing else, I don't think that approach would work with me. But both of the counsellors I've worked with have asked some questions before they try to give me any advice. So they'll sort of ask me something and then let me speak, and then take bits out of what I've shared, and ask me if I've noticed that. Then, at the end, they'll come with a bit of a wrap up: 'Okay, these seem to be things we've noticed together that you want to work on. And now I'll give you some tools to work on them'. Instead of just continuously 'Why do you think you did that? Why do you think you did that?' and you walk out thinking 'Did I just answer all of my own questions?' (TW5)*

Conversely, the insight tāngata whaiora held about their mental health difficulties and efforts to cope were invalidated when kaimahi failed to listen to the needs they expressed. As these tāngata whaiora indicated this was experienced as frustrating and negated the potential for progress in recovery, leaving Māori in a space of unwellness and resulting in reduced intentions to use services or complete service disengagement.

> *I felt like she didn't really listen to me when I told her that I didn't feel like I was making any progress. Between sessions I'd still feel as miserable as I had the time before. And from the start to the end of the session I might feel less sad for example, but I felt more frustrated because I didn't feel very listened to... I said to her what I wanted was to deal with some things right then and there; that those other 'bigger things' I perhaps wanted to park. But she kept tryna tell me that... these big ways that I have of thinking were affecting my right now and I just didn't tend to agree.*

> *I was like those have always been there, I just need you to help me with why I'm overwhelmed at the moment (TW1)*

> *Listen to the person, don't over talk them. Because I've had a few clinicians where I felt like I was talking and they were trying to override what I was saying or making me constantly repeat myself. That's one thing I don't like... And I've met a few people that say the same thing, they want someone who will actually listen and then at the end indicate what needs to be worked on... Like for myself, I'll start expressing what's affecting me, how I'm trying to deal with it, and then I'll be like 'Okay what do you think?' It's not helpful when I'm talking and they cut me off and go 'Oh what about this thing?' It's like hang on, hang on, I haven't even finished' (TW4)*

The importance of being supported to have one's perspective privileged in mental health care was particularly salient for tāngata whaiora who did not have a voice during their time with services. These tāngata whaiora spoke to their involvement in initiatives that ensured Māori had the ability to be heard and fully participate in their wellbeing journey from the outset of service engagement.

> *I'm actually a chairperson on the Kaupapa Māori Service's committee for tāngata whaiora... the whānau will tell me there's something that they don't like and they know they can come and tell us [the committee] and then we go back and say 'This is what needs to change' or 'This is what needs to be done'. It's taken me forever to be able to speak up how I really feel about being in certain providers but I'm starting to find my voice (TW4)*

In summary, tāngata whaiora reflected being empowered to enact tino rangatiratanga, to have their voice heard within the mental health care journey was a practice that facilitated service engagement as it enabled the wellbeing needs of Māori to be met in a meaningful and mana enhancing way.

Relationships

This theme reflects the potential of meaningful, trustworthy relationships between tāngata whaiora and kaimahi to positively transform Māori service engagement. Accessing mental health care required tāngata whaiora to situate themselves within a vulnerable space to process and learn to cope with difficult lived experiences. As this tangata whaiora expressed, a genuine connection with kaimahi provided assurance they would be supported and held safely in the journey through care which in turn facilitated willingness to engage with services.

> *I don't think I was offering up too much at the start. I suppose that it's a very vulnerable place to be as a person, going to see a counsellor and disclosing quite a lot of very intimate things about yourself, about how you're feeling and why you're feeling like that... I definitely feel I had to have rapport before I could admit to myself why I was feeling the way I was feeling. I couldn't just be vulnerable with anybody (TW1)*

The benefits of relationality within mental health practice were affirmed by another tangata whaiora who explained interactions with kaimahi characterised by manaakitanga and the absence of judgement cultivated helpful care experiences and trust to seek help from services.

> *Through my whole experience [with mental health services] I haven't encountered one person who's made me feel bad about being there. I felt nothing but just amazing support, such great people right across... I think that's definitely been the*

> *biggest thing... it's almost like they're living the full potential of what a human can be in terms of their kindness (TW3)*

The bearing relationality had on mental health service engagement was particularly evident when tāngata whaiora experienced an absence of genuine relationships in care. In example this tangata whaiora described being unable to commit to treatment, as rapport had not developed after several sessions. However, upon raising the possibility of working with a different kaimahi, the service arranged a transfer of care. This prioritisation of relationality by the service enabled the tangata whaiora to continue on her wellbeing journey.

> *I said 'Would you mind if I switched to another clinician?' and they were fine with that... It didn't feel that we [the counsellor and I] fit well. After those two or three sessions I didn't feel like we were making any headway in me feeling comfortable in talking with her (TW1)*

Likewise, another tangata whaiora recounted how Māori engagement was supported when services adapted mental health practice so relationships were nurtured. The following quote describes how one kaiāwhina facilitated a connection between a tangata whaiora and her psychiatrist by attending appointments, and how the resulting change in dynamic enabled best practice care.

> *The whole dynamic changes once you go and see a psychiatrist... it becomes a formal doctor to patient situation as opposed to a conversation about your mental health... So one of the things the mental health service did really well was at some point along the line they stopped sending whaiora in to see the psychiatrist by themselves. Instead they sent me in with my kaiāwhina because while I didn't have a relationship with the psychiatrist, she did, she saw him everyday... so she was quite informal and relaxed and that helped a lot, it changed the atmosphere. Things*

> *that I might be a little bit hesitant about bringing up, she wasn't, because she had a relationship with me and she also had a relationship with him. It was like a mediation sort of thing and it made sure that he got the information across, but on the first visit that wasn't there (TW2)*

By comparison, when opportunities for tāngata whaiora and kaimahi to develop relationships as a kaupapa whānau were not supported within services Māori experienced a sense of disconnection from their care team. As this tangata whaiora described, continual changes to her key worker led to a loss of trust in mental health services and disengagement from care.

> *I asked to be transferred [from the service] ... I lost count of how many different key workers they shipped me to... I didn't feel like I was getting very much support at all and that's why I asked to go ... it was never explained why my key workers were getting changed every fortnight. Every time I had a meeting booked in to see my key worker to see what was going to be happening it was always someone different.... It really annoyed me because they could of given me a heads up. And that's why I lost faith in working with the service (TW4)*

Notably, tāngata whaiora spoke to how working with Māori kaimahi positively shaped service experiences by making Te Ao Māori present within mental health care. In this example, a mutual understanding between tangata whaiora and kaimahi about the value and importance of tikanga meant time was made for whakawhanaungatanga where whakapapa and similar lived experiences were shared. This reciprocity in relationships placed Māori at ease and made undertaking the difficult mahi within treatment possible.

> *He immediately disclosed more of himself. I don't mean that in terms of his personal life, though as sessions progressed, I learned tiny little bits about him for example that he's a father. That helped because part of my problem was that I'd just had a*

> *baby and it was really difficult, so he would disclose just enough for me to know 'Okay, so this guy understands'. But when I first went there he told me about his whakapapa, where he was from, and what he had done. And it just made it easier for me to disclose stuff about myself when someone was telling me about themself (TW1)*

As the following tangata whaiora expressed, this cultural connection within therapeutic relationships also opened new possibilities for Māori in mental health care such as how their culture, tūpuna, and Te Ao Māori were a source of strength in wellbeing.

> *What I found most helpful about my counsellor was that she was Māori and you don't really realise how much it makes a difference... It also really made me realise how much missing the Māori world was actually really affecting me and had a lot to do with the strength that I didn't have that I really needed... My counsellor never pushed any of that stuff but I think her just being Māori and understanding my worldviews, she really helped open that door for me (TW5)*

Taken together, privileging genuine, meaningful relationships in mental health care helped tāngata whaiora feel safe and confident to engage with services. Furthermore, the especial connection tāngata whaiora and Māori kaimahi held supported a culturally responsive journey towards wellbeing within services as relationality and Te Ao Māori were placed at the centre of care.

Flexible Mental Health Practice

This theme reflects the increased ability Māori had to engage with services when mental health practice was flexible and accommodating of life circumstances and commitments. Tāngata whaiora articulated this approach to practice related to tamariki being able to attend therapy sessions or when care was offered outside a service environment in local, culturally familiar places. In example, the following tangata whaiora highlighted home visits were the most helpful aspect of mental health care the service provided as they reduced disruptions to daily life and made the journey to wellbeing feel achievable.

> *What the service did which was really helpful was while I still had to see my psychiatrist at the office, the rest of the mental health kaimahi would come to my home... having to constantly go to the hospital was really disruptive because I'd have to get out of work and I'd have to pull the kids out of school sometimes. Whereas this was 'Well you're home we'll come when you're here, when you're ready, and work around you'. And that made life less complicated. It made what I was trying to manage a lot easier to manage (TW2)*

Similarly, another tangata whaiora explained engagement with mental health services was made possible by the manaakitanga and dedication to meet her needs and those of her pēpē shown by kaimahi.

> *When I had the Māori clinician that was great. I had my young baby... and I was really worried about what I was going to do with him. And he [the clinician] made it very clear that I was welcome to bring baby. He said 'You need to stop we can stop. I've organised to have a little bit of extra time in case you need to feed baby' or 'Would you like us to find a bigger room?' And when I first came in he asked 'Is this room warm enough? Is baby okay?' And as soon as baby cried he said 'Do you wanna tend to baby?' Stuff like that, you know, he was very accommodating of my needs and my baby's needs and with him doing that I felt completely comfortable to bring baby and I didn't feel like I was a burden on him (TW1)*

To support the opportunities Māori had to use services, tāngata whaiora suggested technological advances could be utilised in mental health practice by offering assessment and intervention over video calling applications or the phone. This flexibility in how care was provided could mitigate limitations on engaging with services that Māori experienced as a result of time, transport, whānau, or geographical circumstances.

> *These days with internet and phone, maybe we don't need to go and sit in person. You know, some people live out in the country and they can't get anywhere... why can't mental health services offer some of these services over the phone or by Skype?... just open up and use more options, it seems like it's still very far back... say to a mum of five 'You don't need to leave the house for us to have our session. When's baby go down for a nap?' Little things like that, that's going to make a massive difference (TW5)*

Tāngata whaiora also shared the aspiration that kaimahi become increasingly familiar faces in culturally meaningful, everyday environments such as the marae or kura so Māori felt more willing to engage with services.

> *I'd just love to see mental health services engaging in different ways. Come to us at the marae or at the kōhanga or at schools. I think if they could just be everywhere, not all the time, but just be seen; I think that would make such a big difference... You'd feel a connection, instead of just a phone number. You'd be like 'I met her [the therapist] and she was quite nice, I'll try her out'. I just think that would be the best if they [Māori] just felt like it was just an everyday appointment (TW5)*

In summary, tāngata whaiora spoke to how flexible, accommodating mental health practice that was sensitive and responsive to the needs of themselves and their whānau reduced barriers to engaging with services. Through altering the environment assessment and therapy was offered in, opportunities were created for Māori to receive care they otherwise would be unable to and begin the journey towards wellbeing.

Mental Health Literacy

This theme reflects the perspective of tāngata whaiora that low mental health literacy contributed towards service engagement rates among Māori which were incommensurate with wellbeing needs. In their kōrero, tāngata whaiora referred to an absence of knowledge about available services, referral pathways, criteria to access care, and the nature of mental health interventions. For example, this tangata whaiora attributed delays in seeking help to being uninformed about free mental health care entitlements and whether her experience of unwellness met service entry requirements.

> *I didn't know that I had free access to mental health services... and I was worried in my own mind because of my own anxieties that my situation wasn't bad enough, I thought that perhaps they might not see me (TW1)*

Without prior mental health service experience, tāngata whaiora related there was often no guidance for Māori about how to initiate contact with services or what taking part in mental health care involved. This led to concerns about confidentiality and the degree of emotional distress associated with undertaking treatment.

> *A lot of people that need the help haven't had the help before, so you're not going to try out something new if you really don't have a clue what it's like... I just think that a lot of us aren't engaging with services just because we don't have the knowledge of what it actually entails, I think that's the biggest thing (TW5)*

> *If I think about the first time I went it's very intimidating. You don't know what to expect, you don't know the process, you don't know if you're going to be able to answer questions, you don't know what they're gonna to ask you, you don't know if it's going to be a difficult process... you don't have any idea what it's actually like, so I think that is a major issue... I was scared about completely just going upfront and disclosing information without knowing what was confidential... and what*

> *clinicians might pass onto their colleagues. So I didn't know about confidentiality or anything at that point when I first engaged (TW1)*

Further to this, a lack of understanding about mental health problems and the effect on daily life functioning were referenced by tāngata whaiora who described feeling unsure how their experiences of unwellness were positioned in relation to normal life difficulties and whether service engagement was merited.

> *As life went on I was tryna come to grips with what does this major depressive disorder look like for me?... I didn't understand that my lows and what I thought was me going into crisis could just be what everyone else was experiencing around me, and that was just me panicking about life (TW2)*

> *When I first got connected with the mental health service I didn't even know what was going on. Anything to do with mental health, like depression, it wasn't really advertised. And not even my family understood what I was going through and I think even to this day they still don't (TW4)*

In this regard, tāngata whaiora recommended education initiatives which helped Māori better recognise and understand mental health problems as a solution to address low service engagement.

> *A lot of people don't actually understand what's really going on with them. I think what we need is a service that provides specifically for Māori, to help the whānau and the person... give them a bit more understanding of what's going on (TW4)*

In summary, uncertainty about referral pathways, entitlements to access care, what assessment and intervention entailed, and a lack of understanding that services could offer help with the experience of unwellness were perceived to hinder service engagement. The potential to alter service engagement outcomes was suggested to lie in education programmes that supported mental health literacy through disseminating relevant information to Māori communities.

Mental Health Sector Resourcing

This theme captures tāngata whaiora kōrero about how Māori service engagement was detrimentally impacted as a result of the mental health sector being under-resourced. As the following tāngata whaiora indicated, this compromised the ability of services and kaimahi to provide responsive, timely care so whānau in need often missed out and intervention by services only occurred when acute unwellness was experienced.

> *As a whole there are just too many gaps in mental health services (TW5)*

> *I feel like you really have to be at the bottom of the cliff before things happen sometimes (TW3)*

Further to this, the growth in mental health problems among pakeke and rangatahi Māori meant allocated resources were insufficient to deliver the necessary level of care. Tāngata whaiora reflected on the pressure kaimahi experienced as they worked with whānau to the best of their ability under high caseloads and the need for greater support within the mental health sector moving forward.

> *I think mental health services and practitioners need a bit more support because lately I've noticed that most providers are just being run off their feet. And because now it's not just the adults, the youth have been struck with mental health problems (TW4)*

> *I feel like there's a lot of support that is needed for them, for the people working inside the mental health system. So I spose the question is not really 'What can mental health services do [to help improve Māori engagement]?' it's 'What can the government or what can the support structures around mental health services do to*

> *help lessen the load for everybody?'... We hear shit about the mental health system failing and that kind of irks me. It's such a disrespectful thing to say about the awesome people working within it; they're not failing, it's totally the lack of support (TW3)*

The limited number of free mental health care sessions offered through different referral pathways was perceived to discourage Māori from seeking help. Tāngata whaiora explained this was informed by uncertainty regarding the value of service engagement; whether strategies to manage the lived experience of unwellness could be gained in a few sessions, or if opening up about one's difficulties was safe when additional, necessary sessions could not be afforded.

> *I think the fact that they put an amount on the free sessions at the start is a hold back because a lot of people that need the help don't have that money... because the numbering's in your head like 'Am I going to be able to afford it later? Am I going to be able to sort everything out in three sessions?' (TW5)*

Ideally, to ensure all whānau could engage with services to receive help, tāngata whaiora articulated that more government funded mental health care sessions were required.

> *I think it would be really great if the government did offer a little bit more; I was lucky that three counselling sessions were enough at that time. But then when I ended up getting postnatal depression, I found that three free sessions definitely weren't enough (TW5)*

Overall, tāngata whaiora indicated Māori engagement with services was negatively affected by the current resourcing of the mental health sector. The efforts by kaimahi and services to offer responsive mental health care within this structure were acknowledged, however the limited availability of access to funded sessions led Māori to consider whether seeking help was worthwhile. Therefore, additional support for the sector was recommended so appropriate and timely assessment and intervention could be provided to uplift the wellbeing of Māori.

Chapter Eight: Findings – Whānau Member Perspectives on Māori Mental Health Service Engagement

This chapter presents the research findings from interviews with whānau members who shared their perspectives about Māori mental health service engagement. Research findings are organised into eight themes and five sub-themes, as outlined in Table 2, and discussed as they align with the journey whānau members had through mental health services alongside their whanaunga.

Table 2. Whānau Member Themes and Sub-themes

Theme	Sub-Theme
Pathway to Service Engagement: Whānau Support, Whakamā, and Guilt	
Whānau-Centred Approach	Collaborating with Whānau
	Supporting Whānau Wellness
	Whānau as Advocates
Empowering Whānau to Navigate Mental Health Services	
Relationships	Cultural Connection
	Genuine Relationships
Mātauranga Māori: Wellbeing is Holistic	
Mana Enhancing and Tailored Interventions	
Communication	
Mental Health Service Resourcing	

Pathway to Service Engagement: Whānau Support, Whakamā, and Guilt

This theme captures the journey and conflicting emotional experience of whānau members as they supported their whanaunga to engage with mental health services. When whānau believed they could no longer appropriately care for tangata whaiora wellbeing, they initiated contact with mental health services through acute pathways. While it was recognised service engagement would benefit their whanaunga, this experience could be negative for whānau where they felt whakamā, guilt, judgement, and fear. These emotions originated internally from their own values, beliefs, and perceptions, and were also imposed by other whānau members or kaimahi in services.

Whānau members articulated ‘crisis point’ was the catalyst to accessing acute mental health services such as the crisis team and police on behalf of their whanaunga. This ‘crisis point’ was a period where tāngata whaiora experienced severe unwellness and which proceeded earlier attempts by whānau to engage them with services. The following whānau member highlighted tensions between the knowledge an inpatient admission would tautoko the mental wellbeing of their whanaunga and the whakamā and grief associated with this decision for whānau.

> *I think we hit real... crisis point because he couldn’t even walk five steps without responding to voices, so he actually physically couldn’t walk, couldn’t take another step and he’d just, you know, just couldn’t focus. So we tried to take him to the ward and that didn’t work, so we called both the police and the crisis team... It was really hard at the same time because there was that shame and that stigma like ‘How could you do that?’ And so I had my mother wailing like a banshee, had other members of his family sort of saying, you know, ‘You guys, you call yourself family, you guys are shit. How dare you, there’s nothing wrong with him’... so the police*

> *came out, everyone was crying, it was this big deal, and then we went into the ward with him and they put him in IPC Unit [Intensive Psychiatric Care Unit] (W1)*

Whānau members communicated they felt guilty and incompetent as a support system when mental health services were used, especially when their whanaunga pleaded not to be admitted to the inpatient ward. As previously expressed, this feeling was further compounded by other whānau members who denigrated their ability to care for their whanaunga.

> *I think because your whānau member won't like it in there, they're gonna say 'I wanna come home,' you know. It's that guilt thing; you can't take care of your own family member, how useless are you? You're sposed to be family, why can't you fix them? Yeah, I think guilt has a lot to do with it as well coz it's not cool leaving someone in the ward especially when they're begging you not to (W1)*

This notion of being without solutions was shared by another whānau member alongside fear about the outcome for her daughter if she continued down a particular path without intervention from mental health services.

> *I share with my daughter that I get that scared and actually just don't know what to do, so I go and talk to people [mental health professionals] and tell them her business... I've seen it escalate from cigarettes to alcohol, to marijuana to Class A drugs, to boys and sex and sexual abuse... I've offered her rehab and my own family have looked at me and gone 'Rehab? She's 17'. And I've gone 'Yeah, well what solutions do we have? I don't know what to do' (W3)*

The same whānau member indicated whakamā was imposed by kaimahi when her daughter's unwellness culminated in a suicide attempt and engagement with acute mental health services at the hospital. The following is an account of the response given by a staff member when the mother queried why her daughter had been removed from a room without being allocated another space. Both mother and daughter experienced this interaction as demeaning and invalidating of the particular mental health difficulties they were seeking to manage.

> *The nurse said 'I had to move yous out' and I said 'Is there any reason why?' She said 'What do you mean? We needed the room.' I said 'Oh okay, so what's my daughter supposed to do?' And she said to me 'Well this is the drug overdose, yeah? Well we've got real patients that need real care going on in there'... that nurse definitely made me feel anger and made my daughter feel shame (W3)*

Furthermore, throughout their engagement with acute mental health services, the whānau encountered judgement. The quote below conveys the sense that the whānau had to prove their commitment to their daughter.

> *It felt like having to prove our love for my daughter. It felt like we were on the jury stand. It felt like they [the staff] were saying to us that we didn't know her (W3)*

At a collective level, Māori whānau experienced whakamā and judgement during service engagement. This extended beyond stigma surrounding mental health to values of whakapapa and whānau structure whereby Māori may have large whānau, as told by a mother:

> *There's shame. There's a real sense of shame, especially for Māori... you feel a shame that you've let your daughter down, you know. And of course you have to out up with the whole 'I've got five children' so [staff respond] 'Well, you shouldn't of had so many children' (W3)*

In addition, whānau members perceived the stigma and fear elicited by long-standing, inaccurate discourses about mental health problems and treatment dissuaded service engagement. While mental health awareness campaigns were recognised to have facilitated newer, more helpful discourses, whānau members indicated a significant degree of stigma and shame were still attached to mental health and seeking help.

> *I still think even though there's a lot of awareness around mental health, you know the whole John Kirwan, Mike King bringing all that stuff up, the stigma is so still there, the judgment is so still there. Fear, because of lack of knowledge is another one. I think a lot of people think if we're gonna get help they'll get chucked in the looney bin and then what?... all those horror stories stay with you, you know, like the Tokanui horror stories. What's actually happening to them in the open ward?... you just think what if that person attacks him or what if his medication gets mixed up or what if he goes missing? ... It's all those other things too, how do you know he's gonna be safe and what if like on the movies they put on a straightjacket? (W1)*

The value of further normalising and promoting accurate discourses about mental health problems and help seeking behaviour for Māori was illustrated in the story shared by another whānau member. As his father had been a tangata whaiora since his childhood, contact with mental health services was part of the normal fabric of life. This was evidenced by the absence of whakamā in his kōrero about the journey whānau members take alongside their whanaunga through services and recovery. Rather, from a whānau perspective, service engagement was evaluated according to whether or not his father's mauri could be appropriately nurtured with whānau support and creative mediums or the through additional tautoko of mental health services.

> *Because I was ten when he was first diagnosed my brother and I went through a lifetime of not knowing anything different. Like if dad was really up there and hyped, 'Okay he's just in another show, that's his wairua, that's his mauri', we would see that on stage you know... when he was really low he would not engage with us so we would take him out, we'd get him involved in community things, we'd spend time*

> *with him to bring him back up. Or if we were concerned about it, we got to the stage where we could read it that well, you know 'I think that dad needs some assistance now who can we bring in [from mental health services]?' (W2)*

The same whānau member articulated the important role whānau had in the ability of tāngata whaiora to manage wellness outside of mental health services. The nature and duration of this whānau support and decision-making process around service engagement potentially allowed this son to facilitate ward admissions for his father without a strong feeling of guilt.

> *Dad used whānau support... I remember over the years that when my father became ill my aunties would come around and clean the house and cook and take us kids off his hands for short periods, so he was very lucky he had a strong whānau support network... and his friends in acting and theatre were a kaupapa whānau that also would help him. But there were times I remember throughout my life where he became manic that nobody could connect with him and those were the times that he was admitted to institutions or wards (W2)*

Through sharing their experiences of mental health service engagement, the unwavering dedication and manaakitanga of whānau members to support the wellbeing of their whanaunga was apparent. In what was often described as a disempowering and emotionally challenging journey, this is a testament to the immense strength and courage whānau possess, as aptly captured by the following whānau member:

> *You know your person's unwell and even though you know that's [the ward] probably the best place for them it's still hard to leave them there (W1)*

In summary, whānau members articulated whakamā, guilt, judgement, and fear were present from internal and external sources in the journey to and through mental health services alongside their whanaunga. These negative emotional experiences were perceived to influence low service engagement among Māori. As indicated by whānau members, future mahi in further normalising and creating accurate discourses around mental health and help seeking could remove whakamā, guilt, and fear for tāngata whaiora and whānau to improve service engagement.

Whānau-Centred Approach

This theme speaks to the importance of adopting a whānau-centred approach in mental health practice which recognises tāngata whaiora are situated within a whānau who care for their wellbeing and support them with service engagement. Within service settings, a whānau-centred approach involved kaimahi collaborating with whānau, supporting whānau wellness, and appreciating whānau were advocates for their whanaunga.

Collaborating with whānau. Whānau members articulated experiences and engagement with mental health services were influenced by the degree to which care teams worked alongside them in the care of their whanaunga. In their kōrero, whānau members differentiated between the collaborative approaches taken by mental health services as either a necessary, tokenistic process outlined by policy where whānau were invited to hui and talked *at*, or as a genuine practice where kaimahi talked *with* and listened to the perspective of whānau. As expressed by an aunty, the inability of whānau to care for their whanaunga without service intervention did not diminish their want to.

> *The openness, the willingness not just to have whānau involved for a tick box measure but to actually engage whānau, encourage them to come along, listen to what is said. There's a difference and I think we've experienced it between getting family to come along, talking at you, and then ticking the box and saying 'Yup, we did it.' Or actually wanting to know 'Whānau, what do you think would be helpful*

> *and how can we help you?' Or 'How can we help you to help him?' And at the end of the day that's all we want to do. Like obviously we weren't capable ourselves of doing it so we've had to have outside people involved, but at the same time you still wanna be involved and everyone wants the same thing (W1)*

Similarly, whānau members indicated the opportunity, willingness, and commitment by services to involve whānau in the mental health care of their whanaunga was a helpful, appreciated practice that supported service engagement and tangata whaiora wellness. This aligned with the collective nature of wellbeing within Te Ao Māori where whānau tautoko the ability of one another to live well.

> *If you're gonna help somebody chances are you're not just helping them, you're helping their whānau. So yeah, if you can go into it like that, you're not looking at one person really... if it works it's not gonna just work in isolation (W1)*

> *Considering the client comes first but considering for that client, who are their community of support? Like it might not always be their parents but work with their community of support whether it's a school member, or mum, or koro, or nana and just really enable the whānau to be empowered by giving information. Of course the individual makes the decision but whānau should be a part of that too, you know. Whānau should be a part of making the decisions, being able to advocate for having a whānau role in those care plans, the next steps for your loved one (W3)*

Conversely, some mental health services placed whānau on the periphery of tangata whaiora care. This was experienced as invalidating by whānau members given they shared the journey to wellbeing with their whanaunga. Whānau perceived this practice resulted in less responsive care as it negated the opportunity for whānau to offer pertinent, relevant information to services.

> *I don't remember having any really bad experiences other than not feeling heard, and validated, or involved as a whānau. I think those are the shitty things (W1)*

> *People make decisions for the lives of tāngata whaiora and their whānau that the whānau are not really involved in in any way, shape, or form (W2)*

When accessing mental health services where an individual-oriented approach was prioritised, whānau members indicated their involvement was limited to facilitating tangata whaiora participation in treatment when they were non-responsive. Likewise, while whānau respected processes such as confidentiality, few attempts were made to integrate these within Te Ao Māori to allow for the constructive outcome where whānau could receive information relevant to supporting the wellbeing of their whanaunga outside of services.

> *Initially I was asked to wait in the waiting room but when she [my daughter] wouldn't engage they then asked her if they could bring me in, and I knew what was going on... all of a sudden they're talking to me and I said 'Well you need to talk to her' but they're saying 'She doesn't want to engage'. I said 'Well I've really just been made to feel like the taxi, nobody has engaged with me'. They said 'She has a right to confidentiality' and I said 'Yup and I understand that but when I'm the one looking after her you might wanna let me in the loop, you might wanna let me know what's going on because I'm the very one that wants to see this kid happy and healthy' (W3)*

Support for integrating cultural and clinical practice in mental health care was provided by another whānau member who suggested applying this approach to the information gathering style used by kaimahi in services. For example, whānau involvement could be facilitated by identifying with tāngata whaiora important whānau members who could offer support in their wellbeing journey, as expressed in the following quote.

> *I understand confidentiality and not wanting to bring heaps of people in but if you were whānau focused you'd be looking at tāngata whaiora and saying 'What are the supports out there for you?' It's how mental health services ask the question 'Who's important to you in your whānau?' 'Aww my brother coz he helps me' 'Aww okay sweet. Would you like your brother to be a part of this? Or would you like your aunty to be a part of this journey with you? Who are the supports out in the community now?' (W2)*

In line with this idea, whānau members talked about kaimahi who effectively balanced cultural and clinical approaches in their practice by situating tāngata whaiora mental health and recovery within a whānau context and how this encouraged service engagement. These accounts offer evidence that kaimahi cultural competency enables Te Ao Māori to be present in mental health care for the benefit of Māori.

> *Being able to be involved in the decision-making. I appreciate that my daughter's the person, the individual, the client-centred person. I appreciate that 100% and counselling or psychologist's visits those were always one-on-one... I was happy she was engaging, but you see the same thing again with the psychologist: Relatable. And relatable to me doesn't mean he's listening to me as the mother, no not at all. He understands my role as the mother... he had a wider understanding of the role of whānau. He can piece it together: this girl's gotta go home with somebody. So he's working in that context you know, he's not just working with her and then saying to me you need to do this, this, this, and that. It's very inclusive, she's the priority but you can still do that within a whānau system (W3)*

Supporting whānau wellness. Given whānau members support the wellbeing of tāngata whaiora, upholding whānau wellness by offering respite, counselling, or additional support during mental health contact is a way service engagement could be facilitated. However, whānau members often described feeling their contributions to the care of their whanaunga and associated decreases in personal wellbeing went unrecognised by services. One son described how mental health kaimahi inquired about his father's progress without checking how the whānau were coping, despite their active involvement in managing his wellness. This absence of whānau consideration appeared to leave this son with a sense of disappointment and neglect.

> *That's one thing that I think over the forty odd years with my dad nobody asked the question of how my brother and I were. 'Did we need some support?' That was never asked. I don't remember anyone ever saying that. They'd ask to come and visit dad... and then ask questions about 'How is he going? Is he eating? Is he doing alright?' But they never asked us how we were (W2)*

Supporting tāngata whaiora often had a detrimental impact on whānau wellbeing as a result of the stress, worry, and humility required to engage with mental health services on behalf of their whanaunga. Consequently, whānau members articulated they had to enact their own self-care strategies or rely on one another to continue alongside their whanaunga in the recovery journey.

> *I love my nephew so I'm there. But I'm also there because I need to take care of my mum and so lifting some of that stress off her is how I can sort of take care of them both in a little way (W1)*

> *I had counselling myself... because sometimes things got so bad that I had to put the strategies into practice. We have to be so humble; I've had to sit in front of so many people and apologise and listen to the things they've said about my daughter... so the strategies are about care and it also puts me back on track to put her first (W3)*

Nevertheless, whānau members indicated mental health services attended to whānau wellbeing through the provision of acute interventions such as crisis respite, where they cared for tāngata whaiora in a state of unwellness unable to be managed by whānau. This was a helpful practice that offered whānau an opportunity to rest and nurture their own wellbeing.

> *Respite and providing an acute service... that's what the mental health services provided for my dad over a long period of time. When he got to the stage where he was so manic we couldn't manage it, couldn't connect with him. We needed those services and we needed that respite (W2)*

Based on his experiences the same son suggested if services intentionally considered whānau wellbeing while providing mental health care for tāngata whaiora, whānau wellness could be upheld and in turn Māori service engagement improved. Services could offer this support by extending to whānau the opportunity to receive counselling for the trauma, grief, and guilt often associated with the mental health difficulties of their whanaunga.

> *People are working, people live their lives, people have got their own trauma around why their son or their daughter or their father is mentally ill. I think the whānau sometimes blame themselves probably so the other thing I think they [services] need to add is more whānau support, like the whānau may need counselling (W2)*

Whānau as advocates. Whānau members articulated part of engaging with mental health services involved assuming the role of advocate for tāngata whaiora. During interactions with care teams, whānau members sought to be a voice of hope and strength that represented the needs, attributes, and aspirations of their whanaunga when they were unable to speak for themselves. Similarly, unlike care teams in mental health services, whānau members talked about knowing their whanaunga in their entirety; both as a person who was well and thriving and as a person who experienced unwellness.

> *Having the opportunity to be present at those meetings or appointments where my nephew might not be in the space to have his own voice really or maybe because he needs someone to look ahead for him and use some insight. Coz at the end of the day we know him better than the staff, you know. They've only met the unwell him, they don't know the well him. The other thing I do try and do when they [the care team] are talking about my nephew, and what do I think would be helpful, is I always try and mention what he was good at or talk about it like he is still good at it, just to try and reinforce some positives for him (W1)*

As advocates, whānau members also discussed needing to protect their whanaunga from mental health system processes which felt unresponsive and devoid of manaakitanga. In example, a mother described having to assert with kaimahi the opportunity for her daughter to be medically cleared and to rest and regain some of her strength took priority over documentation for disclosure of sexual abuse.

> *There's definitely been a need to advocate and protect her being a young woman (W3)*

> *We had established that [the sexual abuse] was new information so then the social worker said 'We're now going to have to do a report'. I said 'No, not before we get her medically tested and treated, that's what's going to be happening next. And then if she's too tired your paperwork will just have to wait' (W3)*

In summary, this theme reflects the perspective of whānau members that Māori service engagement could be enhanced with a whānau-centred approach to mental health practice which recognises the role whānau have in supporting tangata whaiora wellbeing and recovery. Based on their experiences, whānau members articulated this would involve services collaborating with whānau in mental health care opposed to placing them on the periphery. Furthermore, by offering appropriate support to ensure whānau wellbeing is maintained and facilitating whānau voice so they can advocate for their whanaunga in treatment, mental health services could empower Māori to move towards wellness in future.

Empowering Whānau to Navigate Mental Health Services

This theme reflects the relative sense of empowerment or disempowerment Māori whānau experience while navigating mental health services in support of their whanaunga. Whānau members articulated particular life circumstances provided them with opportunities to attain 'inside' knowledge of how the mental health system worked. As expressed in the following account, this enabled them to feel confident to ask pertinent questions and challenge service processes to obtain best practice care for their whanaunga.

> *I spose studying has been an advantage in that you get a bit of inside knowledge and then of course going to work in an NGO [Non-Government Organisation] and learning the system inside out. So I make it a point that I schedule all his [my nephew's] appointments into my phone and I follow up the week before and a few days before to make sure that the appointments are happening... I think with some knowledge and knowing the right questions to ask it definitely helps to get, and it sounds shitty for these families out there that don't have that advantage, but it definitely helps to get the better service... they [the staff] sort of start recognising your face and they think 'Aww right, okay well we can't sort of skip around this one' (W1)*

Importantly, whānau members reflected on the disempowerment experienced by Māori whānau who did not understand the workings of the mental health system or hold the skill set to navigate it. The difficulty these whānau had engaging with services was evident in their uncertainty about entitlements to care, what constituted responsive practice, and the value of diplomacy in challenging situations. As such, whānau members highlighted the importance of improving mental health literacy among Māori, and training staff to support tāngata whaiora and whānau as they developed and learned to apply competencies to engage effectively with services.

> *You don't know what you can push for and you don't know that 'Hey you're behind on this appointment, these are sposed to happen every 12 weeks, you're failing in your delivery (W1)*

> *I work in community so I'm very fortunate that I have the skills and knowledge already to know how to access services because we refer people all the time, we share information, I'm an information broker... I'm able to articulate myself, I can show that I'm cooperating, I can keep a low tone, I don't swear, I'm quite capable of acting and all of these are good pluses for me. But at the same time there was a whānau there [at the hospital] that didn't have those skills. They were frustrated and they were kicking off. They weren't threatening anybody personally, they were frustrated. But unfortunately because frontline staff don't all have that training to be able to discern 'There's a safety risk here' and 'Ohmygoodness this person is just frustrated and I'm actually just needing to put this stuff to the side and work this person down, de-escalate' they often run into problems that in my opinion are really avoidable, that are unnecessary (W3)*

The kōrero of whānau members discussed here makes salient the differential mental health care experiences Māori have and the compounding barriers that negate service engagement and perpetuate unwellness. In future, to ensure all tāngata whaiora and whānau are empowered to engage with the mental health system and receive responsive treatment, education initiatives that help whānau develop relevant knowledge and skills were recommended.

Relationships

This theme represents the importance that meaningful relationships within mental health care had on Māori service engagement intentions. Whānau members spoke about relationality in terms of a unique cultural connection among Māori kaimahi, tāngata whaiora, and whānau in addition to the presence of genuine relationships among Māori and non-Māori alike.

Cultural connection. Whānau members described holding a special relationship with Māori kaimahi who worked in mental health services. This relationality was attributed to tāngata whaiora, whānau, and kaimahi all being able to share in Te Ao Māori and the inherent understanding about Māori ways of living in the world. Likewise, the traditional structure of relationships such as those between kuia and mokopuna, or whaea and tamariki, guided the behaviours of whānau members and tāngata whaiora to help them re-centre and engage with mental health services.

> *The beautiful lady from St Johns said to me 'Have you asked for cultural support? I can see you're Māori... you can ask one of the aunties. And of course I'm Māori so I know exactly what one of the aunties' mean. And I said 'I would love to have one of the aunties come and sit with me'... I hadn't even thought to ask for an aunty because I was so wrapped in what was going on. And she brought this Māori lady and she hardly said anything but she was just there and it was just lovely (W3)*
>
> *I've got two kuia, well two aunties, sitting in the room with me. It's a check and balance to say 'Tone yourself down, breathe, think about what you're gonna say, absolutely do not swear, talk respectfully, talk honestly, and talk slowly'. So with*

> *their presence in the room, just that respect you see, I'd calmed down and I was talking to the junior doctor and it was coming across really well (W3)*

Whānau members articulated the shared worldview and integration of whanaungatanga into clinical practice by Māori kaimahi helped make connections with tāngata whaiora and whānau that facilitated mental health service engagement. In the following example, a whānau member described how a kaumatua with the CRS used cultural imperatives of relationality with his father to reduce the distress and disempowerment associated with a psychiatric assessment and possible inpatient ward admission.

> *I remember one time when we took him into the hospital ward he was so manic, no one could connect with him, and an older Māori male who was attached to the crisis team came out to his house. And it was simply a brown face, and someone that was not a young face, who was able to coax dad out of his house without requiring force to hop in the car and to go for an assessment in front of the psychiatrist. But that gentleman used cultural imperatives if you like; whanaungatanga, making connections, a lot of the things we talk about in practice. Now the gentleman used those to connect even when dad was really manic and to calmly get him to leave his house and go and get an assessment... I suspect if he hadn't come and it hadn't been an older Māori male they would of needed police and people to restrain him and get him out of his house (W2)*

The same whānau member contrasted the intentions of his whanaunga to use services between working with kaumātua in mental health care and non-Māori kaimahi where a mutual understanding of, and engagement in Te Ao Māori, was absent. An inability to bridge this divide meant a relationship was not formed with the kaimahi which significantly contributed towards his father's disengagement with mental health services.

Although this whānau member acknowledged the opportunity for tāngata whaiora to engage with Māori kaimahi had improved to a degree, this option was not present during the lifetime of their whanaunga.

> *Quite often the practitioners that he was working with were not reflective of Māori... and dad just couldn't connect with them you know, they didn't reflect his world or his life. And I think that's about Māori working in mental health and it's changed a lot now, to an extent there are some Māori options. But you're talking over twenty years ago you know, there weren't those options as much and he [dad] just didn't engage (W2)*

The relationality and implicit understanding of Te Ao Māori present within the mental health practice of Māori kaimahi provided culturally responsive service experiences and therein a willingness to engage. Consequently, whānau members suggested building on this unique cultural connection by supporting Māori workforce development so mental health services could reach Māori in need.

> *I do wonder if Māori staff make a difference, there's just the rapport that the clients seem to get, it's just, it's easier... I think they start seeing the staff sort of like whānau, you know, they start calling some of the staff aunty or whaea... so I do think there's that little something extra of having Māori staff (W1)*

> *[Māori practitioners] are able to connect with the whānau and the connections in the community... they know that whakapapa and they can draw those connections and build those connections with tāngata whaiora. I think that is a place, or a process, that enables the whānau to be involved (W2)*

Genuine relationships. Beyond a cultural connection, wellbeing and mental health service engagement was supported when nurturing, relatable, people-centred relationships between kaimahi, tāngata whaiora, and whānau were present. In example, a mother shared it was the genuine relationship with a non-Māori psychologist that facilitated her daughter's engagement when other attempts of service contact had failed.

> *We had organised visits with a psychologist... we found someone that she really liked… just really relatable, so respectful and I hit it off with him, my daughter hit it off with him, and it was great. She went to him for about three months or til two and a half months. Every week we went and it was good for her (W3)*

The simple act of showing manaakitanga towards tāngata whaiora and whānau in emotionally overwhelming situations also helped build trusting relationships and perseverance to engage effectively with acute mental health services. For instance, one whānau member shared how a nurse treated her daughter and herself with kindness and compassion following their mistreatment by a colleague.

> *[The nurse] had been witnessing what was going on and she'd come into the waiting room and she said 'I'm gonna get you a room ready darling' to my daughter. She said 'Look I could get in trouble for saying that, we're supposed to use names around here, but you're the same age as my son... about 16 or 17?' And my daughter said 'I'm 17' and she goes 'Yup, you're about the same age as my son so I have to call you darling because that's what I call him'... then she said to me 'Look why don't you go and have a cup of tea, I'll sit with your daughter'. And you know what, I said to her 'Thank you, I will do that' and yet I didn't want to leave her [my daughter] before, that was the first time. I felt in that short amount of time we had established some trust (W3)*

Contrary to positive relationship experiences, whānau members expressed they felt concerned and hesitant to entrust the care of their whanaunga to services where kaimahi presented as disinterested or desensitised to mental health problems. This highlights the importance of relationality when Māori decide whether to engage with mental health services, as expressed by the following whānau member.

> *I met him [the psychiatrist] and he just, he must have been having a bad day. We walked in and he was sort of slumped, with his arms crossed, back in his chair. He wouldn't really make eye contact, he sort of was picking at his nails and talking to his hands and I was thinking 'What the eff?' because you know, I'd built it up... I was just not happy when I walked outta there. And I did consider a complaint, I didn't complain but I did consider it. But he was much better next time and the visits since he's been really good (W1)*

> *You're not there. You're giving your care of your loved whānau member over to a bunch of strangers that can sometimes be so clinical and not very good people mannered... I do think sometimes people who work in that field become a bit desensitised... I don't think they mean to but you know, yeah, some of the language, you start think mmm maybe you need another line of work (W1)*

Relationships were at the centre of recommendations for how mental health practice could enhance Māori service engagement. Whānau members advocated for a workforce composed of Māori and non-Māori kaimahi alike who brought the qualities of kindness, empathy, and humility to therapeutic relationships alongside a passion to help Māori experience mental wellbeing.

> *It's not just Māori that work with Māori. It's Māori and non-Indigenous people that work passionately with our people, really love and care and have so much respect and humility and all the sharing and caring in the world. When I think of working with my people and moving them to a better place, I don't just see a world of Māori doing that. And I like to get alongside anyone that wants to work with Māori, they're my friend, they're my friend for life. I can't even work with my own daughter so you*

> *know we need these people. So when I think about making things better for Māori it's a whole community approach (W3)*

In summary, whānau members indicated meaningful, authentic relationships with Māori and non-Māori kaimahi in care facilitated service engagement intentions. Notably, whānau members articulated privileging relationality within mental health practice represented a promising pathway for services to reach more Māori in need. This recommendation involved further developing the Māori workforce alongside encouraging a collective approach between Māori and non-Māori kaimahi to manaaki and tautoko the mental wellbeing of tāngata whaiora and whānau.

Mātauranga Māori: Wellbeing is Holistic

Whānau members articulated the use of mātauranga Māori in mental health practice provided culturally and clinically responsive care experiences which encouraged service engagement. Mātauranga Māori was perceived to facilitate an appreciation among kaimahi and services that wellbeing is holistic; that wairua and relational health sit alongside mental wellness. As an aunty explained, translating this understanding into clinical practice benefitted tāngata whaiora whereby it helped them to make progress in recovery and live well.

> *The framework of care... it's sort of like the [Te Whare] Tapa Whā complex... is tryna focus on those holistic things, incorporating more wairua into care. That's where the Tai Chi works for my nephew, that's his little wairua bit. He's got whānau in there too, where he used to go out every Friday to my mum's (W1)*

Alternatively, the value of mātauranga Māori was illustrated within a kaupapa whānau context. By supporting their whanaunga to participate in the creative arts and strengthen his connections with wairua, the kaupapa whānau helped nurture holistic wellbeing. This uplifted the mauri of the tangata whaiora and enabled him to effectively manage his mental health problems using a Te Ao Māori approach.

> *Some of the rangatira in Māori arts theatre were dad's mates in the seventies and eighties and whenever they saw or heard from us that dad was a bit poorly they'd come and get him involved in a new show, you know, because they knew that would pick him up. He'd connect with wairua through his acting or through the networks of people, so there were long periods of time where he managed his mental illness through non-pharmaceutical methods (W2)*

By comparison whānau members indicated mental health care provided for Māori by services was adversely impacted when mātauranga Māori was absent, as psychological health was solely focused on to the detriment of holistic wellbeing. As such, whānau members suggested an improvement in mental health practice could be enhancing knowledge of Māori health models to enable kaimahi and services to work competently with holistic assessment and interventions approaches.

> *I think [mainstream] just don't get the picture, they don't. I think that holistic thing is so missing. It's okay to say the words but if you don't understand it coz you don't practice it, it's meaningless, it's just words. I know Mason [Durie] sort of made the Te Whare Tapa Whā model not so much for us [Māori] but so other people could have a bit more understanding into what would work better (W1)*

Another aspiration of whānau members for future mental health practice was that services would refrain from using Pākehā diagnostic frameworks for culturally bound experiences which are valid and responsively managed within Te Ao Māori. One whānau member used matakite, the ability to see between the spiritual and physical realm, as an example where tāngata whaiora could be given the opportunity to use mātauranga Māori and explore this experience in relation to wairua. This Māori perspective was contrasted with a clinical one which would ascribe the experience to drug use and prevent tāngata whaiora from engaging in a culturally meaningful sense-making process.

> *Don't use DSM-IV and DSM-V to diagnose Māori because there's no culture in either of them... probably one of the biggest hopes I have, and that's along the holistic line, is that mental health practitioners are educated in what matakite means and feels like from a Māori perspective... it's about appreciating a Māori view of the world and not saying that matakite is related to the P you've been taking. It may be drug abuse but allow the tangata whaiora to explore their world... it also may be a true wairua experience for them. My aspiration for the future is... understanding the concept of Māori spirituality, wairua, and matakite (W2)*

Overall, the perspectives of whānau members discussed here speak to the value of creating space for Māori to be as Māori in services by grounding mental health practice within mātauranga Māori. This approach has the potential to provide tāngata whaiora and whānau with affirming experiences that facilitate willingness to engage with mental health services.

Mana Enhancing and Tailored Interventions

Whānau perceived responsive mental health care was tailored to who their whanaunga was as a unique person, valuing their abilities, experiences, and worldview. When interventions did not seek to enhance the mana of tāngata whaiora and whānau setbacks in recovery and service disengagement occurred. For example, a whānau member related his father would not engage with mental health services because the pharmaceutical management of bipolar did not align with his holistic understanding of wellbeing.

> *He didn't engage with mental health services. He basically would play the game if you like, take the medication until they would release him [from the inpatient ward] and once they would release him, he sought to find his own ways of managing his mental illness... karakia, things like waiata. I remember people throughout my life bringing priests to talk dad up or talk him down depending on where he was in his bipolar. I remember them even bringing tohunga to speak with him... the other thing he did too is he got heavily involved with theatre, the Māori artists, writers... and he would use the endorphins and the dopamine that he had generated from adrenaline from being on stage to maintain his mental health (W2)*

Alternatively, when kaimahi developed rapport with tāngata whaiora, interventions could be appropriately tailored to their unique needs and personality thereby encouraging service engagement. This approach to mental health practice was supported in the account by the same son regarding the discovery of his father's journal collection that held writings and reflections from challenging times of unwellness. The son surmised journaling was an effective coping strategy suggested by kaimahi who understood his father as a person and which he subsequently utilised because it connected with his worldview and artistic passion.

> *He was a prolific writer... and I think that was one of the strategies he got given was to write down what he was thinking and feeling. I was going through those [writings] after he passed away... I got to read some of the things that he wrote and some of that was really really black, you know, when he very suicidal and what he thought of himself during those times... that was a strategy somebody gave him from the mental health services, just to write things and to get them out, not to have them inside... he would adopt [strategies] if he felt they were logical or they worked for him (W2)*

Interventions that empowered tāngata whaiora to live a full life also offered whānau members hope about the future their whanaunga. As an aunty relayed, when her nephew's care team shared with the whānau positive aspects about his recovery in a residential setting, both tangata whaiora and whānau mana were enhanced.

> *You always get the phone call when shit goes wrong, but you don't necessarily always get that same thing when stuff goes right. And what I do like about what's happening with my nephew's care worker at the moment is... he sends me pictures of my nephew cooking this amazing Thai food or stir fry or... pictures of him mowing the lawn or you know all those little things which are good... I think as a family that makes a difference... it gives everyone a little bit of hope I think (W1)*

Notably, whānau members perceived the suitability and therefore effectiveness of interventions changed throughout the lifetime of their whanaunga. This perspective reflects the dynamic nature of mental health care and the necessity for regular consultation with tāngata whaiora and whānau to ensure that best practice, service engagement, and wellbeing is maintained. For instance, a son indicated his father's opposition to pharmaceutical interventions reduced as an older adult whereby physical health problems and the inability to participate in creative arts made medication a more acceptable, effective option to help him maintain wellness.

> *He used to hate antipsychotics because he felt they took away all his energy for acting and acting was his passion, you know, so that's one of many of the reasons why he wouldn't take them. And they would affect his personality so much he just didn't have the normal mauri that was him... He did finish the end of his life on antipsychotics that being said though, the last probably 5 or 6 years he had lots of health issues to do with his heart and diabetes and other things... when he became physically unable to do a lot of the theatre he started taking more of the*

> *antipsychotics just to keep him stable and calm and happy, you know, coz he wasn't using other ways of managing it (W2)*

Nevertheless, whānau members expressed the process of mental health services attempting to negotiate a suitable intervention for their whanaunga could be distressing and disheartening. One whānau member perceived services 'experimented' with his father with a constant cycle of unsuitable treatment medications.

> *I felt as a whānau member they were constantly experimenting with my dad. They didn't know what type of antipsychotics or what level of medication would work for him because of being readmitted. This is just my opinion, you know, but I felt that they would always try different things to improve dad's mental ill health and yeah, I don't think they ever really totally got it right for him (W2)*

Likewise, another whānau member indicated her daughter was positioned as powerless in mental health care thereby discounting the strength tāngata whaiora draw from their whānau and tūpuna.

> *I said 'My daughter's got a lot more strength than what anyone might think'. She [the CRS social worker] said 'No, she's vulnerable, she's a victim'. I said 'Oh no doubt, but she's also a strong woman as well. You don't know the line of women that she descends from... there's her mother, and then there's her mother's mother, and her mother's mother's mother, so she has a lot of strong blood running through her veins (W3)*

Building on this resilience Māori possess, whānau members expressed it was integral the mana and strength of their whanaunga was uplifted within mental health care. In practice, this involved services helping tāngata whaiora to realise their potential through facilitating participation in conversations about their life plan and by using strengths-based positioning.

> *People in their brokenness, they have strength, however minute. Whatever their capacity to give to their own kaupapa, they can contribute and we've got to stop victimising them - the fact they're made a victim as a result of their experience, what they may have been through, been afflicted by. But when it comes to their lives we've got to look for the opportunities, however small they are, to be able to have people be a part of their life plan that we're talking about (W3)*

One mother shared her hope that in future services would equip whānau with the capabilities to help tāngata whaiora maintain wellbeing after discharge. When mental health services took on this role, a degree of dependency on the system was created that was mana decreasing for Māori.

> *I'm all down for professionals but if they fill those gaps for whānau there's no opportunity to self-determine. It becomes like a benefit, a welfare system that you become dependent on: 'Oh well someone else will do it for us' and that's what's happened to a lot of our whānau (W3)*

As a collective, whānau members described experiences of responsive, mana enhancing interventions alongside disempowering treatment approaches while supporting their whanaunga through mental health services. To facilitate best practice that uplifts wellbeing and service engagement among Māori, whānau members suggested interventions be tailored across the lifespan to who tāngata whaiora are as a person with unique attributes, histories, and worldviews.

Communication

Effective communication in mental health care influenced Māori service experiences and engagement intentions. Whānau members explained communication involved kaimahi sharing information in a clear and consistent way; providing whānau an opportunity to ask questions so they could understand the mental health problem and care plan of their whanaunga; upholding standards of confidentiality and accuracy in recording and disclosing information; and informing whānau about progress in mental health care being provided.

Whānau members articulated the use of clear, understandable language was integral during interactions with mental health services. This communication style enabled everyone present, from kaimahi to tāngata whaiora and whānau, to hold a shared perspective of the care plan being discussed so informed decisions could be made. For instance, an aunty recounted herself and her whānau were confused after attending an appointment with the psychiatrist because of the clinical language used. Consequently, little value or progress for the whānau was gained from the interaction and served as a deterrent to engage with services in support of their whanaunga.

> *You know all the big jargon, I saw it with my mother and my niece; they would sit there nod and nod and nod walk out - 'I don't know what he just said' (W1)*

Similarly, variability in the nature of information provided to whānau members by kaimahi negated their ability to meaningfully understanding the mental health difficulties their whanaunga experienced. Although whānau members continued to engage with services because their whanaunga was acutely unwell, they perceived a lack of clear and consistent communication led to mistrust in mental health services and lower access rates among Māori.

> *They [clinicians] tried to give us [my brother and I] an explanation of what's wrong with dad, you know. I remember those starting really early when I was a teenager and going 'Do you know what's wrong with your dad?' [and us responding] 'Aww, yeah yeah yeah'. But then as time went on you'd get different practitioners that*

> *would tell you what bipolar manic depression meant to them from their diagnosis, and that might change depending on the practitioner... so most of my life I did not have a lot of faith in mental health services and I think even now I don't believe that mental health services are focused on Māori (W2)*

The same whānau member relayed that in later years, after studying in the field of mental health, he finally gained an understanding about the diagnostic criteria and descriptors of mental health problems and in turn his father's lived experience with bipolar. As a whānau member, he expressed a sense of lamentation at the lost opportunity for deeper empathy for his father and how this could have influenced the nature of whānau support provided.

> *I used to describe that I knew more about bipolar manic depression than some of the people from health services coz I'd had thirty years of it, thirty years of descriptions being given to me... it wasn't til studying DSM-IV and DSM-V in my degree that I started seeing they work off slightly different descriptions, like 'severe' or the types of bipolar that are in DSM-IV. And I thought aww people didn't really explain that to me so this is probably the space that my dad was in (W2)*

Whānau members indicated a genuine manner in communication displayed by kaimahi facilitated helpful mental health service experiences. This involved kaimahi inviting whānau to ask questions, share their perspective, and collaborate in a recovery plan for their whanaunga.

> *What I do like is that they don't just say 'Has anyone got any questions?' and carry on. They pointedly will look at you [and ask] 'Do you have any questions?' or 'Is there anything that you need to see or need to know? (W1)*

However, whānau members perceived consultation and judicious application of confidentiality that would enable whānau to uphold tangata whaiora wellbeing were sometimes absent in mental health services. For example, a mother discussed the process of negotiating consent for information that protected her daughter's right to privacy and gave whānau an understanding about her risk and a safety plan following an attempted suicide. This experience left this mother feeling she was placed on the periphery of her daughter's care by services despite being her support system.

> *Navigating the services up at the hospital, that was challenging, particularly around gaining consent. The CRS had been called in and she [my daughter] sort of says 'Oh, I'd like you to leave'... and I go and wait out there and then get called back in and then I get told 'You know, you're safe for her to come home with'. And quite literally just got told like that 'Look we've done an assessment and we've deemed you safe for your daughter to go home with'. No consultation. (W3)*

Whānau members also indicated standards of confidentiality were compromised during mental health service engagement with the disclosure of sensitive information to inappropriate parties. The same mother recounted a kaimahi had made assumptions about who was in her daughter's whānau and openly began to discuss her care in a non-private space. When she brought this breach of confidentiality to the kaimahi's attention, she perceived a lack of professional awareness and remorse was present. This suggests renewed efforts by services to ensure kaimahi adhere to tangata whaiora and whānau rights in mental health care can facilitate empowering, trustworthy experiences that support service engagement.

> *The nurse came into us and there was another lady in there and the nurse starts talking about her [my daughter's] business in front of this other lady. And I said 'I just need to stop you there, this is not very appropriate, it's not confidential for a start'. And she said 'Oh I'm sorry, I thought you were all together'. I said 'I don't*

> *know how you would know that because you didn't check that' and she said 'It wasn't intentional' (W3)*

With respect to the accurate recording of information, whānau members described instances of having to take an active role to ensure the appointments for their whanaunga were correctly documented. Although tāngata whaiora benefitted in the receipt of mental health care when whānau assumed this role, whānau members perceived it was a reasonable expectation of service delivery that kaimahi could fulfil this responsibility. Nevertheless, whānau members indicated when information from hui with the care team of their whanaunga was accurately recorded, encounters with services were helpful as kaimahi and whānau were on the same page in supporting tangata whaiora recovery.

> *What I find helpful is... having the information correct and accurate. So I've had to ring sometimes and say 'Is this appointment still happening on this day at this time?' [The staff say] 'Umm oh ah no it's not in our book' and it's just because someone didn't write it down. I schedule everything into my phone. And then [staff query] 'Why do you think that's happening?' [and I respond] 'Well at this meeting, on this date, at this time it was decided and this person and this person and this person were there' [staff ask] 'Um can I ring you back?' And so I get really annoyed, I mean if I'm only a family member and I can have all that information I expect better from people who are paid and have responsibility to provide that service you know, I expect them to have that information and do it right (W1)*

Lastly, effective communication involved mental health services maintaining contact with whānau about progress in treatment for their whanaunga. Whānau members indicated that when care teams relayed information to them, even if it was of an undesirable nature, the perspective and respect this offered helped facilitate service engagement. For example, a mother explained her whānau would have appreciated being advised about the wait period for the CRS risk assessment opposed to being kept in the dark and a constant state of anxiety.

> *Communication, even if it was not what we wanted to hear just talking, communicating, keeping us at ease. Saying 'Look the CRS team is going to be at least another 3 hours and unfortunately you have to stay here, but there's a coffee machine down there, you know, feel free to go and grab a magazine'. Communication (W3)*

Further to this, another whānau member explained the most unhelpful experiences with services were when whānau were uninformed about changes in the mental health care of their whanaunga. This ranged from whānau not being advised about rescheduled appointments to when tāngata whaiora were placed under, or removed from, the Mental Health Act. The acuity of unwellness necessitated continued engagement by whānau members in support of their whanaunga, however these poor communication practices by services demonstrated little consideration for the role of whānau in recovery.

> *I think the crappiest experiences have just been when we haven't been informed. When we haven't been advised of appointments or especially things like when he's either put under the [Mental Health] Act or removed from the [Mental Health] Act (W1)*

To conclude, whānau members described varied experiences of effective communication during contact with mental health services. Providing information in a clear, consistent, and understandable manner, inviting whānau to be a part of conversations regarding the care of their whanaunga, and upholding ethical and legal standards of practice were highlighted as holding potential to influence the nature of mental health care experiences and therefore service engagement among Māori.

Mental Health Service Resourcing

This theme captures how Māori service engagement was detrimentally affected by the resource constraints services faced which reduced their ability to respond to mental wellbeing needs. Whānau members described experiencing delayed response times as they attempted to access professional support for their whanaunga. While whānau members understood the mental health sector was under pressure and overworked staff were trying their best to deliver appropriate and timely care, the limited capacity of services was perceived to lower intentions to seek help among Māori.

> *Services are overloaded in mental health at the moment and it's impacting more on Māori than anybody else (W2)*

> *They [the acute hospital staff] said we need an urgent evaluation from the CRS team. We've been in there 6 hours already before the CRS team turn up... this is their urgent (W3)*

Similarly, the following whānau member explained that after a six-week waitlist period for service entry, her daughter felt uncared for and that her difficulties with mental health were unimportant which led her to prematurely disengage with the service.

> *We went to CAMHS but it was at least a 6 week waiting period so by the time we got in there, and I know it's not their fault, we've got such a lack of capacity and capability across our workforce at the moment that everybody's stuck and everybody's trying to do the best they can including our services so I understand that, but by the time we got in there my daughter just wouldn't engage with them. She sort of had this chip on her shoulder that 'Oh if you really thought I was that urgent you would have seen me 6 weeks ago' (W3)*

Overall, whānau members reflected how the current allocation of resources to mental health services deterred engagement among Māori. The accounts provided described situations where upon seeking help, tāngata whaiora and whānau encountered long wait times to receive care which was experienced as invalidating. This highlights the importance of restructuring funding so the mental health sector can meet the wellbeing needs of Māori.

Chapter Nine: Findings – Māori Kaimahi Perspectives on Māori Mental Health Service Engagement

This chapter presents the research findings with Māori kaimahi who shared their perspectives about Māori mental health service engagement. Research findings are organised into five themes and ten sub-themes, as outlined in Table 3, and considered in line with the emphasis kaimahi placed upon them during interview kōrero.

Table 3. Māori Kaimahi Themes and Sub-themes

Theme	Sub-Theme
Practicing in Te Ao Māori	Tūrangawaewae: A Place to Stand
	Tikanga and Mātauranga Māori
	Working Alongside Whānau
	Blending Cultural and Clinical Waters
	Kaimahi Cultural Identity and Competency
Weaving Relationships	Collegial Relationships
	Relationships Between Services
	Relationality in Practice
Communication	
Misconceptions and Mistrust of Services	
Framework of the Mental Health System	Policy Tensions
	Lack of Resourcing

Practicing Within Te Ao Māori

Māori kaimahi articulated a fundamental determinant of service engagement was the provision of mental health care guided by Te Ao Māori: a Māori worldview, knowledge, beliefs, practices, values, and social structures. Practicing within Te Ao Māori involved facilitating cultural reconnection for tāngata whaiora and whānau, following tikanga and mātauranga Māori, involving whānau in mental health care and upholding their wellness, integrating cultural and clinical perspectives in practice, and kaimahi acknowledging their own cultural identity and competency.

Tūrangawaewae: A place to stand. Reconnection with Māoritanga as part of one's identity was considered a source of strength in recovery for Māori that was empowering and mana enhancing. Kaimahi indicated when tāngata whaiora were supported to learn about and understand themselves within their whakapapa, culture, and world they discovered their tūrangawaewae, their place to stand. Given the inherent ties between cultural identity and wellbeing, kaimahi related integrating cultural reconnection in mental health care was an affirming experience for Māori which uplifted wellness and encouraged service engagement. This perspective was aptly captured by the following kaimahi:

> *I see us as having a responsibility to promote cultural practices, you know. And as Mason Durie says identity is so important for our mental health. I guess that's where that idea is about promoting cultural reconnection if they're [tāngata whaiora and whānau] not already connected (K4)*

Kaimahi facilitated cultural reconnection through a variety of approaches within their mahi. In example, traditional Māori arts such as harakeke weaving were used as an intervention by one kaimahi to help a tangata whaiora make sense of her lived experiences and whakapapa in a culturally meaningful way. Learning harakeke weaving supported the tangata whaiora to receive knowledge from her tūpuna this art form held, grow in her identity as Māori, and engage with mental health services.

> *She's been responding really well to the cultural activities... we'll weave harakeke and make flowers and I'll kind of use that in the intervention. We split the harakeke up into the different segments and what each segment represents, like the things that might be important to her inner life, and then we'll weave it together (K1)*

Importantly, tāngata whaiora and whānau were supported to reconnect with Māoritanga in a way that matched where they were placed in their cultural identity journey. As the following kamahi explained, while some whānau were firmly grounded in Te Ao Māori others were beginning to walk in this world and therefore held concerns about having to be well versed in te reo Māori or tikanga to access Kaupapa Māori services. As such, cultural reconnection was uniquely tailored to each whānau by offering options around tikanga to help them feel at ease within the service environment and reduce engagement barriers.

> *It's allowing them [tāngata whaiora and whānau] to be who they are in a Māori mental health service. Because there's so many families that come in who are disconnected or don't speak te reo Māori who sort of, at times, have an idea that... because we're a Māori mental health service they need to know te reo Māori, so they get a bit anxious. I guess it's about giving options when you meet with them. One of our things is about promoting cultural input, promoting karakia, promoting waiata, promoting processes... so for me I go in and say 'Would you like to open with a karakia?' and they may say 'Yes'. And if they say 'No' that's fine. I say 'Let's start off with introductions'. So I guess it's about giving them options around the cultural thing (K4)*

For the duration of mental health service contact, kaimahi continued to facilitate cultural reconnection at a pace that complimented tangata whaiora and whānau growth in their identity as Māori. In example, one kaimahi relayed that in her practice she built upon particular interests tāngata whaiora held in Māoritanga such as karakia. In each care interaction, she and the tangata whaiora worked together to learn a karakia, with the tangata whaiora eventually taking the lead as her knowledge and confidence to engage in Te Ao Māori increased.

> *If it seems like they're [tāngata whaiora] interested in karakia I might give them a flashcard so they can read the karakia. With one tangata whaiora I was working with we were doing the drawing therapy, so we would automatically open and close with karakia because it was sort of tapu or sacred work... I'd give her a flashcard and we'd start off where I would do the karakia, and then it was 'How about we read it together?'. And then, two or three times after reading it together I said 'How about you read it on your own?' and by then she was doing it without the card (K4)*

Kaimahi spoke to the sense of completeness an understanding of one's identity and whakapapa to tūpuna, iwi, hapū, whānau, and whenua could give tāngata whaiora. This cultural reconnection could be promoted in mental health practice simply through asking the question 'No hea koe? Where are you from?' This provided kaimahi, tāngata whaiora, and whānau the opportunity to collaboratively seek out these connections and work alongside people, like kaumātua, who may hold this knowledge. Although kaimahi acknowledged this was currently practiced in some services, they expressed the hope that in future cultural reconnection would be embedded in the provision of mental health care for Māori.

> *Imagine if the therapist or whoever said 'Do you understand where you come from?' Even if you're an adopted child or you're a whāngai'd child, is there*

> *someone we can connect with? If you're the practitioner and you said 'Where do you whakapapa to? Do you know?' and the whaiora replied 'I don't know' so then you said 'Well okay, let's have a look and see if we can find a kaumatua or kuia who may know that connection'. And I do see that as the practitioner's role, in whichever level... you are the right person to try and find the connection (K3)*

Tikanga and mātauranga Māori. Kaimahi articulated following tikanga and mātauranga Māori in mental health care with tāngata whairoa and whānau and as part of organisational culture supported service engagement. This Te Ao Māori approach to practice positioned Māori perspectives, knowledge, values, and customs as normal and legitimate which created space for Māori to be as Māori in mental health services.

Tikanga and cultural values handed down through whakapapa were enacted by kaimahi from the outset of mental health care with tāngata whaiora and whānau. By engaging in whakawhanaungatanga and expressing manaakitanga, kaimahi began to develop caring, meaningful relationships that form the social foundations of Māori culture. Prioritising cultural imperatives above clinical processes helped facilitate the transition into mental health services for tāngata whaiora and whānau and prepare everyone to take part in the journey ahead.

> *I try to whakawhanaungatanga at the beginning. And I spose I always offer tea or coffee or sometimes little biscuits if I've got them just to, you know, make them feel comfortable. And we have a bit of a chat in the beginning before we get into it, rather than it being just full on serious and clinical (K1)*

Likewise, cultural processes that welcomed Māori into services such as the pōwhiri or mihi-whakatau integrated mātauranga Māori within mental health care. The following kaimahi explained how pūrākau about ātua shared in the mihi-whakatau enabled tāngata whaiora and whānau to contextualise mental health problems within Te Ao Māori and develop a positive pathway towards wellbeing.

> *The mihi-whakatau, that's the important part of the engagement. I use a whakataukī and then I can translate that into English. If there's a karakia about Rangi and Papa and their tamariki and those ātua I'll use that. There's a connection with those ātua, you can tell a story about ātua. You can tell the relationship with either Tāne Mahuta or Tangaroa or Tāwhirimātea and align it to our whānau that are presenting (K2)*

At the close of service engagement, relationships with whānau and the progress of tāngata whaiora were honoured through the farewell process of poroporoaki. One kaimahi gave an account where the mauri was returned to a tangata whaiora and his whānau and the transition from tapu to noa in mental wellbeing was celebrated through poroporoaki. This practice of tikanga also acknowledged that relationships formed between kaimahi, tāngata whaiora, and whānau as a kaupapa whānau were lasting. Notably, this Te Ao Māori approach to care aligned with the worldview of the tangata whaiora to provide a positive and responsive service experience that supported engagement.

> *We met with one of our whānau yesterday and part of that process is that we're gonna now hand the mauri back to him and his whānau. That sort of dark cold that he was in, that tapu, we want to now bring that out into noa. And so we're going to his whare, we're going to bring some kai, and we're going to hand the mauri over to him and to his whānau. And he liked that, yeah he really liked that Māori worldview, that it's not 'Oh well you're finished with our service now'. He came in uncertain, he came in feeling sort of in a real dark world and now he's alive, he's cheerful. Yeah, we want to acknowledge that (K2)*

In appreciation that participation in Te Ao Māori can uplift wellbeing within mental health care, kaimahi also provided tāngata whaiora with opportunities to attend tikanga and mātauranga Māori wānanga through their own whakapapa connections. As an example, a kaimahi described how her colleague organised a wānanga at his marae for tāne tāngata whaiora where they were supported to learn about mātauranga Māori and begin developing confidence in tikanga and marae kawa such as pepeha and whaikōrero.

> *My colleague trialled two lots of three day wānanga with whaiora males, Māori males at his marae. He took them for three days with their medications and all of that... and he took them through a series of tikanga Māori. You know, tika, pono, aroha, whaikōrero, karakia, mihimihi the real basics that these Māori men had missed... and yes it was difficult for them that their unwellness had moments but the flow on effect for them is the confidence they have if they go to marae. They're not afraid to go anymore, they're not afraid to be a part of a hui, they're not afraid to have to say who they are, you know, so it's reduced a barrier for them. Things like that make a huge difference (K3)*

However, despite the value of practicing tikanga and mātauranga Māori within care, some barriers were present in the ability of kaimahi to fully do so. In example, the following kaimahi explained mental health services might not have both a kaumatua and kuia to provide balance in cultural processes, which limited the scope to engage in Te Ao Māori with tāngata whaiora and whānau.

> *We have a 0.5 FTE kaumatua. So we don't have a kuia which becomes an issue because effectively, if you want balance around cultural stuff and kaumātua, there should be a female and a male (K4)*

Furthermore, kaimahi indicated engagement was influenced by the degree to which mental health service culture and practice was guided by tikanga and mātauranga

Māori. Based on their experience, kaimahi related services founded on Kaupapa Māori culture had better engagement rates and capacity to meet the cultural and clinical needs of tāngata whaiora and whānau.

> *With the Māori services that I've worked with, everything they do is about Māori kaupapa protocol principles, how to strengthen cultural values. And that's the way they work with whānau. But with mainstream services that I've worked with it's just not an integral part of the service (K1)*

Consequently, kaimahi suggested developing mental health service standards of practice on Māori principles and values to improve engagement. This would positively influence the overall organisational culture from the ahua of the environment to the therapeutic approaches used.

> *Coming from a service that didn't really have Māori cultural values... my hopes for them would be that they would make it [Māori cultural values] an integral part of their organisation. Then that will just flow down to the way that practitioners are with Māori. Maybe they'll take cultural values more into consideration when they are developing policies and services and programmes, and the way that they want Māori to feel when they come into their service. I don't think they think about how they want Māori to feel. It's like if you put effort into that, I think that would probably go a long way (K1)*

Overall, as one kaimahi expressed, mental health practice and service culture that were guided by tikanga and mātauranga Māori created responsive care experiences for tāngata whaiora and whānau which supported service engagement.

> *What we are doing well is we're tryna implement more Māori practices into our clinical practice which is the use of pūrākau, which is the use of Māori health models, and which is the use of tikanga Māori (K4)*

Working alongside whānau. Whānau uphold the wellbeing of tāngata whaiora within Te Ao Māori, providing their whanaunga with aroha and support to engage with mental health services and navigate recovery. Kaimahi discussed how adopting a whānau-centred approach to practice where they worked alongside both tāngata whaiora and whānau in care planning, decision-making, and interventions facilitated positive service experiences and encouraged engagement.

> *It's got to be about whānau needs and whānau solutions, because there's no individual that is not connected in some way (K3)*

Kaimahi sought to manaaki and collaborate with whānau through hui, a cultural process which enabled the perspectives, concerns, and aspirations of everyone present to be communicated and subsequently developed into a wellbeing plan. As one kaimahi articulated, hui ensured reciprocity in mental health care where feedback could be shared, progress monitored, and plans amended to best support tangata whaiora and whānau success.

> *Manaakitanga, the caring and sharing to ensure that there is a plan at the end of the hui and involving our whānau and whaiora with that plan. And if it doesn't sort of work then saying 'Let's come back and have a look at it' (K2)*

Kaimahi also spoke to the validation and assurance whānau experienced upon accessing mental health services for additional support when care teams expressed to whānau their continued involvement in the wellbeing journey of their whanaunga was valued. Clear communication and respect for whānau perspectives facilitated confidence among whānau about the cultural and clinical responsiveness of care and a willingness to engage with services.

> *They're [whānau] going out with a bounce in their step. They're going out safe and secure that their people will be looked after, that their questions will be answered in a way that they can understand, that they feel valued for their input such as 'So and so needs to do this' and 'This is helpful in their recovery'. They're part of the recovery plan, you know, rather than being told what the plan is (K3)*

Recognising the important role whānau have in recovery, kaimahi explained whānau-centred practice extended to facilitating reconnection between tāngata whaiora and whānau. During service engagement kaimahi worked with tāngata whaiora to establish whakapapa connections and invite their whānau along to hui to mend relationships. As such, whakawhanaungatanga gave whānau an opportunity to be involved in tangata whaiora mental health care where a shared understanding and plan could be developed and new strategies learned to uphold wellbeing upon service discharge.

> *We'll find a connection with the whānau if the whaiora is disconnected and then call them in and we'll have a whānau hui and we'll talk about what's going on for them. Then we'll meet with the family individually and talk with our whaiora over the time that they're with us so that by the time they're discharged home, the environment they're walking into is actually an environment of love and support and understanding (K3)*

Given the collective nature of wellbeing in Māori culture, kaimahi indicated ensuring whānau wellness was an essential part of mental health care provision by services. In example, upon entry to inpatient services, care teams could manaaki whānau wellbeing by communicating it was both okay and important to nurture their health with self-care following the emotional stress they had experienced regarding the safety of their whanaunga.

> *We say it's your time to rest as whānau. It's now your time to take a break, you know. While they're [the tangata whaiora] having respite you need to have some too. Allow yourself to sleep through the night or allow yourself to sleep without worrying or second-guessing what's going on out in the other room. Because they're just exhausted as our whaiora (K3)*

Likewise, kaimahi articulated engagement was influenced by whether mental health services considered and attended to the social stressors whānau experienced. Lack of a wider support system and socioeconomic hardship in providing necessities meant that, on balance, whānau were unable to make therapeutic interventions the first priority without support from services. Kaimahi perceived services held a duty of care to respond to determinants of Māori wellbeing and engagement. Therefore, they suggested whānau be provided with wrap-around support to manage social stressors to make engaging in mental health care possible.

> *If you have whānau out there and they're really struggling and there's not enough support networks around them, coming to therapy might be the last thing on their priority list. Because, you know, they're just tryna keep the roof over their heads or feed their kids. Services are supposed to think of that, that whānau really need the support and for their situation to be taken into consideration before you think about therapy (K1)*

> *Make it [the service space] more welcoming, have a toy box inside of the room. It doesn't have to be a hundred toys, it could be two: a train and a book. Because nine times out of ten families have little people and they've got no choice but to bring little people (K3)*

Blending cultural and clinical waters. In appreciation that the current mental health system framework is not yet grounded within Te Ao Māori, kaimahi articulated care experiences and service engagement were improved for Māori by integrating cultural and clinical competencies. Within their practice kaimahi described equally privileging Te Ao Māori and Te Ao Pākehā, the two worlds tāngata whaiora and whānau walked between, where benefits from both approaches could be used to uplift wellbeing.

> *Working so the clinical and the cultural practices work alongside each other rather than one over the other (K4)*
>
> *We have a balance of a Māori worldview and a Westernised worldview (K2)*

During care interactions kaimahi provided a culturally meaningful framework for Māori to understand mental health problems by using Māori models of wellbeing and assessment. The following kaimahi recounted how holistic wellbeing was reviewed with tāngata whaiora and whānau at the beginning of service engagement with Te Whare Tapa Whā. Pounamu, a bicultural model for assessment and formulation, was then applied to help Māori recognise the coping skills they possessed and how their emotions, grief, and pain contributed towards unwellness.

> *In the mihi-whakatau we bring on board Te Whare Tapa Whā and explain what it means... and we use Pounamu as a visual about the presenting issues, the coping strategies, the whatumanawa, the deep-seated unresolved grief for where whaiora are on the continuum (K2)*

Likewise, the adaptation of therapeutic approaches to align with Te Ao Māori was considered to offer tāngata whaiora culturally and clinically responsive mental health care and promote willingness to engage with services. As an example, one kaimahi explained how tikanga and mātauranga Māori were integrated within the Choice and Partnership Approach (CAPA) model of clinical engagement at her service. This involved sharing pūrākau about how the atua Tāne ascended the twelve realms and retrieved the three kete of knowledge for humankind about how to live in the world. Through wānanga, tāngata whaiora and whānau could relate their lived experiences to the pūrākau to identify their wellbeing goals and how their strengths could be used to overcome challenges in reaching them. Compared to Pākehā clinical practice, kaimahi prioritised whakawhanaungatanga within this engagement process by allowing for additional sessions to build relationships.

> *We've taken CAPA [a clinical engagement process] and sort of developed what we see as a culturally appropriate process using pūrākau. So we use the Tāne Mahuta story about how he retrieved the three baskets of knowledge. CAPA's a set amount of sessions but for us we know engagement's important, so most times there is at least three or four sessions when you're engaging and building that relationship (K4)*

In the absence of formally developed bicultural approaches to mental health care, kaimahi demonstrated creativity in their practice to incorporate cultural realities within Pākehā therapies. As an example, while working with a tangata whaiora to develop a personalised grounding technique, the following kaimahi created space for Māoritanga to be present as a coping strategy. To manage difficult moments of unwellness the kaimahi helped guide the tangata whaiora to place himself on his marae, the heart of Māori culture, which represented a place of serenity, safeness, and connection to Papatūānuku.

> *Say if we're doing a grounding technique it might be 'Where do you feel the most grounded?' And it might be visualising you're standing on your marae, on your ground there, and you can feel the strength from the whenua coming up through you. I've had a client that really responded well to that. So just finding things that whaiora identify with that we can build into the therapy techniques that we already have (K1)*

In sharing their perspectives about integrating cultural and clinical knowledge and practices to benefit Māori in mental health care, kaimahi used the metaphor of merging two currents of water. For tāngata whaiora and whānau, living between Te Ao Māori and Te Ao Pākehā could lead to confusion when attempting to make sense of and manage mental health problems. However, as practitioners, kaimahi relayed they were capable of astutely taking the benefits both worlds offered to help Māori navigate their waka towards calmer waters to reach wellbeing.

> *Whānau don't know how to navigate that sort of merging of waters, to know where Kaupapa Pākehā can be helpful and beneficial within Kaupapa Māori. I don't think it needs to be one or the other and I think that's what Māori mental health practitioners or whānau are actually trying to do, they're trying to... find a way to navigate the colliding of waters.... It's about how we [as kaimahi] navigate that environment, a sort of calmer current for tāngata whaiora and whānau to sail upon... and that's really difficult but I think we can do that, we can navigate that quite successfully... we have an ability to be respectful and to take the best of both so that we can support our people to become their best (K3)*

Kaimahi cultural identity and competency. Māori kaimahi reflected how their mental health practice was shaped by their cultural identity and the positive influence this had on Māori service engagement. This began with answering the karanga to work alongside tāngata whaiora and whānau and pursue changes in mental health, which was motivated by aroha and relationality with 'their people'.

> *It's about that connection, that sort of trust and that whanaungatanga. I wouldn't want it any other way. And I wouldn't change the way that I practice... The drive is, will always be, my love to be there for our people (K2)*

> *We're all there wanting to improve Māori mental health, so we're all there to do the work (K4)*

The cultural and clinical responsibilities kaimahi fulfilled within mental health services were informed by their identity as Māori kaimahi. In example, one kaimahi explained how caring for tāngata whaiora and whānau involved using a combination of tikanga and nursing competencies.

> *First and foremost it [the role as kaimahi] involves being the Māori, being the male Māori, being the Māori registered nurse, being the kaikōrero (K2)*

While kaimahi reflected their Māori whakapapa was integral to their personal and professional identity, on some occasions the cultural responsibilities placed upon them by services created discomfort within their practice. This highlights the importance of developing cultural competency across the entire mental health workforce so the provision of culturally and clinically responsive care does not rest solely with Māori kaimahi.

> *Culturally we also have responsibilities, you know, making sure we stick to our tikanga... other roles are doing karanga, stepping up to do waiata at work, and all those cultural things. For me, the service is under the kawa of my iwi so... I feel some of the responsibility falls on me, which for me is really hard. I don't like it, I don't like having that responsibility... it feels hard sometimes because to me coz I'm not fluent in te reo Māori (K4)*

Furthermore, in seeking to integrate their cultural and professional identities in mental health care, kaimahi described having to navigate tensions between Te Ao Māori and Te Ao Clinical. To engage with tāngata whaiora and whānau as a Māori wahine with clinical skills, the following kaimahi had to find a place where she felt at rest, that balanced relationality with her Māori community with meeting her responsibilities as a kaimahi to ensure service integrity.

> *We are who we are. And we live in this community, we work in this community, and we raise our children in this community, so therefore we are this community. There's always tensions between that and we try and move through those tensions without compromising our organisation but also without compromising who we are... finding where your heart is happy to be (K3)*

Alternatively, kaimahi relayed their non-Māori colleagues could build tāngata whaiora and whānau confidence to engage with services with sincere and culturally competent mental health practice. This involved reflexivity such as acknowledging one came from a place of unknowing when differences in cultural identity were present, and working alongside Māori within an open heart and mind.

> *Being really respectful and wanting to know. Like, you can go in and start working and just think everything's cool, but it's really nice when you acknowledge that maybe there could be cultural differences or there could be things about culture that you could learn about. And just being genuinely interested, and wanting to know, and wanting to develop trust and respect with clients (K1)*

In addition, the willingness of non-Māori kaimahi to learn about and seek support in mātauranga Māori and tikanga from Māori colleagues, kaumātua, or cultural advisors positively influenced mental health service encounters. As the following kaimahi described, this included inviting colleagues to sit in on their sessions with tāngata whaiora and whānau to tautoko the kaupapa and provide them with feedback to enhance future practice.

> *We've got non-Māori kaimahi in our service who are actually doing amazing work with our people. And what is cool is from my perspective is they're there for the*

> *right reasons. They are there to help our people. They take guidance from the Māori clinicians or our kaumātua or cultural therapists in regards to tikanga Māori. They're willing to learn our culture, to be able to implement it with our whānau. If they're unsure they will invite a cultural therapist or kaumātua into their sessions to support in a cultural manner (K4)*

In summary, this theme reflects the perception among Māori kaimahi that practicing within Te Ao Māori in mental health care provided tāngata whaiora and whānau with a culturally relevant pathway to understand psychological problems and develop a plan for wellbeing during and beyond service engagement. Kaimahi articulated this nature of care involved facilitating cultural reconnection where knowing one's identity and tūrangawaewae enhanced mana and wellbeing, positioning Māori ways of being as valid and normal by following tikanga and mātauranga Māori, and being whānau-centred in practice. Furthermore, a Te Ao Māori approach included blending cultural and clinical competencies, providing kaimahi with the scope to integrate their Māori identity within practice, and cultural competency and reflexivity across the entire mental health workforce. From the perspective of Māori kaimahi, this mental health practice would enable services to connect with Māori in need, uplift their wellbeing, and improve engagement.

Weaving Relationships

This theme reflects the perception among Māori kaimahi that Māori mental health service engagement was supported by trustworthy, meaningful relationships between colleagues, the services involved in mental health care, and kaimahi, tāngata whaiora, and whānau.

Collegial relationships. Trust and support between colleagues enabled care teams to work effectively with tāngata whaiora and whānau and uphold positive service engagement intentions. For instance, relationality allowed the complimentary skills and knowledge colleagues brought from different mental health disciplines to be applied so that holistic wellbeing was nurtured. Similarly, team cohesion created a safe space for kaimahi to share their perspectives of how colleagues could make a valuable contribution to the care of tāngata whaiora with the competencies and attributes they held.

> *My colleagues, my peers, we all have skills in different areas and we all harness each other's skills and we never assume to have other ones, you know, we share the responsibility. Or if we think one whaiora and their whānau would work better with that worker, we tell that worker. Or that worker might come to us and say 'The whānau could really do this'. We communicate all the time... it's really about how we work together as a whānau to support whaiora and their whānau (K3)*

> *The referral comes... then the team says 'Well, I think you'll be the best person for this because you're male, you're Māori' (K2)*

This kaimahi articulated the bond shared with her team gave her the confidence to practice within Te Ao Māori. Notably, this approach to mental health care facilitated service engagement as it aligned with the worldview of tāngata whaiora and whānau.

> *You know that you have the confidence in yourself and the confidence in the support of your peers to operate like that [practicing tikanga Māori] (K3)*

The bearing collegial relationships had on Māori mental health service use was affirmed by the following kaimahi, who noted service engagement varied according to whether positive team dynamics were present.

> *I know services that work really well as a team, like social workers work really well with the psychologist; they've got a relationship. And then I know other services where it's just not so closely knit and those are the ones I think that probably struggle with access more (K1)*

By comparison, another kaimahi explained how the absence of collegial unity could detrimentally affect service engagement. This occurred in circumstances where kaimahi had high caseloads and felt unsupported to carry out their work with Māori in a culturally and clinically responsive manner. Kaimahi were unable to rely on another during this difficult time, as they felt compelled to focus on their own work. Subsequently, a sense of mistrust developed which prevented the team from working cohesively to provide helpful mental health care experiences for tāngata whaiora and whānau.

> *My caseload was just ridiculous and actually everyone's caseloads were very high, so we found it hard to be able to do the work. And I found it hard to be able to support my staff to be able to work effectively, and then I didn't have the support from management.... yeah, very stressful and the dynamics in the team turned quite bad... at one time it was a very mistrusting time (K4)*

Relationships between services. Kaimahi expressed tāngata whaiora and whānau were supported to engage in holistic mental health care when relationships were present between different services in the sector. Collaboration in treatment approaches and coordination of respective resources enabled services to attend to the psychological, cultural, social, and physical needs of Māori. In turn, this created an integrated pathway for service access and positively changed the trajectory of tangata whaiora and whānau wellbeing.

> *I've worked with a Whānau Ora team which was really good. I had a teenager that was going to court for issues, had severe mental health problems, had a lot of things*

> *going on... and that whole family had Whānau Ora support. So meetings with juvenile justice and stuff they [Whānau Ora] always went there to be advocates and help support the whānau. They'd always made sure that he could come to his sessions... and then in the end he had a really good outcome. He ended up finishing the court order that he was on and hasn't been involved in any crime since then (K1)*

Similarly, relationships between mental health services allowed kaimahi to focus on their specialised areas of wellbeing. As the following kaimahi described, while social issues were recognised as an important facet of mental health, there were insufficient resources for one service to provide this level of holistic care. Working alongside Whānau Ora Navigators allowed community mental health teams to dedicate time and effort into their scope of practice to tautoko recovery.

> *[Whānau Ora] navigators are now a big part of recovery. The navigators come on board to help with, assist, and guide social issues... the navigator plans what their [the tangata whaiora] day looks like or their week looks like. So that could be from an employment point of view, to looking at voluntary work... it takes a load off ourselves... now we can focus on (1) the safety (2) the wellbeing (3) the recovery and (4) the regular reviews with the psychiatrists or with the clinical psychologists. Yeah, so all NGO's have an important part of the recovery of our people (K2)*

Nevertheless, relationality among services required kaimahi to balance responsibilities to their own team with those of other services working with tāngata whaiora in recovery. An example involved the CRS requesting cultural input from Māori mental health in a risk assessment for a tangata whaiora. This kaimahi explained that as CRS was often the initial contact point in mental health care when safety concerns were present, taking time to nurture this relationship by supporting the mahi of CRS facilitated service engagement and the quality of care Māori received.

> *If the CRS team ask for cultural support then we've got to be seen to support that... sometimes we have to drop stuff and then go and help them, because of that relationship to the front runners of mental health, the CRS team. If you don't have that rapport, that relationship, then it can make it even worse when you're trying to ask them to help you (K2)*

Looking to the future, kaimahi suggested an effective solution to improve Māori service engagement was the continued development of service wide relationships and an understanding about each organisation's role in mental health care. Importantly, kaimahi considered the challenges that may arise while establishing this coordinated care pathway could be overcome, as services were committed to the shared kaupapa of uplifting tangata whaiora and whānau wellbeing.

> *At the moment the service wants to work closely with a NGO but none of the staff there have any background in mental health. So it's a struggle for us because we're sharing this [kaupapa] but then they're coming from a different angle. And yeah, some of our clinicians are sort of frustrated but the NGO is not at fault though. So what should happen? I think we should still maintain that relationship and we should make things in layman terms, not nursing or psychiatry... make it so it's something that they can understand and that is clear (K2)*

> *Those people that our whaiora and whānau have contact with [on first entering the mental health system] need to be knowledgeable in what they're doing. For instance, the clinicians at the mental health and addictions contact centre need to know about the services they're sending the referral to. That used to be part of the problem for our service is that none of those kaimahi really knew what we [as a*

> *mental health service] did, and so the families would be misinformed about our service. So being knowledgeable about services is really important (K4)*

Relationality in practice. Guided by tikanga, kaimahi articulated relationships with tāngata whaiora and whānau were the foundation mental health service engagement grew from. Thus, kaimahi privileged whakawhanaungatanga in their practice by taking time to make connections and develop a genuine bond with Māori. As one kaimahi expressed, relationality created a safe space to have conversations about sensitive, difficult issues and built confidence to take part in treatment.

> *Developing relationships with tāngata whaiora, that's really important. So that might be a phone call introduction before turning up and meeting a stranger out of the blue to talk about your whole life... you know Māori, you like to feel connected. And if you feel like you're not connected, you're not gonna wanna come (K1)*

Alongside facilitating initial service engagement, relationships supported tāngata whaiora to continue with mental health care during particularly challenging periods of unwellness. Kaimahi indicated this trust and relationality were tied to upholding tikanga in mental health practice whereby Māori were fully acknowledged for who they were, including their cultural identity.

> *If you don't engage with our people then you're pushing shit up hill. And being Māori there are ways that we engage with our people. And that first important engagement is that harirū, and that hongi, and that 'Kia ora'. And then you know that even if they're psychotically unwell, even if they're in a manic phase of their bipolar or a depressive phase, at least you acknowledge them as a Māori and not just an unwell person...develop that rapport and then everything should fall into place (K2)*

In line with Te Ao Māori, relationships between tāngata whaiora, whānau, and kaimahi matured into one of a kaupapa whānau who shared a commitment to work together towards wellbeing. This whānau bond lasted beyond mental health service contact where the manaakitanga present within care interactions remained as a memory or spiritual connection for tāngata whaiora, which served to uphold engagement intentions if unwellness was experienced in future.

> *We can call them our whānau and I spose that's the important part... because in the Māori worldview they are part of your whānau now (K2)*

> *We will always be in that waka as practitioners because they [tāngata whaiora and whānau] have that ability to recall that time and space that we shared. They might not have it on a physical space but they have it as a memory, as an essence, as a spiritual connection: that they were valued by that person in that moment. They were listened to for their entirety, for everything that they had or everything that they wanted, you know, without judgement (K3)*

Furthermore kaimahi explained reciprocity, expressed in the mutual sharing of lived experiences, was integral to meaningful relationships in mental health care with Māori. Reciprocity created a synergy between the respective journeys of kaimahi, tāngata whaiora, and whānau and consequently fostered willingness to engage with services.

> *You go there, you talk to them, you engage that harirū, that hongi, that te reo Māori. And then you tell them 'You're not alone. Because your lived experiences and my lived experiences are the same... I know what you're going through'... At the end, our whānau are really thankful because we've heard about their personal journey and then you're sharing your personal journey with them. So it's about that connection, that sort of trust, and that whanaungatanga (K2)*

> *I think working effectively with families, life experiences have so much to do with it, and sharing some of it you know. Obviously as clinicians there's a boundary of how much you share, but I think it's that reciprocal relationship; that if you expect someone to share something with you, you need to accept that you need to be sharing something with them (K4)*

Kaimahi described balancing professional standards of practice with Te Ao Māori relationality through sharing their personal background and small conversations about everyday life. This approach helped form connections and maintain professional integrity while ensuring tāngata whaiora and whānau felt valued within interactions and assured their wellbeing and recovery journey were the priority.

> *I don't over share because then it becomes about me and not them [tāngata whaiora and whānau] and I wouldn't want them to feel like that. But I'll share a little bit at the beginning about who I am: I'm a mum, and I'm this, and that. And then it might be just, you know, every now and again when we're talking about going to the marae and saying 'You gotta put up with everybody snoring and being asleep and it's really hard'. Just those normal, everyday type things in passing (K1)*

As a collective, kaimahi reflected relationships were a pillar of mental health practice that supported Māori service engagement. Relationality benefited the care tāngata whaiora and whānau received as the skill sets among colleagues and across services could be applied so that wellbeing was holistically nurtured. Likewise, meaningful connections between kaimahi, tāngata whaiora, and whānau that were facilitated through tikanga and reciprocity allowed for trust and collaboration in the journey to mental wellbeing.

Communication

This theme speaks to the importance of open and reciprocal conversations in mental health care as a determinant of Māori service engagement. Adopting this communication approach enabled the perspectives of kaimahi, tāngata whaiora, and whānau to be safely expressed and thoughtfully considered, and realistic expectations about the support mental health services could offer to be established. For example, in the following account kaimahi acknowledged inviting and reflecting upon feedback from tāngata whaiora and whānau was an integral part of improving their future practice. Giving opportunity for honest conversations to take place was also perceived to help keep Māori engaged with mental health services as kaimahi, tāngata whaiora, and whānau alike were collectively re-oriented to a new, mutually beneficial care pathway.

> *Communication is so important... as an example the psychiatrist and I got an email from a whānau member we've been working with and she didn't feel we did enough...we asked her for feedback... part of what she was saying was right, part of it was not quite accurate from our point of view. What we did with her was what we would do with any family, but she wanted more, you know. So it's about allowing them [tāngata whaiora and whānau] to express the stuff that they're not happy with... the psychiatrist and I met and talked over the email and said 'Okay so what are we going to do from here?' It's trying to mend the issue the whānau have had and acknowledging our part in it, acknowledging it to the family, and just doing something about it to get that back on track (K4)*

Similarly, transparency in communication had the potential to preserve Māori service engagement when undesirable mental health interventions were necessary. Kaimahi gave the example of being honest with whānau that it was a necessary part of clinical practice to notify social agencies if risk of harm to self or others was present.

Although some Māori disengaged with mental health services during this challenging time, for other whānau open conversations conveyed respect for their mana and enabled kaimahi to continue working alongside them.

> *A good example of wanting to change or withdraw from our service is when we make a CYFs notification. So it's really important to express to the family when you first meet them... that as a health clinician if we have any inkling of any type of abuse our responsibility is to make a notification. But also, I think our responsibility is to talk to the family before we actually make that notification. Even if we do that, sometimes it doesn't make a difference... some of them are like 'Yup, okay yup, I agree we should make it'. Others are like 'Okay yup we'll make it' then the next minute they're going 'We don't want your service because of this notification' (K4)*

Alternatively, kaimahi relayed the process of clarifying with tāngata whaiora and whānau the nature of care mental health services provided influenced engagement. By collaboratively setting realistic expectations of support from the outset, kaimahi avoided making false promises that reduced confidence Māori held in services and intentions to reach out for help.

> *Honesty is the best policy. Don't deliver what you say you can't do (K2)*

> *I often hear 'We've just been thrown from service to service and no one is doing anything'. I think it's acknowledging that but making it clear what our role is as a mental health service and that we're here to do this piece of work if it's for us, because we do the top 3% in New Zealand so we're moderate to severe mental health (K4)*

In summary, collaboration and honesty in communication among kaimahi, tāngata whaiora, and whānau in mental health care served to benefit Māori service engagement as it created opportunity for a shared understanding about the care pathway to be developed and trust in one another and services moving forward.

Misconceptions and Mistrust of Services

Kaimahi reflected reticence among Māori to seek help from services during times of unwellness was related to low mental health literacy. Oftentimes the decision-making process about whether to seek help was informed by discourses that were inaccurately based on the institutionalisation era of mental health care. This elicited fear among tāngata whaiora and whānau about the intervention's services used alongside being stigmatised which served as a barrier to engagement. Without prior experience of accessing mental health services, this sense of mistrust Māori held in services was heightened by the anticipation of entering an uninviting environment where interactions were not mutually respectful.

> *When whānau bring in their whaiora, if they've never presented to mental health services before... they're really scared. It's the looney bin, like where the crazies go. It's really cold and very clinical... you get talked down at... there's a real negative association with using mental health services... whaiora and whānau are just so frightened of the stereotypes or the discourses that are out there around Māori and whānau accessing mental health services. It's still very much tied up in that it's a straightjacket and padded bedrooms (K3)*

Kaupapa Māori service engagement was particularly affected by low mental health literacy. As the following kaimahi explained, some tāngata whaiora were unaware about the availability of different services which could be better suited to nurturing mental wellbeing in accordance with a Māori worldview.

> *Some of our Māori whānau may enjoy and like mainstream, but they don't know about us [Māori mental health]... it's not until further on down the track when things become too difficult for mainstream and they transfer care to us, it's not until tāngata whaiora and whānau engage with Māori mental health that they say 'Aww I wish I would have known that yous were here' (K2)*

Likewise, misconceptions about experiences with or criteria for accessing Kaupapa Māori mental health services were identified as contributing towards low service engagement. For instance, some tāngata whaiora and whānau believed fluency in te reo Māori was needed to receive help while others declined mental health care based on second hand accounts about unhelpful service experiences. Kaimahi described addressing this engagement deterrent by providing Māori referred to the service with information about entry criteria and care approaches to facilitate mental health literacy. This practice enabled tāngata whaiora and whānau to make informed choices and feel confident to engage with services.

> *I used to receive the referrals and so often we would have written 'They don't want Māori mental health'. One of my roles was to call and say 'Hey, I'm just ringing and I see you're not wanting Māori mental health services, are we able to discuss the reasons around that?' Sometimes it was 'Oh I've heard bad things about you'... Sometimes it was 'Oh coz I need to be able to speak te reo Māori'. So sometimes there was a misconception about our service... they didn't know what our service was about, so it was about me sort of saying 'This is what our service is' (K4)*

To conclude, given the detrimental effect low mental health literacy had on service engagement, practices that improved tāngata whaiora and whānau knowledge of care interventions, available services, and access pathways could be adopted across the mental health workforce to improve the ability of services to reach Māori in need.

Framework of the Mental Health System

This theme concerns the difficulties Māori kaimahi encountered with mental health system policies, processes, and resourcing as they sought to provide culturally and clinically appropriate care that supported Māori service engagement.

Policy tensions. Kaimahi expressed that dissimilar to tikanga Māori, mental health sector policies placed temporal boundaries on the whanaungatanga and manaakitanga they shared with tāngata whaiora and whānau. This incongruence between Te Ao Māori and Te Ao Pākehā approaches to mental health practice was perceived to hinder service engagement as the care offered was not responsive to how Māori work towards wellbeing.

> *We're still constrained by policy and regulation... we're not allowed to follow up with whaiora when they get discharged home. Once they get discharged from the service they then become the responsibility of the key worker and so we're not allowed to check in and see how they are, unless we happen to see their key worker and say 'How's so and so doing?'... yet in Kaupapa Māori or tikanga Māori they become part of your whānau. You going to visit them at home with their whānau to check in on them to have a cup of tea is culturally right, it's just not policy right (K3)*

A sense of lamentation was voiced by kaimahi that despite an evidence base that supported practicing within Te Ao Māori with tāngata whaiora and whānau, the scope to apply this approach within their mahi was constrained by policies and processes. However, as articulated by this kaimahi, the motivation and determination to enact change so Māori could experience responsive mental health care remained.

> *Policy stops you from actually providing wellbeing in a holistic sense and that's still very difficult. Even though all the research is out there, that's still very difficult for that to be put into a practical application in our mahi... but we fight for it every day (K3)*

Furthermore, kaimahi perceived the level of documentation and statistics services were required to complete tended to supersede the needs of tāngata whaiora and whānau whereby less time could be dedicated to in person mental health care. As a solution, kaimahi proposed the time allocated between administrative responsibilities and working directly with tāngata whaiora and whānau be redistributed to accurately reflect Māori mental health needs.

> *Half of our time is spent doing documentation and statistics. Trying to meet the needs of the Ministry of Health rather than what we're employed to do which is meet the needs of the people, the whaiora and their whānau. So we spend half of our time getting papers signed or doing statistics or having to update information every three months... it's just ongoing and I think it's a huge barrier. If it was turned around, if we were able to work with our families 60% or 70% of the time and do administration work 30% or 40% of the time, I think we'd have a healthier New Zealand (K4)*

Lack of resourcing. Insufficient resourcing created challenges in the ability of kaimahi and services to make contact with Māori and provide culturally and clinically responsive mental health care. For instance, one kaimahi reflected upon the limited number of Kaupapa Māori mental health services operating under the DHB relative to mainstream mental health services. This model of service availability was problematic as it did not align with the disproportionate experience of psychological problems among Māori and need for culturally informed care.

> *There are barriers in regards to how we are able to practice as a Māori mental health speciality service... under the DHB we're the only Māori mental health service... so we're 'The' service. We cover the whole of the region but we have the same about of staff as the mainstream services have in each of their teams (K4)*

Similarly, based on career experience, kaimahi indicated funding allocated to Kaupapa Māori services did not account for cultural processes in mental health practice such as pōwhiri or poroporoaki which welcome and farewell Māori within care. This resulted in kaimahi using personal finances to ensure tikanga was upheld as they recognised the value it held for tāngata whaiora and whānau. As captured in the account below, this speaks to the need for resourcing that sustainably supports culturally and clinically responsive practice that underpins Māori service engagement.

> *We talk about resources clinically but we also need to talk about resources culturally... we don't really get money to practice as a Māori mental health speciality service... food's important, pōwhiri is important, poroporoaki is important. To be able to have those you need money to provide food to cater for your manuhiri, your visitors. We don't have a cost code or we don't have pūtea to cover those which means most of the money for food comes from kaimahi, from staff. And when you're having one every two or three weeks it adds up... kaimahi are providing a service for the DHB in a sense, but because of the value of the service the kaimahi make sure those processes are followed (K4)*

In summary, kaimahi indicated Māori service engagement could be enhanced by developing mental health sector policies and processes in line with Te Ao Māori and ensuring resource distribution is reflective of the cultural and clinical needs of tāngata whaiora

Chapter Ten: Discussion – A Narrative Woven by Tāngata Whaiora, Whānau Members, and Māori Kaimahi

Presented in this chapter is a narrative that integrates the perspectives of tāngata whaiora, whānau members, and Māori kaimahi and conveys the key findings regarding Māori mental health service engagement. These findings are considered in relation to literature about Māori care experiences and mental wellbeing, tikanga and mātauranga Māori, and service engagement among other Indigenous peoples. The clinical significance of these findings is discussed in the recommendations for how kaimahi and services could evolve their practice to support and improve Māori mental health service engagement. The strengths and limitations of this research will then be reflected upon followed by opportunities for future research. Lastly, final conclusions about this rangahau are offered.

A Narrative to Convey Key Findings

Practicing in Te Ao Māori. As a collective, tāngata whaiora, whānau members, and Māori kaimahi articulated that mental health practice guided by Te Ao Māori supported service engagement by providing culturally and clinically responsive care experiences. This involved drawing on tikanga and mātauranga Māori in assessment and intervention, privileging Māori identity, facilitating cultural reconnection, and adopting a whānau-centred approach to care. Importantly, practicing in Te Ao Māori created space for tāngata whaiora and whānau to be as Māori in mental health services by positioning a Māori worldview, values, beliefs, and ways of being as valid and important.

Tikanga and mātauranga Māori. Whakawhanaungatanga was an integral expression of tikanga within mental health practice. As an intrinsically reciprocal process whakawhanaungatanga enabled the development of genuine, meaningful connections among tāngata whaiora, whānau, and kaimahi. This involved making time to share whakapapa connections, similar lived experiences, and small everyday conversations about life. Māori kaimahi prioritised whakawhanaungatanga based on the understanding that building relationships helped prepare tāngata whaiora and whānau to undertake the difficult mahi involved in treatment. Tikanga not only fostered these relationships but ensured they were acknowledged for the duration of mental health care. Services and kaimahi practiced mihi-whakatau or pōwhiri and poroporoaki to welcome and farewell Māori in care and to celebrate the transition from tapu to noa in their wellbeing journey. The value of upholding cultural processes within practice was affirmed by tāngata whaiora who relayed tikanga placed Māori at ease in mental health care and fostered trust to engage with services for help. The demonstration of values such as manaakitanga, kaitiakitanga, wairuatanga, and hūmarietanga assured tāngata whaiora and whānau they would be guided through treatment with compassion, humility, and an understanding of Māori realities. These perspectives align with research findings which indicate following tikanga within mental health practice is essential for working effectively with Māori and facilitating positive, helpful care experiences (Bennett et al., 2016; Mitchell, 2015; Mooney, 2012; Pomare, 2015).

Mātauranga Māori was privileged in mental health practice by providing culturally meaningful, mana enhancing frameworks from which Māori could make sense of their lived experiences and develop positive pathways towards wellbeing. Akin to a growing movement within the mental health sector (Cherrington, 2016; Kingi et al., 2017; Rangihuna et al., 2018), Māori kaimahi utilised pūrākau about ātua Māori as an approach to engagement, assessment, and intervention. The adaptive ways ātua navigated life situations were discussed and metaphorically applied to the difficulties tāngata whaiora and whānau faced alongside the strengths they possessed. Culturally informed assessment and formulation were likewise facilitated by using Māori models of health such as Te Whare Tapa Whā or Pounamu which recognised wellbeing as holistic. Furthermore, Māori kaimahi creatively integrated mātauranga Māori within Pākehā therapeutic techniques so in times of distress tāngata whaiora could manage by connecting with, and drawing strength from, Te Ao Māori. Effectively, mātauranga Māori informed practice engendered confidence among tāngata whaiora and whānau that engaging with mental health services was worthwhile by empowering Māori to explore and respond to emotions held in their whatumanawa and mamae in a culturally safe and responsive manner.

For tāngata whaiora and whānau mātauranga Māori was experienced through the use of interventions which nurtured holistic wellbeing by positioning spiritual, relational, and physical health alongside mental health. When treatment aligned with the pathway to wellbeing tāngata whaiora envisaged for themselves they were encouraged to engage with services for support in this journey. Tāngata whaiora and whānau members indicated this involved the opportunity to access cultural approaches to healing such as mirimiri massage, tai chi, nutrition, te reo Māori classes, creative arts, and taking part in social activities as a kaupapa whānau. Similarly, when kaimahi and tāngata whaiora were both attuned to wairua, tūpuna could impart guidance so mental health care continued to uplift wellbeing as tangata whaiora needs evolved in a way that Western informed practice could not. By comparison, whānau members reflected tāngata whaiora would disengage from services when treatment exclusively focused on psychological health, as this approach to care did not align with Māori holistic understandings of wellbeing. Taken together these findings build upon previous national research (Bennett et al., 2014; Kingi et al., 2017; McLachlan et al., 2017; Rangihuna et al., 2018) by linking experiences of mātauranga Māori within mental health care with service engagement.

Cultural identity and reconnection. Mental health care experiences and service engagement intentions were positively transformed for Māori when cultural identity was acknowledged and privileged in practice. Tāngata whaiora spoke to how culture is part of the mauri of a person, shaping the phenomenology of unwellness and therefore the pathways to wellbeing. For Māori, cultural identity and opportunities to connect with Te Ao Māori reflect a source of strength that can be drawn upon in mental health (Durie, 2001). It is therefore significant that Māori kaimahi identified service engagement was supported by facilitating cultural reconnection within mental health care. Through practices such as karakia, te reo Māori, learning whakapapa, harakeke weaving, and marae based wānanga, tāngata whaiora gained the knowledge and skills passed down by tūpuna about how to live well. Furthermore, as tāngata whaiora learned where they were located within their whakapapa, whenua, and culture, they discovered their tūrangawaewae. This sense of belonging and experience of being able to centre one's self amidst challenging times uplifted wellbeing in ways Māori had not anticipated when seeking mental health care, but which was precious to them.

Importantly, Māori kaimahi recognised diversity in cultural identity was present whereby some tāngata whaiora and whānau were confidently grounded within Te Ao Māori while others also walked within Te Ao Pākehā. As such, to ensure reconnection to Māoritanga was a mana enhancing experience, Māori kaimahi tailored their practice to align with where tāngata whaiora and whānau positioned themselves in their cultural identity journey. This approach to care was appreciated by tāngata whaiora who reflected being guided into Te Ao Māori with such humility and consideration placed them at ease and made them feel confident to continue engaging with services.

Whānau-centred practice. Māori engagement with mental health services was facilitated by whānau-centred practice. This approach to care recognised whānau members loved and cared for tāngata whaiora, supporting them to seek help from services and realise and maintain wellness. Whānau-centred practice was evident when services were willing and committed to genuinely work alongside whānau in care planning, decision-making, and interventions. Māori kaimahi described inviting whānau to attend hui with their whanaunga so the perspectives and aspirations of each person involved in nurturing wellbeing were heard and integrated within care. Whānau members appreciated the reassurance by services their continued involvement in the recovery journey of their whanaunga was valued. This collaboration was a particularly affirming and uplifting experience for whānau members as seeking help from services on behalf of tāngata whaiora was often associated with feelings of failure as a support system. Furthermore, the information whānau contributed in hui helped to develop an accurate formulation and treatment plan tailored to the unique attributes, needs, and worldview of tāngata whaiora which facilitated progress in recovery. Tāngata whaiora echoed whānau involvement in mental health care helped them to process therapeutic learnings and apply coping strategies to life situations both during and beyond service contact. As such, navigating services without the support of whānau to listen, encourage, and offer advice could lead to care experiences that reduced help-seeking intentions.

Accounts of individual-oriented practice were also provided where services placed whānau on the periphery of tangata whaiora mental health care and failed to recognise the collective nature of Māori wellbeing. For example, whānau members spoke of not being given treatment progress updates or information pertinent to ensuring the safety of their whanaunga when risk of harm to self was present. Without this shared understanding of the psychological problems tāngata whaiora experienced and the care plan moving forward, whānau members perceived their whanaunga would likely become unwell again in future. Furthermore, the confidence whānau members had in the ability of services to provide culturally and clinically responsive care that situated recovery in a whānau context was detrimentally affected.

Whānau-centred practice extended to upholding whānau wellness. As whānau walked alongside tāngata whaiora in mental health care, service engagement could be improved by checking in with whānau about how they were coping and exploring what supports could be provided so whānau had the opportunity to self-care. Whānau members articulated this included services offering counselling to process the emotions tied to the unwellness of their whanaunga or providing crisis respite so whānau could rest safe in the knowledge tāngata whaiora were cared for. This practice validated the contribution of whānau members in managing tangata whaiora unwellness and the associated impact on personal wellbeing. Alternatively, Māori kaimahi indicated services held a duty of care to respond to the social stressors whānau experienced such as childcare and work commitments, financial hardship, or transport constraints. Through providing whānau with wrap-around support, akin to that offered by Whānau Ora, the basic necessities of life could be met and engaging in mental health care made the priority for whānau Māori.

In summary, the perspectives of tāngata whaiora, whānau members, and Māori kaimahi align with those of other Indigenous people within the literature who articulated willingness to engage with services is enhanced through the provision of culturally responsive care (Berry & Crowe, 2009; George et al., 2019; Gone & Trimble, 2012; Mehl-Medrona, 2009; Westerman, 2004). Likewise, similarities were drawn regarding how service engagement was deterred by organisational standards of practice developed on a Western worldview that created unhelpful care experiences (Coffin, 2007; Westerman, 2004). Unlike culturally informed mental health practice, Western approaches to care privileged psychological health above holistic wellbeing, failed to recognise the source of strength Māoritanga represents in the recovery journey, and placed whānau members on the margins of care through an individually-oriented focus in assessment and intervention.

Relationships. Relationships hold the potential to positively transform mental health service engagement outcomes and uplift wellbeing for Māori. Tāngata whaiora and whānau members articulated meaningful, genuine relationships formed the most memorable and helpful care experiences that cultivated trust to seek help from services. The process of opening up about the lived experience of mental health problems and learning ways to cope and move forward required tāngata whaiora to place themselves within a vulnerable position. Willingness and a sense of capability to undertake this difficult personal journey grew from a therapeutic relationship where tāngata whaiora were confident of being guided through care with empathy, compassion, and sincerity. The importance of relationality was affirmed by whānau members who indicated when kaimahi were relatable, authentic, and expressed manaakitanga their own spirits were restored and they felt able to continue supporting their whanaunga in treatment. Whānau members also expressed these relationships encouraged tāngata whaiora to engage with services when they had previously been reluctant to.

Equivalently, Māori kaimahi understood relationships were the foundation of helpful mental health care experiences and service engagement and therefore privileged relationality within their practice. This involved making time for whakawhanaungatanga so genuine connections could be formed with tāngata whaiora and whānau and a safe, accepting environment provided for the journey ahead. The reciprocity of whakawhanaungatanga also enabled Māori kaimahi to contribute an authentic part of themselves in treatment by sharing and drawing similarities in personal lived experiences with tāngata whaiora and whānau so a richer empathy was present. Furthermore, relationships of this nature acknowledged tāngata whaiora in their entirety, where they were more than the mental health problems they experienced. This not only built trust among Māori to embark in care, but sustained service engagement during periods of acute unwellness and reduced the distress and disempowerment associated with particular interventions such as ward admissions. The value of this relationality in practice was acknowledged by tāngata whaiora and whānau members who felt a special cultural connection with Māori kaimahi. A shared understanding of tikanga, mātauranga, and ways of being as Māori permitted tāngata whaiora and whānau to be authentically and unapologetically Māori within mental health care. As such, not having to balance managing unwellness with attempts to bridge a disconnection between Te Ao Māori and Te Ao Pākehā in treatment was an important experience that supported service engagement. Similarly, the traditional structure of relationships in Māori culture such as those between kuia and tamariki or mokopuna assisted whānau members to find equilibrium in challenging times and engage effectively with services for the benefit of their whanaunga.

Critically, when genuine and trusting relationships were unable to be developed or were not prioritised within mental health practice, intentions to seek help from services were negatively impacted. Tāngata whaiora described feeling disconnected from their recovery journey while whānau members were reluctant to entrust the care of their whanaunga to services. However, when services responded to these concerns by encouraging opportunities for therapeutic rapport to be developed such as arranging a transfer of care or utilising relationships between colleagues to help change dynamics within care sessions, there was the potential to mitigate disengagement.

The perspectives of tāngata whaiora, whānau members, and Māori kaimahi align with national studies that speak to the importance of relationships in mental health care which privilege Māori values of engagement and relationality (Elder, 2008; McClintock et al., 2011; McClintock et al., 2013; Mitchell, 2014; Mooney, 2012; Pomare, 2015; Tricklebank, 2017; Wharewera-Mika, 2012; Wilson & Baker, 2012). Significantly, these findings elucidate a connection between positive Māori service engagement intentions and experiences of genuine, meaningful relationships in mental health care. This compliments outcomes reported in literature that explored the service engagement among other Indigenous peoples (Berry & Crowe, 2009; Hepworth et al., 2015; Hinton et al., 2015; Isaacs et al., 2012; Vicary & Bishop, 2005; Vukic et al., 2009).

Openness, support, and literacy around mental wellbeing. Tāngata whaiora, whānau members, and Māori kaimahi shared the perspective service engagement was detrimentally affected by an absence of openness, support, and literacy around mental wellbeing within Aotearoa. An outcome of this culture was Māori often experienced tension between understanding the value of seeking help and feeling whakamā, mataku, mistrustful, or guilty about accessing care.

Tāngata whaiora spoke to a need for everyday conversations about mental wellbeing as the current silence which surrounded lived experiences of mental health problems and service use created the perception that being unwell was not okay. The inability to appear emotionally vulnerable fed into discourses of Māori stoicism and prevented tāngata whaiora from speaking openly with whānau about their difficulties. Consequently, the chance for whānau to offer tautoko, aroha, manaakitanga, and encouragement to seek help from services was negated. This led to a growing sense of isolation, unwellness and too often completed suicide. Tāngata whaiora and whānau members reflected the lack of open kōrero and opportunities to give and receive support for mental health also upheld the whakamā and stigma attached to unwellness and service use, thereby reducing engagement intentions. Significantly, when the barriers of shame and stigma were overcome and the emotionally conflicting decision to access care was made, tāngata whaiora and whānau members encountered judgement and discrimination within services for being Māori rather than help to live well. Furthermore, whānau members expressed whakamā and guilt about initiating service contact on behalf of tāngata whaiora was imposed by other relatives, who denigrated their ability to care for their whanaunga. This augmented the belief whānau members held that they had failed as a support system for their whanaunga. In line with findings about CAMHS engagement (Pomare, 2015), these care experiences were unhelpful, invalidating, and mana decreasing for tāngata whaiora and whānau members and contributed towards the disinclination to engage with mental health services.

Interconnected with the absence of open, supportive attitudes and perspectives towards mental wellbeing was low mental health literacy. The collective accounts of tāngata whaiora, whānau members, and Māori kaimahi illustrated how a lack of knowledge about the nature of psychological problems, interventions, and help available from services negatively influenced Māori service engagement. Prior to accessing mental health care, tāngata whaiora articulated they were unable to identify how their experience of unwellness differed from the normal challenges one encountered in life, let alone appreciate and feel informed about what assessment and intervention entailed. Similarly, whānau members and Māori kamahi spoke to how inaccurate discourses about the type of mental health care that services provided elicited mataku and deterred engagement. Despite mental health awareness campaigns many Māori still held the belief contact with services would result in being removed from whānau and life in the world and placed into a psychiatric ward with straightjackets and padded rooms. The enduring and detrimental effect that discourses informed by the institutionalisation era of mental health care have on service engagement has been noted among other Indigenous populations (Eley et al., 2007)

Uncertainty about referral pathways and service entry criteria also led Māori to delay accessing mental health care. Tāngata whaiora queried whether their unwellness was severe enough to be accepted into treatment while Māori kaimahi reflected common misconceptions among Māori were that Kaupapa Māori services did not exist or were only accessible to those who walked confidently in Te Ao Māori. Notably, Māori kaimahi indicated after tāngata whaiora and whānau were provided with accurate information about receiving culturally informed mental health care they often lamented not having this knowledge earlier to guide the decision-making process for seeking help. The influence mental health literacy had on Māori service engagement was further highlighted by whānau members who explained awareness about care entitlements, standards of practice, and the skill set to effectively apply this knowledge determined whether Māori were empowered to engage with mental health services and have responsive, helpful care experiences.

Taken together these accounts indicate when opportunities for Māori to develop mental health literacy outside of treatment are lacking service engagement will be incommensurate with mental wellbeing needs. These findings are congruent with research where Indigenous clients, families, and clinicians expressed cultural values, attitudes, and behaviours towards mental health problems and service use detrimentally impacted care experiences and engagement decisions (Hinton et al., 2015; Isaacs et al., 2013; Lee et al., 2014; Vukic et al., 2009).

Empowering Māori voices in mental health care. Privileging the voices of tāngata whaiora within mental health practice created validating, helpful care experiences that supported service engagement among Māori. Through active listening and shared conversations, tangata whaiora were empowered to enact tino rangatiratanga whereby their needs, values, and worldview were heard and respected in the journey to mental wellbeing.

Complementary to the perspectives of other Indigenous peoples (Berry & Crowe, 2009; Eley et al., 2006; Vicary & Bishop, 2005; Westerman, 2004) tāngata whaiora, whānau members, and Māori kaimahi spoke to how trust and a collective understanding were nurtured through collaboration in assessment and intervention. For example, when tāngata whaiora were acknowledged as experts of their lived experiences they could kōrero with confidence about their mental wellbeing. This was made possible when kaimahi listened to tāngata whaiora describe their difficulties, efforts to cope, and the effectiveness of therapeutic strategies. In seeking a place of greater understanding kaimahi could discern how mental health care could be tailored to help tāngata whaiora realise their wellbeing aspirations in a mana enhancing way. Therefore, as collaborative conversations facilitated meaningful participation and informed decision-making in mental health care, Māori kaimahi actively sought to support the voices of Māori by adopting an open and reciprocal communication style. This enabled kaimahi to check in with tāngata whaiora and whānau about how they perceived care was progressing and reflect on their professional practice. It also provided an opportunity for the kaupapa whānau to come together and revise the treatment plan so the journey to mental wellbeing could continue.

By comparison, tāngata whaiora felt frustrated, invalidated, and unable to move forward when their voice went unheard in mental health care which led to a disinclination to engage with services for help. Alternatively, in situations where tāngata whaiora were unable speak for themselves because of acute unwellness, whānau members assumed an advocacy role to ensure the needs and hopes of their whanaunga were fulfilled. For whānau to represent their whanaunga it was important services provided them with treatment updates and used clear, understandable language, although variable experiences of this practice were described by whānau members.

These findings align with national literature which indicate responsive service experiences are connected with Māori being supported to articulate and have respected their needs, aspirations, and worldview in mental health care (Eade, 2014; McClintock et al., 2011; McClintock et al., 2013; Pomare, 2015; Wharewera-Mika, 2012). Significantly, the perspectives of tāngata whaiora, whānau members, and Māori kaimahi suggested mental health service engagement could be improved by empowering Māori to have an authentic voice in their wellbeing journey through active listening and shared conversations in mental health practice.

Mental health sector resourcing. Concerns regarding the detrimental impact the current state of the New Zealand mental health sector had on Māori service engagement and mental wellbeing were expressed by tāngata whaiora, whānau members, and Māori kaimahi. An inadequate allocation of resources coupled with growing rates of unwellness among pakeke and rangatahi Māori compromised the ability of services to respond in a timely and appropriate manner. Tāngata whaiora articulated intervention by services often occurred when acute unwellness was experienced opposed to earlier in time when mental health care could have had a significant and enduring effect in uplifting wellbeing. Similarly, whānau members described how resource constraints created long waitlists for entry into services which left their whanaunga feeling unvalued and invalidated following the emotional conflict and courage associated with the decision to seek help. This experience resulted in premature service disengagement and reduced intentions to access support in future. In addition, tāngata whaiora highlighted the limited number of funded mental health care sessions did not reflect the time needed to talk about and learn strategies to manage psychological problems. This led Māori to evaluate whether engaging with services and placing themselves in a vulnerable position was a safe, worthwhile decision if further sessions could not be afforded.

Nonetheless, tāngata whaiora and whānau members recognised the efforts kaimahi made to provide quality mental health care and nurture the wellbeing of Māori despite the pressures faced by services. As such, they loaned their voices to those of Māori kaimahi in calling for greater support for the mental health sector so integral mahi could be carried out. This involved redressing how the current funding structure limited the ability of services to reach tāngata whaiora and whānau in need. Māori kaimahi articulated high caseloads and time spent completing the documentation and statistics required to secure resources left little time to practice kanohi ki te kanohi with tangata whaiora and whānau. In addition, the sustainable provision of culturally responsive mental health care that underpinned Māori service engagement was not accounted for in the allocation of resources to services. Māori kaimahi described using personal finances for pōwhiri, kai, and poroporoaki to ensure tikanga was upheld. Likewise, the number of DHB Kaupapa Māori services was indicated to be disproportionate with the prevalence of mental health problems experienced among Māori and the need for culturally informed care.

Collectively, these accounts make salient the detrimental and far reaching impact that an under-supported New Zealand mental health sector has on Māori service engagement. This extends from Māori kaimahi who work to provide mental health care within resource constrained services to tāngata whaiora and whānau seeking help to manage mental health problems. In line with national concerns regarding the ability of services to deliver culturally and clinically responsive interventions that are commensurate with wellbeing needs, and the persistence of mental health disparities among Māori (Government Inquiry into Mental Health and Addictions, Baxter et al., 2006), these findings highlight the urgency of providing greater resourcing for the mental health sector within Aotearoa.

Clinical Implications: Recommendations for Mental Health Practice

Mental health practice guided by Te Ao Māori. To support and improve Māori mental health service engagement and wellbeing it is recommended that mental health practice be guided by Te Ao Māori. Through upholding tikanga, drawing on mātauranga Māori, facilitating cultural reconnection, and working alongside whānau, cultural realities can be made present and valued within mental health care. This can create space for tāngata whaiora and whānau to be authentically Māori within services, in all their diversity, where engagement, assessment, formulation, and intervention are responsive to clinical *and* cultural needs.

Pragmatically, tikanga can be integrated in mental health practice through engaging in whakawhanaungatanga with tāngata whaiora and whānau to develop genuine, meaningful, and empathic relationships. Māori and non-Māori kaimahi alike can share their whakapapa or familial connections alongside small conversations and similar lived experiences about the difficult, joyful, and everyday moments of life. Mihi-whakatau and poroporoaki ensure these relationships are nurtured and the progress that tāngata whaiora and whānau have made in the wellbeing journey is acknowledged. These cultural practices can be followed over a cup of tea, kai, and kōrero. Furthermore, offering options around opening or closing sessions with karakia or waiata can restore the balance of everyone present while a whakataukī could be used to guide the therapeutic learnings of the session.

As Māori recognise wellbeing as holistic, kaimahi and services are encouraged to be knowledgeable and competent in using culturally meaningful and mana enhancing frameworks in mental health care such as pūrākau, Te Whare Tapa Whā, Te Wheke, the Meihana model, or Pounamu. Drawing on mātauranga Māori, these approaches nurture relational, spiritual, and physical health alongside mental health and help Māori to make sense of lived experiences through a culturally safe and responsive lens.

Another solution to improve service engagement is facilitating opportunities for tāngata whaiora to reconnect with or strengthen ties to Māoritanga within mental health care. In order to safeguard the healing, empowering nature of this experience it is important to be mindful of the diversity in cultural identity among Māori. Māori and non-Māori kaimahi and services have the ability to support cultural reconnection either in their own practice or by linking tāngata whaiora in with people who can help in this journey such as kaumātua, cultural advisors or therapists, Māori service providers or colleagues, or local iwi and hapū.

The transition from individual-oriented practice to whānau-centred practice in mental health care is recommended. Services and kaimahi can work alongside whānau members by clearly and genuinely communicating from the outset of engagement they are welcomed and valued in the recovery journey of their whanaunga. As whānau support tāngata whaiora mental wellbeing outside of sessions and beyond service contact, seeking their perspectives in planning, decision-making, and treatment enables best practice care to be provided. Correspondingly, whānau-centred practice involves upholding the wellbeing of whānau by regularly asking how they are managing and providing or connecting them with resources such as counselling, self-care strategies, or crisis respite.

To ensure Māori mental health service engagement is supported and improved in a sustainable way, it is integral Te Ao Māori guided practice is embedded within the mental health sector culture, policies, and processes. As kaimahi and services are the kaitiaki of clinically and culturally responsive care experiences, a culturally competent workforce and provision of Kaupapa Māori services that is commensurate with the prevalence of mental health problems among Māori is necessary. If kaimahi and services are unsure how to apply these recommendations or are unable to seek guidance from cultural advisors, kaumātua, Māori colleagues, or local iwi and hapū, it would be helpful to attend wānanga and professional development trainings about the origins of Te Tiriti o Waitangi, tikanga, and frameworks or models of Māori mental wellbeing.

In summary, practicing in Te Ao Māori enables the knowledge and teachings that helped our tūpuna navigate life and flourish within Aotearoa and the source of strength that Māoritanga represents to be passed on and uplift the wellbeing of present generations by supporting mental health service engagement.

Privileging and nurturing relationships. Māori mental health service engagement can be positively transformed by privileging and nurturing genuine, meaningful relationships with tāngata whaiora and whānau in mental health practice. Māori and non-Māori kaimahi can develop these relationships simply by expressing manaakitanga in care interactions and talking with tāngata whaiora and whānau about their own whakapapa or familial connections, personal background and interests, and shared lived experiences to facilitate reciprocity. This approach to relationality recognises Māori are more than the psychological problems they seek help for and cultivates trust to begin, and remain engaged in, mental health care. While tensions between upholding tikanga and professional integrity have been described by kaimahi, the process of nurturing relationality as outlined in these research findings demonstrates therapeutically beneficial and balanced disclosure is possible. Given the influence relationships have on engagement decisions and intentions among Māori, it is recommended mental health services remain attuned to and prioritise relationship dynamics within organisational standards of practice.

Congruent with the aspirations of tāngata whaiora and whānau, Māori service engagement can be facilitated through further developing the Māori mental health workforce. This would enable Māori to be as Māori within services where cultural realities are understood and the energy of tāngata whaiora and whānau can be wholly directed towards taking part in mental health care to experience wellbeing.

Initiatives supporting cultural change towards mental wellbeing. These findings provide support for the movement occurring within Aotearoa towards creating a culture of understanding, manaakitanga, and literacy around mental wellbeing. To communicate the message 'It's okay not to be okay' and lessen the isolation, whakamā, stigma, and mataku associated with mental health problems, encouraging open, everyday conversations about the experience of unwellness and reaching out for help is important. Beginning these conversations in safe, familiar, and culturally meaningful environments such as at home over a pot of tea with whānau or friends, in schools, or at the marae can help to lessen anxiety which may arise for some Māori. Alternatively, as recommended by tāngata whaiora, services could invite kaumātua to be part of the culture they represent where mental unwellness and accessing support is normalised. Through sharing their experiences of this environment with whānau and with the mana they hold, kaumātua can begin a new narrative about mental wellbeing and seeking help that can be passed onto current and future generations of Māori. Correspondingly, in line with the suggestion of tāngata whaiora, mental health kaimahi could work to become a familiar presence within everyday environments. Being the 'seen face' would enable a connection between kaimahi and potential future tāngata whaiora to be developed and further normalise seeking support from mental health services.

The development and provision of mental health literacy education programmes using approaches that are responsive to a Māori worldview, tikanga, and ways of being is recommended. Delivering these programmes in an engaging manner that builds knowledge in a clear and understandable way within safe environments can help encourage participation and aid their effectiveness. Education programmes could be joint initiatives with local iwi and hapū that are offered to whānau through hui or the marae, or as partnerships with mental health services or schools in the community. These resources would empower tāngata whaiora and whānau to identity a change in their wellbeing, know about the help available from services, and follow a pathway of care that aligns with their worldview and values as Māori without whakamā, mataku, or guilt. Overall, supporting mental health literacy can help to build new, helpful discourses around mental wellbeing and seeking support thereby improving service engagement among Māori and uplifting wellbeing.

Strengths-based, collaborative mental health practice. A pathway to improving Māori service engagement lay in strengths-based, collaborative practice that recognises tāngata whaiora are descended from a culture of wellbeing and empowers them to fully take part in their mental health care journey. This involves kaimahi appreciating the clinical knowledge and skills they hold are most valuable in uplifting wellbeing when integrated with the insights tāngata whaiora have into their lived experiences. As such, by privileging active listening and open, reciprocal conversations within mental health practice, kaimahi can support Māori to have their voice heard and respected in care. This will enable tāngata whaiora to enact tino rangatiratanga, to fulfil their wellbeing aspirations in a direction that is meaningful to them and congruent with their values and worldview.

Improved mental health sector resourcing. These findings indicate increased resourcing for the mental health sector is vital to improving Māori service engagement and addressing persisting disparities in mental wellbeing. Notably, resource allocation should account for the importance and sustainable provision of clinically *and* culturally responsive care by mental health services. Alleviating resource constraints can reduce kaimahi caseloads and facilitate the timely response by services where tāngata whaiora feel validated in the decision to seek help and experience the benefits early mental health intervention provides. This will require systemic change whereby appropriate funding for mental health in Aotearoa is embedded as a priority in policy that remains stable when changes in government occur.

Strengths, Limitations, and Future Research Directions

This research can help the mental health sector begin to understand why Māori service engagement is incommensurate with mental wellbeing needs. The perspectives of pakeke tāngata whaiora, whānau members, and Māori kaimahi were heard and integrated within a narrative that explored how mental health care experiences influenced service engagement. These findings revealed current practices that Māori found helpful and responsive to their needs and, significantly, informed practical solutions about how mental health practice could evolve to improve Māori service engagement in a culturally and clinically appropriate manner. Importantly, by following a qualitative Kaupapa Māori Research approach, the rich insights participants shared could be interpreted within a Māori worldview so the findings retained an authentically Māori perspective. Privileging Te Ao Māori created space for Māori to be as Māori within research which, alongside positioning participants as experts in their lived experiences of engaging with or working in mental health services, was mana enhancing. In the context of persisting disparities in Māori mental health outcomes and the priorities identified within national inquiries, research, and strategies, this reflects a valuable contribution in knowledge to the mental health sector.

Although guided by an interview schedule, kōrero with participants was fluid and resembled a meaningful yet everyday conversation. This not only facilitated rich accounts and a deeper understanding into mental health service engagement but, as acknowledged by participants, an opportunity for them to have their stories heard and validated for the first time. Furthermore, participants commented they felt lending their voice to a narrative that sought constructive outcomes for Māori mental health was important, purposeful mahi. This reflected the enactment of tino rangatiratanga where participants were supported and encouraged throughout the rangahau to recognise they were capable of developing solutions to uplift the mental wellbeing of our people.

Despite the value this research holds towards understanding and improving Māori mental health service engagement outcomes, several limitations are present. These represent areas for future research to continue the journey towards flourishing as our tūpuna did and will be discussed accordingly.

The perspectives of Māori who experience mental unwellness and do not seek help from services are absent within this research. Kōrero with this rōpū could have provided pertinent insights that strengthened the narrative explaining why Māori engage with services less and how mental health practice could be transformed to improve this outcome. As referred to earlier, the significant challenges associated with recruitment of this rōpū led to the decision to speak with tāngata whaiora, people with lived experience of mental health problems who engaged with services. Tāngata whaiora participants described varied experiences and decisions around engagement, disengagement, and re-engagement with services which helped develop an understanding of Māori service engagement outcomes. However, future research with and alongside Māori who experience unwellness and do not seek help from mental health services is important for a balanced and fully informed explanation that the mental health sector seeks.

The tāngata whaiora, whānau members, and Māori kaimahi who took part in this rangahau indicated they came from well-educated backgrounds and described, or presented as, having reflected on their mental health care experiences. This may have contributed towards participants feeling comfortable and willing to engage in kōrero with a doctoral candidate on the area of Māori mental health service engagement. Together, these factors could mean the perspectives articulated within the research narrative may not appropriately reflect those of Māori with different life circumstances and opportunities to consolidate their experiences of unwellness and seeking help from services. This limitation may relate to the recruitment of participants using snowball sampling among the networks of the researcher and primary supervisor. Similarly, interviews took place with tāngata whaiora, whānau members, and Māori kaimahi who resided within urban communities. As such, the perspectives of Māori living in rural Aotearoa and the different lived experiences of service engagement this cohort hold is absent within this research. Future studies could address these methodological limitations by utilising a broader recruitment approach to capture these missing perspectives.

The structure of this qualification placed temporal limitations on the scope to which a Kaupapa Māori Research methodology could be as fully applied as I would have desired. Although tāngata whaiora, whānau members, and Māori kaimahi expressed the aims and aspirations of this research were fitting and reflected a valuable direction for Māori mental health, consultation outside of my own Māori networks may have honed the areas of focus in interviews to provide relevant information about mental health practice not captured within these findings.

In the context of the strengths and limitations of this research future studies could also seek to work alongside iwi, hapū, or community organisations to develop and provide mental health literacy education programmes for Māori. The effect these resources have on service engagement intentions and mental health care experiences could be explored in follow up hui with programme attendees. These findings could offer another dimension and depth of understanding for how mental health practice could continue evolving to support Māori to seek help from services.

Research that takes a service specific focus towards exploring the influence of mental health care experiences on Māori service engagement would also be valuable. For example, this could involve seeking the perspectives of tāngata whaiora, whānau members, and Māori kaimahi with experience of engaging with or working in Kaupapa Māori, mainstream, community, or inpatient mental health services. This would provide services with an understanding about mental health practices which facilitate or deter engagement that is directly relevant and applicable to them.

Future studies could also explore Māori service engagement from the perspectives of tāngata whaiora and whānau as they progress through mental health care, from service entry through to service exit. This approach may capture rich and comprehensive understandings into how Māori mental health service engagement is shaped as tāngata whaiora and whānau would kōrero about their experiences and engagement intentions as they occur in the moment.

Final Conclusions

In summary, this research provides an understanding into why mental health service engagement is incommensurate with mental wellbeing needs among pakeke Māori. The narrative developed alongside tāngata whaiora, whānau members, and Māori kaimahi elucidates how mental health care experiences influence service engagement. Findings spoke to how mental health practice that is guided by Te Ao Māori, privileges relationships, is mana enhancing and empowers Māori voices in care, encourages openness and literacy around mental wellbeing, and is supported with appropriate sector resourcing can improve mental health service engagement.

This research contributes to the movement taking place within Aotearoa towards enacting positive change in Māori mental wellbeing by providing guidance for how mental health practice can evolve in a culturally and clinically responsive manner to address low service engagement. I am optimistic the people of Aotearoa can come together as a kaupapa whānau and instil hope among Māori that mental health services can offer help and care to realise their moemoeā for living well.

The whakataukī which opens this thesis '*Mā tō tātou whanaungatanga e whakataki i te ritenga tika'* was reflected in the knowledge tāngata whaiora, whānau members, and Māori kaimahi held and applied to develop solutions for how Māori wellbeing can be restored. In turn, it is tika to close this thesis with the words of those who shaped this rangahau and pathway forward:

> *Consideration of cultural identity just needs to be as you would consider any other thing in a person's life that's affecting them. You cannot remove a person from their culture, it is embedded in them, it is who they are.*

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Appendix A

Participant Information Sheets

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Tangata Whaiora Participant Information Sheet

Māori Experiences with Mental Health Services

Tēnā koe,

You are invited to take part in a study looking at the experiences that Māori tāngata whaiora, whānau of tangata whaiora, and kaimahi have with mental health services.

My name is Amelia Backhouse-Smith and I am a Clinical Psychology Trainee at Massey University in Wellington. I am carrying out this research as part of my doctoral studies. I whakapapa to Ngāti Whātua from my matua (dad), and Ngāti Pākehā from my whaea (mum). I grew up in Waitakere, Auckland but have moved to Wellington to do more study so I can help improve the hauora (health) of my whānau, hapū, iwi, and fellow Māori.

My supervisors are Dr Simon Bennett, Associate Professor Ross Flett, and Dr Natasha Tassell-Matamua. Simon is a clinical psychologist with iwi ties to Ngāti Whakaue, Ngā Puhi, and Kai Tahu. Natasha teaches at Massey University and has iwi connections to Te Ātiawa and Ngāti Makea kei Rarotonga. Ross also teaches at Massey University and has worked on many Māori research projects. We are all very interested in research which can benefit Māori.

This Participant Information Sheet will help you decide if you would like to take part in this study. If you have any questions, please feel free to get in touch with me using the contact details at the end of this Information Sheet. You may also want to talk about the study with other people such as whānau, friends, kaumātua, or your mental health care worker.

This document is 4 pages long. Please make sure you have read and understood all of the pages.

What is this study about?

You have received this information pack and been invited to take part in this study because your views as a current or past tangata whaiora would be very helpful. The kaupapa (aim) of this study is to look at how Māori experiences with mental health services can influence the use of these services by Māori. This involves looking at helpful or unhelpful mental health service experiences, and how these could be changed and made better for Māori. We can then share ideas about which mental health service practices are culturally appropriate and helpful for Māori. We hope this study can improve Māori hauora (health) by encouraging more Māori with mental health problems to seek help.

This study is using a Kaupapa Māori approach. This means tikanga Māori is followed and Māori world-views are respected.

Can I take part in this study?

You can take part in this study if you identify as Māori, are 18 years or older, and are a current or past tangata whaiora.

What would taking part in this study involve?

Taking part in this study would involve meeting with Amelia for 1 interview to kōrero (talk) about your experiences with mental health services. This would be at the Massey University Psychology Clinic in Wellington, over video-calling apps like Skype, or over the phone. You could also meet with Amelia at your place of work, home, or a community location if you live in Wellington, Palmerston North, or Auckland. We might kōrero (talk) for 30 minutes to one and a half hours based on what you would like to share and how much time you have. Our kōrero (talk) would be voice-recorded. We might talk about experiences which could upset you. Please remember that you do not have to answer a question if you do not want to, and that tautoko (support) can be given by the people listed at the end of this Information Sheet. Whānau or support people are welcome to come along. They would not have to answer any questions.

You could also choose to meet up with Amelia to whakawhanaungatanga and get to know each other a bit better over a cup of tea or coffee and some kai (food) before the interview. This would be at Massey University, over video-calling apps like Skype, or over the phone. You could also meet up with Amelia to whakawhanaungatanga at your place of work, home, or a community location if you live in Wellington, Palmerston North, or Auckland. Whānau or support people are welcome to come along too. You do not have to do this if you do not want to.

How will I get to the study?

If you need some help getting to the study, Amelia will help sort out transport for you.

Koha

As a thank you for taking the time to share your experiences, we would like to offer you a $35 VISA Prezzy gift card as a koha.

What are your rights?

- Participation in this study is voluntary. You do not have to take part in this study if you do not want to.
- If you do not want to take part in this study, this will **not affect** your health care or health care your whānau may be receiving.
- If you do not want to take part in this study, this will **not affect** your relationship with your mental health care provider.
- You can leave the study at any time. This will **not affect** your health care or health care your whānau may be receiving.
- You can leave the study at any time. This will **not affect** your relationship with your mental health care provider.
- You can ask questions at any time.
- You do not have to answer any questions you do not want to when talking with Amelia.

- You are free to make a complaint about a mental health service, but this study will not help with this.

Will my information stay private?

Amelia and her supervisors will not know who you are or any of your personal information until you agree to take part in this study. They will not be told any of your health information other than what you might share with Amelia in the interview or allow you mental health care worker to share. Your name and other information which might tell people who you are will be changed when the study findings are shared. Also, the name of the mental health service you go to will not be included in the study findings. All forms and written information will be safely stored. Voice-recordings and computer files will have a password. Only Amelia and her supervisors can use this information. After the study is over, all of this information will be kept in a safe place at Massey University in Wellington for 10 years and then destroyed.

Please know that your mental health service provider has posted this information pack to you on behalf of Amelia and her supervisors. This means Amelia and her supervisors do not know your address. This also means that your mental health service provider does not know whether you will take part in this study.

What happens after the study?

We would like to share the study findings with you. On the Informed Consent Form you can choose to be sent a small summary of the study findings. This can be posted or emailed to you. It can also be sent to your mental health care provider to give to you. Hui will also be held at Massey University in Wellington to share the findings kanohi ki te kanohi (face to face). At the hui you can ask questions, give feedback, and meet other participants. Kai (food) will be provided and whānau or support people are welcome to come along too.

What do I do if I want to take part?

If you would like to take part in this study, please fill out and sign the Informed Consent Form in this information pack. Please return the signed Informed Consent Form using the FreePost return envelope addressed to the Massey University Psychology Clinic, Wellington or by email to Amelia’s email address below. A Participant Information Sheet and Informed Consent Form will also be given to you at the interview with Amelia or talked about again if the interview is over video-calling apps like Skype or over the phone.

Contact details

If you have any questions or would like some more information about the study, please feel free to get in touch with Amelia or her supervisors using the contact details below:

Amelia Backhouse-Smith
Co-ordinating Investigator
Massey University, Wellington
Email: amelia.backhouse-smith.1@uni.massey.ac.nz
Phone: 0800 222886
Text: 021463637

Dr Simon Bennett
Primary Supervisor (Co-Investigator)
Massey University, Wellington
Email: S.T.Bennett@massey.ac.nz
Phone: (04) 801 5977 ext. 63609

Associate Professor Ross Flett
Co-Supervisor (Co-Investigator)
Massey University, Palmerston North
Email: R.A.Flett@massey.ac.nz

Phone: (06) 356 9099 ext. 85081

Dr Natasha Tassell-Matamua
Co-Supervisor (Co-Investigator)
Massey University, Palmerston North
Email: N.A.Tassell-Matamua@massey.ac.nz
Phone: (06) 356 9099 ext. 85080

If you have any concerns or wish to talk with someone who is not involved in this study, you can contact a health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

For Māori cultural support, you may find talking to your whānau, kaumātua, mental health care worker, or Dr Simon Bennett is helpful.

If you would like support from people who are not involved in this study, you can contact the following places:

Name: Lifeline
Phone: 0800 543 354

Name: The Family Centre
Phone: (04) 569 7112
Address: 71 Woburn Road, Lower Hutt

Name: Kahungunu Whānau Services (Kahungunu Social Services Wellington Māori Counsellors)
Phone: (04) 384 6252
Address: 2 Lukes Lane, Te Aro, Wellington

Name: Wellington Psychological Associates
Phone: (04) 472 0710
Address: Level 5, 199 Featherston Street, Wellington

This project has been reviewed and approved by the Northern B Health and Disability Ethics Committee, Application 16/NTB/165.

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UNIVERSITY OF NEW ZEALAND

Whānau Participant Information Sheet

Māori Experiences with Mental Health Services

Tēnā koe,

You are invited to take part in a study looking at the experiences that Māori tāngata whaiora, whānau of tangata whaiora, and kaimahi have with mental health services.

My name is Amelia Backhouse-Smith and I am a Clinical Psychology Trainee at Massey University in Wellington. I am carrying out this research as part of my doctoral studies. I whakapapa to Ngāti Whātua from my matua (dad), and Ngāti Pākehā from my whaea (mum). I grew up in Waitakere, Auckland but have moved to Wellington to do more study so I can help improve the hauora (health) of my whānau, hapū, iwi, and fellow Māori.

My supervisors are Dr Simon Bennett, Associate Professor Ross Flett, and Dr Natasha Tassell-Matamua. Simon is a clinical psychologist with iwi ties to Ngāti Whakaue, Ngā Puhi, and Kai Tahu. Natasha teaches at Massey University and has iwi connections to Te Ātiawa and Ngāti Makea kei Rarotonga. Ross also teaches at Massey University and has worked on many Māori research projects. We are all very interested in research which can benefit Māori.

This Participant Information Sheet will help you decide if you would like to take part in this study. If you have any questions, please feel free to get in touch with me using the contact details at the end of this Information Sheet. You may also want to talk about the study with other people such as whānau, friends, or kaumātua.

This document is 4 pages long. Please make sure you have read and understood all of the pages.

What is this study about?

You have received this information pack and been invited to take part in this study because your views as whānau of tangata whaiora would be very helpful. The kaupapa (aim) of this study is to look at how Māori experiences with mental health services can influence the use of these services by Māori. This involves looking at helpful or unhelpful mental health service experiences, and how these could be changed and made better for Māori. We can then share ideas about which mental health service practices are culturally appropriate and helpful for Māori. We hope this study can improve Māori hauora (health) by encouraging more Māori with mental health problems to seek help.

This study is using a Kaupapa Māori approach. This means tikanga Māori is followed and Māori world-views are respected.

Can I take part in this study?

You can take part in this study if you identify as Māori, are 18 years or older, and are whānau of tangata whaiora.

What would taking part in this study involve?

Taking part in this study would involve meeting with Amelia for 1 interview to kōrero (talk) about your experiences with mental health services as a whānau member of tangata whaiora. This would be at the Massey University Psychology Clinic in Wellington, over video-calling apps like Skype, or over the phone. You could also meet with Amelia at your place of work, home, or a community location if you live in Wellington, Palmerston North, or Auckland. We might kōrero (talk) for 30 minutes to one and a half hours based on what you would like to share and how much time you have. Our kōrero (talk) would be voice-recorded. We might talk about experiences which could upset you. Please remember that you do not have to answer a question if you do not want to, and that tautoko (support) can be given by the people listed at the end of this information sheet. Whānau or support people are welcome to come along. They would not have to answer any questions.

You could also choose to meet up with Amelia to whakawhanaungatanga and get to know each other a bit better over a cup of tea or coffee and some kai (food) before the interview. This would be at Massey University, over video-calling apps like Skype, or over the phone. You could also meet up with Amelia to whakawhanaungatanga at your place of work, home, or a community location if you live in Wellington, Palmerston North, or Auckland. Whānau or support people are welcome to come along too. You do not have to do this if you do not want to.

How will I get to the study?

If you need some help getting to the study, Amelia will help sort out transport for you.

Koha

As a thank you for taking the time to share your experiences, we would like to offer you a $35 VISA Prezzy gift card as a koha.

What are your rights?

- You do not have to take part in this study if do not want to. This will **not affect** any health care you may be receiving or the health care of your whānau.
- You can leave the study at any time. This will **not affect** any health care you may be receiving or the health care of your whānau.
- You can ask questions at any time.
- You do not have to answer any questions you do not want to when talking with Amelia.
- You are free to make a complaint about a mental health service, but this study will not help with this.

Will my information stay private?

Amelia and her supervisors will not know who you are or any of your personal information until you agree to take part in this study. They will not be told any of your health information other than what you might share with Amelia in the interview. Your name and other information which might tell people who you are will be changed when the study findings are shared. Also, the name of the mental health service your whānau member goes to will not be included in the study findings. All forms and written information will be safely stored. Voice-recordings and computer files will have a password. Only Amelia and her supervisors can use this information. After the study is over, all of this information will be kept in a safe place at Massey University in Wellington for 10 years and then destroyed.

What happens after the study?

We would like to share the study findings with you. On the Informed Consent Form you can choose to be sent a small summary of the study findings. This can be posted or emailed to you. Hui will also be held at Massey University in Wellington to share the findings kanohi ki te kanohi (face to face). At the hui you can ask questions, give feedback, and meet other participants. Kai (food) will be provided and whānau or support people are welcome to come along too.

What do I do if I want to take part?

If you would like to take part in this study, please fill out and sign the Informed Consent Form in this information pack. Please return the signed Informed Consent Form using the FreePost return envelope addressed to the Massey University Psychology Clinic, Wellington or by email to Amelia's email address below. A Participant Information Sheet and Informed Consent Form will also be given to you at the interview with Amelia or emailed to you and talked about if the interview is over video-calling apps like Skype or over the phone.

Contact details

If you have any questions or would like some more information about the study, please feel free to get in touch with Amelia or her supervisors using the contact details below:

Amelia Backhouse-Smith
Co-ordinating Investigator
Massey University, Wellington
Email: amelia.backhouse-smith.1@uni.massey.ac.nz
Phone: 0800 222886
Text: 021463637

Dr Simon Bennett
Primary Supervisor (Co-Investigator)
Massey University, Wellington
Email: S.T.Bennett@massey.ac.nz
Phone: (04) 801 5977 ext. 63609

Associate Professor Ross Flett
Co-Supervisor (Co-Investigator)
Massey University, Palmerston North
Email: R.A.Flett@massey.ac.nz
Phone: (06) 356 9099 ext. 85081

Dr Natasha Tassell-Matamua
Co-Supervisor (Co-Investigator)
Massey University, Palmerston North
Email: N.A.Tassell-Matamua@massey.ac.nz
Phone: (06) 356 9099 ext. 85080

If you have any concerns or wish to talk with someone who is not involved in this study, you can contact a health and disability advocate on:

Phone: 0800 555 050
Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

For Māori cultural support, you may find talking to your whānau, kaumātua or Dr Simon Bennett is helpful.

If you would like support from people who are not involved in this study, you can contact the following places:

Name: Lifeline
Phone: 0800 543 354

Name: The Family Centre
Phone: (04) 569 7112
Address: 71 Woburn Road, Lower Hutt

Name: Kahungunu Whānau Services (Kahungunu Social Services Wellington Māori Counsellors)
Phone: (04) 384 6252
Address: 2 Lukes Lane, Te Aro, Wellington

Name: Wellington Psychological Associates
Phone: (04) 472 0710
Address: Level 5, 199 Featherston Street, Wellington

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Māori Kaimahi Participant Information Sheet

Māori Experiences with Mental Health Services

Tēnā koe,

You are invited to take part in a study looking at the experiences that Māori tāngata whaiora, whānau of tangata whaiora, and kaimahi have with mental health services.

My name is Amelia Backhouse-Smith and I am a Clinical Psychology Trainee at Massey University in Wellington. I am carrying out this research as part of my doctoral studies. I whakapapa to Ngāti Whātua from my matua (dad), and Ngāti Pākehā from my whaea (mum). I grew up in Waitakere, Auckland but have moved to Wellington to do more study so I can help improve the hauora (health) of my whānau, hapū, iwi, and fellow Māori.

My supervisors are Dr Simon Bennett, Associate Professor Ross Flett, and Dr Natasha Tassell-Matamua. Simon is a clinical psychologist with iwi ties to Ngāti Whakaue, Ngā Puhi, and Kai Tahu. Natasha teaches at Massey University and has iwi connections to Te Ātiawa and Ngāti Makea kei Rarotonga. Ross also teaches at Massey University and has worked on many Māori research projects. We are all very interested in research which can benefit Māori.

This Participant Information Sheet will help you decide if you would like to take part in this study. If you have any questions, please feel free to get in touch with me using the contact details at the end of this Information Sheet. You may also want to talk about the study with other people such as whānau, friends, or kaumātua.

This document is 4 pages long. Please make sure you have read and understood all of the pages.

What is this study about?

You have received this information pack and been invited to take part in this study because your views as a Māori kaimahi would be very helpful. The kaupapa (aim) of this study is to look at how Māori experiences with mental health services can influence the use of these services by Māori. This involves looking at helpful or unhelpful mental health service experiences, and how these could be changed and made better for Māori. We can then share ideas about which mental health service practices are culturally appropriate and helpful for Māori. We hope this study can improve Māori hauora (health) by encouraging more Māori with mental health problems to seek help.

This study is using a Kaupapa Māori approach. This means tikanga Māori is followed and Māori world-views are respected.

Can I take part in this study?

You can take part in this study if you identify as Māori, are 18 years or older, and are a Māori kaimahi.

What would taking part in this study involve?

Taking part in this study would involve meeting with Amelia for 1 interview to kōrero (talk) about your experiences with mental health services. This would be at the Massey University Psychology Clinic in Wellington, over video-calling apps like Skype, or over the phone. You could also meet with Amelia at your place of work, home, or a community location if you live in Wellington, Palmerston North, or Auckland. We might kōrero (talk) for 30 minutes to one and a half hours based on what you would like to share and how much time you have. Our kōrero (talk) would be voice-recorded. We might talk about experiences which could upset you. Please remember that you do not have to answer a question if you do not want to, and that tautoko (support) can be given by the people listed at the end of this information sheet. Whānau or support people are welcome to come along. They would not have to answer any questions.

You could also choose to meet up with Amelia to whakawhanaungatanga and get to know each other a bit better over a cup of tea or coffee and some kai (food) before the interview. This would be at Massey University, over video-calling apps like Skype, or over the phone. You could also meet up with Amelia to whakawhanaungatanga at your place of work, home, or a community location if you live in Wellington, Palmerston North, or Auckland. Whānau or support people are welcome to come along too. You do not have to do this if you do not want to.

How will I get to the study?

If you need some help getting to the study, Amelia will help sort out transport for you.

Koha

As a thank you for taking the time to share your experiences, we would like to offer you a $35 VISA Prezzy gift card as a koha.

What are your rights?

- Participation in this study is voluntary. You do not have to take part in this study if do not want to. This will **not affect** relationships you may have with Simon, Ross, or Natasha.
- You can leave the study at any time. This will **not affect** relationships you may have with Simon, Ross, or Natasha.
- You can ask questions at any time.
- You do not have to answer any questions you do not want to when talking with Amelia.
- You are free to make a complaint about a mental health service, but this study will not help with this.

Will my information stay private?

Your name and other information which might tell people who you are will be changed when the study findings are shared. Also, the name of the mental health service you work at will not be included in the study findings. All forms and written information will be safely stored. Voice-recordings and computer files will have a password. Only Amelia and her supervisors can use this information. After the study is over, all of this information will be kept in a safe place at Massey University in Wellington for 10 years and then destroyed.

What happens after the study?

We would like to share the study findings with you. On the Informed Consent Form you can choose to be sent a small summary of the study findings. This can be posted or emailed to you. It can also be sent to you at your work. Hui will also be held at Massey University in Wellington to share the findings kanohi ki te kanohi (face to face). At the hui you can ask questions, give feedback, and meet other participants. Kai (food) will be provided and whānau or support people are welcome to come along too.

What do I do if I want to take part?

If you would like to take part in this study, please fill out and sign the Informed Consent Form in this information pack. Please return the signed Informed Consent Form using the FreePost return envelope addressed to the Massey University Psychology Clinic, Wellington or by email to Amelia's email address below. A Participant Information Sheet and Informed Consent Form will also be given to you at the interview with Amelia, or emailed to you and talked about if the interview is over video-calling apps like Skype or over the phone.

Contact details

If you have any questions or would like some more information about the study, please feel free to get in touch with Amelia or her supervisors using the contact details below:

Amelia Backhouse-Smith
Co-ordinating Investigator
Massey University, Wellington
Email: amelia.backhouse-smith.1@uni.massey.ac.nz
Phone: 0800 222886
Text: 021463637

Dr Simon Bennett
Primary Supervisor (Co-Investigator)
Massey University, Wellington
Email: S.T.Bennett@massey.ac.nz
Phone: (04) 801 5799 ext. 63609

Associate Professor Ross Flett
Co-Supervisor (Co-Investigator)
Massey University, Palmerston North
Email: R.A.Flett@massey.ac.nz

Phone: (06) 356 9099 ext. 85081

Dr Natasha Tassell-Matamua
Co-Supervisor (Co-Investigator)
Massey University, Palmerston North
Email: N.A.Tassell-Matamua@massey.ac.nz
Phone: (06) 356 9099 ext. 85080

If you have any concerns or wish to talk with someone who is not involved in this study, you can contact a health and disability advocate on:

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Fax: 0800 2 SUPPORT (0800 2787 7678)
Email: advocacy@hdc.org.nz

For Māori cultural support, you may find talking to your whānau, kaumātua, or Dr Simon Bennett is helpful.

If you would like support from people who are not involved in this study, you can contact the following places:

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Phone: 0800 543 354

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Phone: (04) 569 7112
Address: 71 Woburn Road, Lower Hutt

Name: Kahungunu Whānau Services (Kahungunu Social Services Wellington Māori Counsellors)
Phone: (04) 384 6252
Address: 2 Lukes Lane, Te Aro, Wellington

Name: Wellington Psychological Associates
Phone: (04) 472 0710
Address: Level 5, 199 Featherston Street, Wellington

This project has been reviewed and approved by the Northern B Health and Disability Ethics Committee, Application 16/NTB/165.

Appendix B

Informed Consent Forms

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UNIVERSITY OF NEW ZEALAND

Tangata Whaiora Informed Consent Form

Māori Experiences with Mental Health Services

- I have read and I understand the Participant Information Sheet.
- I have had the chance to ask Amelia questions or be told more about the study.
- I am happy with the information I have been given about the study.
- I understand that I can ask questions at any time.
- I have been given a copy of the Participant Information Sheet and Informed Consent Form to keep.
- I understand that taking part in this study is my choice and that I can leave the study at any time.
- I understand that if I leave the study this will **not affect** my health care or any health care my whānau may be receiving.
- I understand that if I leave the study this will **not affect** my relationship with my health care provider.
- I understand that taking part in this study involves meeting with Amelia once to talk about my experiences with mental health services.
- I understand that I can choose to meet and talk with Amelia at the Massey University Psychology Clinic in Wellington, over video-calling apps like Skype, or over the phone. I understand that I can also meet and talk with Amelia at my place of work, home, or a community location if I live in Wellington, Palmerston North, or Auckland.
- I understand the information I give for this study will be kept private and that no one will know who I am when the study findings are shared.
- I agree to my mental health care provider being told about me taking part in the study. Yes ☐ No ☐
- I understand talking about my experiences could make me upset. I know who to contact for support if this happens. I also know who to contact if I would like specific Māori cultural tautoko (support) for taking part in this study.
- I agree to have my kōrero (talk) with Amelia voice-recorded.
- I know how to contact the Amelia and her supervisors (Simon, Ross, and Natasha) if I have any questions.

I ____ (name) agree to take part in this study.

Signature: _____________________________________ Date: ________________

I would like Amelia to get hold of me by:

(Please tick one or more)

Phone ☐ Phone Number: ____

Email ☐ Email Address: ____

Post ☐ Postal Address: ____

____

____

- I would like to be sent a short summary of the study findings when the study is over:

  Yes ☐ No ☐

  Signature: ____

- If **'Yes'**, I would like this sent to me by:

  Email ☐

  Post ☐

  My mental health care provider ☐

  Mental health care provider contact details: _____________________________________

  ____

MASSEY UNIVERSITY
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UNIVERSITY OF NEW ZEALAND

Whānau Informed Consent Form

Māori Experiences with Mental Health Services

- I have read and I understand the Participant Information Sheet.
- I have had the chance to ask Amelia questions or be told more about the study.
- I am happy with the information I have been given about the study.
- I understand that I can ask questions at any time.
- I have been given a copy of the Participant Information Sheet and Informed Consent Form to keep.
- I understand that taking part in this study is my choice and that I can leave the study at any time.
- I understand that if I leave the study this will **not affect** any health care I may be receiving or the health care of my whānau.
- I understand that taking part in this study involves meeting with Amelia once to talk about my experiences with mental health services as a whānau member of tangata whaiora.
- I understand that I can choose to meet and talk with Amelia at the Massey University Psychology Clinic in Wellington, over video-calling apps like Skype, or over the phone. I understand that I can also meet and talk with Amelia at my place of work, home, or a community location if I live in Wellington, Palmerston North, or Auckland.
- I understand the information I give for this study will be kept private and that no one will know who I am when the study findings are shared.
- I understand talking about my experiences could make me upset. I know who to contact for support if this happens. I also know who to contact if I would like Māori tautoko (support) for taking part in this study.
- I agree to have my kōrero (talk) with Amelia voice-recorded.
- I know how to contact the Amelia and her supervisors (Simon, Ross, and Natasha) if I have any questions.

I ____ (name) agree to take part in this study.

Signature: ____ Date: _________________

I would like Amelia to get hold of me by:

(Please tick one or more)

Phone ☐ Phone Number: ____

Email ☐ Email Address: ____

Post ☐ Postal Address: ____

____

____

- I would like to be sent a short summary of the study findings when the study is over:

  Yes ☐ No ☐

  Signature: ____

- If **'Yes'**, I would like this sent to me by:

  Email ☐

  Post ☐

MASSEY UNIVERSITY
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UNIVERSITY OF NEW ZEALAND

Māori Kaimahi Informed Consent Form

Māori Experiences with Mental Health Services

- I have read and I understand the Participant Information Sheet.
- I have had the chance to ask Amelia questions or be told more about the study.
- I am happy with the information I have been given about the study.
- I understand that I can ask questions at any time.
- I have been given a copy of the Participant Information Sheet and Informed Consent Form to keep.
- I understand that taking part in this study is my choice and that I can leave the study at any time.
- I understand that if I leave the study this will **not affect** relationships I may have with Simon, Ross, and Natasha.
- I understand that taking part in this study involves meeting with Amelia once to talk about my experiences with mental health services.
- I understand that I can choose to meet and talk with Amelia at the Massey University Psychology Clinic in Wellington, over video-calling apps like Skype, or over the phone. I understand that I can also meet and talk with Amelia at my place of work, home, or a community location if I live in Wellington, Palmerston North, or Auckland.
- I understand the information I give for this study will be kept private and that no one will know who I am when the study findings are shared.
- I understand talking about my experiences could make me upset. I know who to contact for support if this happens. I also know who to contact if I would like specific Māori cultural tautoko (support) for taking part in this study.
- I agree to have my kōrero (talk) with Amelia voice-recorded.
- I know how to contact the Amelia and her supervisors (Simon, Ross, and Natasha) if I have any questions.

I ____ (name) agree to take part in this study.

Signature: _______________________________________ Date: _________________

I would like Amelia to get hold of me by:

(Please tick one or more)

Phone ☐ Phone Number: ______________________________

Email ☐ Email Address: ______________________________

Post ☐ Postal Address: ______________________________

____

____

- I would like to be sent a short summary of the study findings when the study is over:

  Yes ☐ No ☐

Signature: ______________________________

- If **'Yes'**, I would like this sent to me by:

  Email ☐

  Post ☐

Appendix C

Tāngata Whaiora and Whānau Member Interview Schedule

- Would you mind sharing how you/your whānau made the decision to seek help from mental health services?

  Prompts:

  - What were your thoughts or feelings around this decision?
  - What led to confidence or willingness to seek help from mental health services?
  - What led to uncertainty or delay in seeking help from mental health services?

- What was it like for you/your whānau the first time you visited the service?

  Prompts:

  - How were you welcomed?
  - Did you feel comfortable or safe? How were you made to feel this way?
  - Did you feel or think the service could be helpful for you/your whānau? What made you feel or think this?

- During the time you/your whānau were at the service, were there any experiences or practices the service used which were helpful and would encourage you/your whānau to use mental health services again?

- During the time you/your whānau were at the service, were there any experiences or practices the service used which were unhelpful and would discourage you/your whānau to use mental health services again?

- Do you have any ideas about why some whānau may not want to use mental health services?

- How do you think mental health services or kaimahi could do things differently to improve Māori service use?

  Prompts:

  - For tāngata whaiora
  - For whānau

- What do you think mental health services or kaimahi currently do well for Māori?

- What are your hopes for how mental health services can help Māori in future?

Appendix D

Māori Kaimahi Interview Schedule

- Could you share a little about what your role at the service involves?

- In your mahi, how do you work to create a helpful service experience for tāngata whaiora and whānau and increase the likelihood they will use mental health services again?

  Prompts:

    - Initial contact
    - Assessment/Intervention
    - Leaving the service

- What supports you to work with tāngata whaiora/whānau in this way?

- What are some of the barriers to working with tāngata whaiora/whānau in this way?

- What mental health service practices do you think tāngata whaiora/whānau find helpful and make them likely to use mental health services again?

- What mental health service practices do you think tāngata whaiora/whānau find unhelpful and make them feel unsure of or not want to use mental health services again?

- What do you think mental health services or kaimahi currently do well for Māori?

- How do you think mental health services or kaimahi could help to improve Māori service use?

  Prompts:

    - For tāngata whaiora
    - For whānau

- What are your hopes for how mental health services can help Māori in future?

Appendix E

Research Case Study

He Māori Ahau: How my Kaupapa Māori Doctoral Research Influenced my Practice as a Māori Intern Psychologist

Amelia Jade Backhouse-Smith

Doctor of Clinical Psychology Candidate, Massey University

Intern Psychologist at Hutt South Adult Community Mental Health and Addictions Services and Mental Health, Addictions, and Intellectual Disability Services 3DHB

This case study represents the mahi of Amelia Jade Backhouse-Smith during her research in 2016, 2017, and 2019 and reflections as a Māori intern psychologist in 2018.

Candidate:	Amelia Backhouse-Smith
Primary Supervisor:	Dr Simon Bennett

Abstract

This case study outlines how my Kaupapa Māori doctoral research influenced my practice as a Māori intern psychologist. To understand why Māori service engagement is incommensurate with mental wellbeing needs, my research explored how mental health care experiences influence service engagement among pakeke Māori from the perspectives of tangata whaiora, whānau members, and Māori kaimahi.

An overview about the position of Māori mental health, research rationale, aims, and qualitative Kaupapa Māori Research methodology will be provided. This is followed by reflections about how engaging in Kaupapa Māori Research guided my mahi alongside Māori tangata whaiora and whānau in mental health care at Central Regional Intellectual Disability Services.

Keywords: Kaupapa Māori Research, Mental Health, Service Engagement, Te Ao Māori

The Position of Māori Mental Health as a Foundation for Rangahau

Māori, the tangata whenua of Aotearoa, descend from a culture of wellbeing (Durie, 2001). Prior to the arrival of Pākehā when mātauranga Māori and Māoritanga guided the way of life, Māori flourished in Aotearoa (Harris & Matutina Williams, 2014). Centuries later, a partnership was formed between Māori and the Crown through the signing of Te Tiriti o Waitangi in 1840 (Durie, 1998). Te Tiriti o Waitangi was intended to provide mutual advancement for Māori and Pākehā in health, education, technology, and trade whilst preserving Māori culture and the sovereignty Māori had over their lives and land. However, the actual outcome of Te Tiriti o Waitangi was colonisation, which detrimentally affected Māori wellbeing through the loss of whenua, reo, mātauranga, tikanga, and whānau structures (Durie, 1998; 2001).

In contemporary Aotearoa, the effects of colonisation are reflected in the disparities in mental health outcome among Māori. Findings from major national studies and inquiries reveal Māori service engagement is incommensurate with mental wellbeing needs (Baxter, Kingi, Tapsell & Durie, 2006; Government Inquiry into Mental Health and Addiction, 2018; Oakley Browne & Wells, 2006. Specifically, while one in three Māori (29.5%) will experience a psychological problem within a 12-month period, two thirds (67.5%) will not engage with services for help. As such, it was concluded a greater understanding about Māori service use and the ability of services to provide culturally and clinically responsive mental health care was necessary (Baxter, 2008; Government Inquiry into Mental Health and Addiction, 2018).

Research Rationale and Aims

Improving Māori mental wellbeing is a priority of the New Zealand mental health sector (Government Inquiry in Mental Health and Addiction, 2018). Findings from major studies in Aotearoa indicate Māori mental health service engagement is incommensurate with the prevalence of psychological problems (Baxter et al., 2006; Government Inquiry into Mental Health and Addiction, 2018; Oakley Browne & Wells, 2006a). Similar outcomes have been reported among other Indigenous populations leading to research that seeks to understand and offer solutions to address Indigenous mental wellbeing needs. This body of literature was informed by the perspectives of clients, families, and clinicians, and suggested a relationship was present between mental health care experiences and service engagement. Specifically, culturally appropriate assessment and intervention, meaningful relationships, communication, flexible practice, and shame, mental health literacy were indicated to influence service engagement. Based on these findings, culturally and clinically responsive recommendations for how mental health practice could be adapted to facilitate service engagement among Indigenous people were provided (Berry & Crowe, 2009; Gone & Trimble, 2012; Hepworth et al., 2015; Hinton et al., 2015; Isaacs et al., 2013; Isaacs et al., 2010; Mehl-Medrona, 2009; Vicary & Westerman, 2004; Vukic et al., 2009; Westerman, 2004).

Research in Aotearoa has not directly explored how mental health care experiences can influence service engagement among pakeke Māori. Presently, studies have only examined whether mental health care experiences were helpful or unhelpful. Therefore, little is known about why Māori seek less help from services and what could be done in mental health practice to improve engagement and uplift wellbeing. Furthermore, the perspectives of pakeke tāngata whaiora, whānau members, and Māori kaimahi have not been collectively considered in one study. This is significant as research that explored CAMHS engagement with rangatahi tāngata whaiora, whānau, and Māori kaimahi offered valuable insights into service engagement patterns and recommendations for mental health practice (Pomare, 2015). Similarly, Mason et al. (2004) suggested integrating the perspectives of those involved in mental health care could help provide coordinated best practice guidelines for services working with Māori. This represents a methodological weakness and gap in understanding as the New Zealand mental health sector seeks explanations for why Māori service engagement is incommensurate with mental wellbeing needs.

The current research will seek to address these limitations by exploring how mental health care experiences may influence Māori service engagement from the perspectives of pakeke tāngata whaiora, whānau members, and Māori kaimahi. Integrating these perspectives, coordinated recommendations for how mental health practice could evolve to support and improve service engagement among Māori in a culturally and clinically responsive manner will be provided.

In light of these considerations, the aims of the current research are presented as follows.

Research Aims

1. Develop an understanding of why Māori mental health service engagement is incommensurate with mental wellbeing needs.
2. Describe how mental health care experiences contribute towards Māori service engagement outcomes by integrating the perspectives of tāngata whaiora, whānau members, and Māori kaimahi.
3. Provide coordinated recommendations for culturally and clinically responsive mental health practice that supports and improves Māori service engagement and mental wellbeing.

Kaupapa Māori Research Approach

The spirit of Kaupapa Māori Research is captured by the orientation towards improving Māori wellbeing through exploring and developing solutions to issues that Māori experience as relevant and important (Smith, 2012; Walker, Eketone & Gibbs, 2006). Kaupapa Māori Research is a unique and distinctly Māori approach to working *with* and *alongside* Māori in research, where Māori worldviews, tikanga, and ways of being in the world are privileged (Smith, 2012; Walker et al., 2006).

Kaupapa Māori refers to being, thinking, and living life as Māori (Smith, 1997). When Kaupapa Māori is applied as a research approach, it seeks to resolve the displacement of authentic Māori voices by non-Māori researchers that sought to understand and construct Māori lived experiences and realities using Pākehā research frameworks (Bishop, 1998). This stance is evident in the ontology and epistemology of Kaupapa Māori Research, which complement and inform one another (Crotty, 1998). Traditional Māori ontology, or beliefs about the nature of reality and human existence, is founded on collectivity (whanaungatanga) among people (kotahitanga), relationships to ātua and the cosmos (wairuatanga), and an appreciation of the role humans have in protecting and nurturing the environment (kaitiakitanga). Taken together, these reflect the connection between the mind, body, and spirit (Henry & Pene, 2001). Kaupapa Māori Research epistemology, or views about what is considered valid and appropriate knowledge, affirms that to be Māori and follow a Māori worldview and practices is normal. As such, Māori philosophies, language, culture, and customs are positioned as legitimate and natural when constructing and understanding Māori knowledge within Kaupapa Māori Research (Henry & Pene, 2001; Pihama, Cram & Walker, 2002).

By its very nature, Kaupapa Māori Research is strengths-based. The approach upholds the mana of Māori communities (Cram, 2001) and offers the potential for positive change in outcomes important to Māori such as mental health (Moewaka Barnes, 2000). These qualities are reflected in the fundamental principle of tino rangatiratanga which relates to self-determination and empowerment (Pihama et al., 2002). The enactment of tino rangatiratanga by Māori within research is captured in the principle of social justice that is concerned with challenging and resolving pervasive inequalities experienced by Māori. Within this research, tino rangatiratanga and social justice were present in the opportunity participants had to develop knowledge and provide solutions to address low Māori mental health service engagement and uplifting wellbeing.

Kaupapa Māori Research is not a prescriptive research approach; it is dynamic and tikanga is fluid depending on the Māori community engaged and the research aims. This research followed Māori principles of engagement articulated by Smith (2012) and elaborated on by Cram (2001) that guide research processes and outcomes:

- Aroha ki te tangata (respect for people)
- Kanohi ki te kanohi (the seen face; appreciating the value of connecting with people face-to-face)
- Titiro, whakarongo, … kōrero (look and listen first, then speak when you have a place of understanding to talk from)
- Manaaki ki te tangata (share, host, and be generous to people; recognise that interactions are collaborative where participants and researchers learn from another and develop shared understandings; reciprocate participants sharing their stories by communicating with them about the research findings)

- Kia tupato (be cautious; be culturally safe; remain reflexive about the insider/outsider status as a researcher)
- Kaua e takahia te mana o te tangata (do not trample over the mana or dignity of people; engage in a genuine and meaningful manner)
- Kia māhaki (do not flaunt your knowledge; be humble in your approach; recognise people are the experts of their lived experiences and aspirations)

Underpinned by these values, Kaupapa Māori Research was considered the most appropriate approach for this research. Through positioning and affirming Māori worldviews, tikanga, and ways of being as normal, the voices of tāngata whaiora, whānau members, and Māori kaimahi created a narrative about how to improve Māori mental health service engagement and uplift wellbeing.

Qualitative Research

Qualitative research provides rich, deep, and meaningful insights into the lived experiences of individuals, whānau, and communities (Braun & Clarke, 2013) and allows for collaboration and relationality between participants and the researcher (Willig, 2008). As such, qualitative research is considered appropriate when engaging in research with and alongside Māori (Moewaka Barnes, 2000). In addition, qualitative research can honour the perspectives of tāngata whaiora, whānau members, and Māori kaimahi by grounding the narrative of meaning within their accounts and holding tensions within the data that capture the complexity of life (Yardley, 2008).

Thematic analysis was selected as the qualitative method of data analysis as it was appropriately suited to addressing the research aims and questions. The theoretical flexibility of thematic analysis enabled a Māori worldview to be applied during data analysis and interpretation (Braun & Clarke, 2006; Elder, 2008; McClintock et al., 2011;

McClintock et al., 2013). An inductive approach was used whereby the codes, themes, and overall narrative were developed from participant interview kōrero. Reflective of the spirit of Kaupapa Māori Research where Māori have the ability to self-determine, an experiential approach was followed. This assumed participants held, and could share, an understanding into an authentic reality of Māori mental health service engagement and care experiences.

Overall the attributes of relationality and empowerment and the rich, meaningful insights into the complexity of participant lived experiences that qualitative research offered made it compatible with a Kaupapa Māori Research approach and the aims and questions of the current research.

Ethical Approval

Ethical approval for this study was granted by the Northern B Health and Disability Ethics Committee, application reference 16/NTB/165.

Participant Recruitment

Eligible participants were individuals who identified as Māori, were aged 18 years and over, and were past or present tāngata whaiora, whānau members of tāngata whaiora, or Māori kaimahi working in mental health services. Participants were recruited from around Aotearoa using snowball sampling by advertising among Māori networks of the researcher and primary supervisor. Interested potential participants contacted the researcher and were emailed or posted the relevant participant information sheet and informed consent form. Ethically, this recruitment approach minimised undue influence to take part, as potential participants were unknown to the researcher until they expressed an interest to participate. Furthermore, this procedure enabled the invitation to take part to be declined without affecting tāngata whaiora or whānau member mental health care and personal or professional relationships. Participant recruitment ceased when data saturation occurred. Depending on the interview kōrero this differed between tāngata whaiora, whānau members, and Māori kaimahi participant groups.

Participants

Given the small size of the Māori mental health community, protecting the identity of participants was paramount. To facilitate a safe and constructive space for kōrero, descriptive attributes of participants were limited to engagement or employment in Kaupapa Māori or mainstream mental health services, professional scope of practice, and nature of the whānau relationship to tāngata whaiora.

In addition, although recruitment procedures removed the researcher from direct contact with potential participants, the researcher had whanaungatanga with several participants which is not uncommon for Māori in a research context. Three participants were friends of the researcher and three were part of a kaupapa whānau the researcher belonged to.

Tāngata whaiora. Five current and past tāngata whaiora took part in the research. Tāngata whaiora reported engagement with Kaupapa Māori and/or mainstream mental health services.

Whānau members. Three whānau members of tāngata whaiora were interviewed. Whānau had relationships with tāngata whaiora as parents, aunties, and children.

Māori kaimahi. Four Māori kaimahi who were employed in Māori and mainstream mental health services participated. Māori kaimahi practiced as mental health nurses, psychologists, and community support workers. This research did not aim to evaluate similarities and differences in the perspectives that mental health professionals from various disciplines held about the relationship between Māori mental health care experiences and service use. Rather, the perspectives of Māori kaimahi were explored using a collective lens that upheld the integrity of the kōrero.

Interviews

Interviews were carried out after informed consent was given by participants. To manaaki participants and ensure each had equal opportunity to share their stories and lived experiences, interviews took place in settings accessible for participants including homes, the Massey University Wellington Psychology Clinic, and over video-calling applications or the phone. Interviews lasted between thirty minutes to two and a half hours. During interviews, the researcher positioned herself as manuhiri and the participants as tangata whenua (Moyle, 2014). Although the researcher hosted the interviews, this positioning acknowledged and respected the mana and mātauranga of participants and their lived experiences. Tangata whenua and manuhiri positions were implicitly communicated by emphasising the collaborative nature of this research and the privilege the researcher felt to share in participants' stories and whakaaro.

Tikanga Māori guided the nature of engagement with participants and emphasised this research took place within a Māori space. Interviews were arranged at a time and place which was suitable for participants. For interviews that took place in person, mihi involved a kiss on the cheek and/or a hug. Prior to beginning the interviews, the researcher's appreciation for participants' sharing their time was communicated and whakawhanaungatanga took place. Whakawhanaungatanga was fluid and matched the nature of the relationship between the researcher and participants and involved a combination of whakapapa sharing, including iwi and hapū affiliations, and whānau and educational background. Whakapapa sharing allowed participants and the researcher to locate one another in their whakapapa, connections to Papatūānuku, and establish or recognise relationships with each other (Durie, 2001). Whakawhanaungatanga also involved kōrero about how life was going, how whānau were, and whakaaro about current events. Prioritising relationships helped build rapport and participant comfort within the research space. The option of opening the interview with a karakia was offered to facilitate a safe space for kōrero and prepare the wairua of participants and the researcher. Karakia was led by the researcher or the participant according to participant preferences.

The researcher hosted the interviews by explaining the research kaupapa and aspirations, providing an overview of areas the kōrero may cover, and emphasising the co-creation of a narrative to improve Māori mental health service engagement and uplift wellbeing. Interview kōrero was guided by the interview schedule and was responsive to participant stories. Whakawhanaungatanga was also woven throughout the interviews. The majority of participants accepted the offer to close the interview with a karakia and restore the wairua. Informal kōrero followed and for interviews where the researcher and participants met in person, kai was provided for an appropriate time. To mihi participants the researcher expressed gratitude to participants for sharing their time and experiences. Furthermore, koha was offered as a tangible expression of manaakitanga. For Māori, the offer of koha has whakapapa in the pōwhiri process where manuhiri lay down a koha before the tangata whenua as a contribution to facilitating the hui (Bishop, 1998). When koha was offered, the researcher stepped away to allow space for participants to consider this koha. This ensured the mana and tapu of participants and the researcher were recognised and upheld (Bishop, 1998). Koha was accepted by most participants, while as is tika the researcher accepted the decision of some participants to take part in this research whakahirahira.

Reflections

My psychology internship with the 3DHB (Capital and Coast, Hutt Valley, and Wairarapa District Health Boards) commenced in January 2018 and was comprised of two six-month placements at Hutt South Adult Community Mental Health and Addictions Services and Central Regional Intellectual Disability Services. The following reflections pertain to how my practice as a Māori intern psychologist was shaped by my Kaupapa Māori doctoral research while at Central Regional Intellectual Disability Services. In this service I had the opportunity to engage with Māori tāngata whaiora and whānau in the forensic inpatient youth unit and in the community team.

Honouring Te Ao Māori

The position Kaupapa Māori research takes that to be, think, feel, and live as Māori is valid and normal guided my practice in mental health care with tāngata whaiora and whānau. A memorable experience was at a care team hui when I advocated that a Te Ao Māori lens be applied to the formulation for a rangatahi I was working with in the inpatient unit. Alongside the Pākehā diagnosis of Psychosis Not Otherwise Specified I proposed matakite be considered. Matakite refers to the ability to see between the spiritual and physical realms and is considered a taonga within Māori culture. The care team welcomed this consideration and it was agreed I would assess the comparative validity of the two constructs in therapy sessions. After the hui concluded I reflected that by claiming space to privilege mātauranga and Māoritanga, a culturally meaningful framework was provided for the rangatahi to make sense of his lived experience.

A community team referral for an assessment led me to meet with a tangata whaiora and his whaea who spoke about visions they had. Understanding the whānau identified strongly as Māori I queried whether they conceptualised these visions as part of a matakite experience. Significantly, by acknowledging the legitimacy of Te Ao Māori within my practice, in line with Kaupapa Māori Research, the tangata whaiora and his whaea appeared more comfortable with being authentically Māori in mental health care. I sought to further empower their voices and uphold their mana by positioning the whānau as tangata whenua of their lived experience of matakite and myself as manuhiri. With this approach to practice, the tangata whaiora and his whaea spoke more openly about the nature of their matakite experiences which included hearing heartbeats communicate and talking with tūpuna. They also explained the whakapapa of this taonga within the whānau and how they learned to understand and manage this taonga. This information was integral to developing a culturally responsive formulation and recommendations for pathways to wellbeing that would not have been developed if engagement and assessment followed a Te Ao Pakeha approach.

Integrating Cultural and Clinical

The orientation of Kaupapa Māori Research towards creating positive change for Māori guided me to be strengths-based in mental health care with tāngata whaiora. This approach to practice involved integrating cultural and clinical knowledge and skills to support tāngata whaiora in their journey to mental wellbeing. As an example, in the rangatahi emotional regulation group I introduced the concept of kotahitanga which underpins Kaupapa Māori Research ontology. Explaining how kotahitanga suggests we can achieve our mahi or aspirations by supporting one another as our tūpuna did encouraged the rangatahi to contribute towards the chain analyses they each completed and shared in turns with the rōpū. This facilitated collective learning about the problems they experienced and pathways forward to realise the goals they held. Furthermore, compared to previous sessions, I observed how integrating mātauranga Māori and tikanga within mental health care supported rangatahi to meaningfully engage in emotional regulation group.

During individual psychology sessions with a rangatahi tangata whaiora, I practiced according to the principles of Mahi a Atua whereby I blended mātauranga Māori and māoritanga with evidence-based emotion regulation therapy. Mahi a Atua involved sharing pūrākau, Māori narratives of creation and custom, about how Atua responded to situations in daily life in helpful and unhelpful ways. For example, Te Ara Waiora ā Tāne was shared with the rangatahi and we related this to his own journey where his goals (ngā kete) were discussed and how his strengths (Tāwhirimātea, Atua of Wind) could help him to overcome the challenges he faced in attaining his goals (Whiro, Atua of Darkness). The transformation in how the rangatahi engaged in psychology sessions as a result of Mahi a Atua made salient how attending to Māori cultural understandings of wellbeing created mana enhancing interactions.

Upholding Tikanga in Engagement

Engagement with rangatahi tāngata whaiora during individual psychology sessions and emotional regulation group was guided by tikanga, which emphasised mental health care took place within a Māori space. My research supported the understanding that meaningful relationships helped tāngata whaiora develop trust to undertake the work involved in mental health care. As such, I privileged whakawhanaungatanga in my practice where I shared my whakapapa connections, programme of study, similar lived experiences, and interests with rangatahi. The authenticity and reciprocity that whakawhanaungatanga introduced within interactions was positively received by rangatahi who in turn told me about their whānau, hobbies, aspirations, life in the unit, and difficult experiences they had. Furthermore, this Te Ao

Māori relationality enabled me to integrate an appropriate and valuable degree of fun and humour into group sessions, challenge rangatahi to participate in their mental wellbeing journey, and guide them to apply therapeutic learnings to their lived experiences. As I reflected on my practice I gained a deeper appreciation of the value of translating a Kaupapa Māori approach to research within mental health care with Māori tāngata whaiora. I found upholding tikanga during engagement nurtured a therapeutic relationship which recognised rangatahi were more than the difficulties they experienced and enabled me to meaningfully and effectively support their rehabilitation progress.

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