Mātauranga Māori in Mental Health Care: Breaking Down Barriers for Better Outcomes

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Abstract

This thesis explores how mental health clinicians in Aotearoa New Zealand engage with Mātauranga Māori in their everyday practice, and what enables or constrains its meaningful integration within mainstream mental health services. Despite policy commitments to equity and cultural safety, Māori continue to face disproportionate rates of mental distress and limited access to culturally grounded care. While the importance of Mātauranga Māori is increasingly acknowledged, its application in clinical settings remains inconsistent and often marginalised.

This research uses a qualitative, interpretive methodology to draw on in-depth interviews with eight Māori and non-Māori clinicians working across diverse roles and services. Thematic analysis, guided by Braun and Clarke (2022), identified key themes related to relational practice, systemic barriers, Māori leadership, clinical workarounds, and structural reform.

Findings highlight the centrality of whakawhanaungatanga as an essential clinical practice, not an optional cultural addition. Participants described institutional constraints such as time pressures, under-resourcing, and the dominance of Western clinical paradigms. Māori clinicians reported carrying the burden of cultural leadership without adequate recognition or support. Despite these challenges, practitioners demonstrated resilience and innovation, finding ways to uphold Mātauranga Māori in their work.

This study contributes to the literature on Indigenous mental health and offers practical recommendations for embedding cultural values into service delivery, training, and system design. It calls for a shift beyond symbolic inclusion towards genuine power-sharing and accountability, in line with Te Tiriti o Waitangi. For mental health services to deliver equitable outcomes, Māori knowledge, leadership, and healing practices must be centred, not sidelined.

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“Nā tō rourou, nā taku rourou ka ora ai te iwi.”
(With your food basket and my food basket, the people will thrive.)

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Glossary of Te Reo Māori

Aotearoa	New Zealand
hapū	sub-tribe
he mihi nui ki a koutou	thank you very much
hinengaro	mind, thoughts, emotions – mental health
hui	gathering, meeting
iwi	tribe
kanohi ki te kanohi	face-to-face
karakia	prayer, incantation
Kaupapa Māori	Māori approach, customary practice
kāwanatanga	governance, government
kōrero	to speak, talk or converse
mana	power, authority, influence, prestige
manaakitanga	caring for and uplifting others
Māori	Indigenous people of Aotearoa, New Zealand
Mātauranga Māori	Māori knowledge, values, and practices
mauriora	secure cultural identity
moko	grandchild
ngā manukura	leadership
ōritetanga	equity, equality
Pākehā	New Zealander of European descent
rangatira	chief, leader
rongoa Māori	traditional healing
taku ngākau	my heart
tama purotu	handsome boy
Tatau Kahukura	Māori Health Chart Book
tautoko	support
Te Ao Māori	the Māori world
te mana whakahaere	autonomy, self-management
te oranga	participation in society
Te Rau Hinengaro	The National Mental Health Survey
te reo	Māori language
te taiao	the natural world; physical environment
Te Tiriti o Waitangi	The Treaty of Waitangi (Māori text)

tikanga	customs, correct practices
tinana	the body, physical health
tino rangatiratanga	self-determination
toiora	healthy lifestyles
waiora	environmental protection, healthy environment
wairua	spirit, soul, spirituality
whakamā	shame, embarrassment
whakapapa	genealogy, lineage
whakawhanaungatanga	relationship building, making connections
whānau	family
whenua	land, placenta

Chapter One: Introduction

"He oranga ngākau, he pikinga waiora."
When the heart is well, the spirit will rise.

1.0 Introduction

Mental health care in *Aotearoa* New Zealand continues to reflect the dominance of Western clinical models that often fail to respond adequately to the needs, values, and worldviews of Māori (Durie, 2001b; Escot & Abraham, 2021; Rangiheuea, 2010). Despite decades of policy commitment to *Te Tiriti o Waitangi* (The Treaty of Waitangi) and the promotion of cultural competency, inequities in the accessibility, quality, and outcomes of mental health services persist for Māori. These disparities are not simply the result of individual clinician biases or cultural misunderstandings; they are embedded in the structural and institutional fabric of the health system, shaped by colonial histories and sustained through ongoing power imbalances (Came et al., 2019; Durie, 2001b; Haitana et al., 2020; Ministry of Health, 2014, 2015).

Mātauranga Māori, which encompasses Māori knowledge systems, values, practices, and ways of understanding well-being, offers a holistic and relational framework for healing. It positions mental health not as an isolated or individual issue, but as something intrinsically linked to *whānau* (family), *wairua* (spirituality), *whenua* (land), and *whakapapa* (genealogy). For many Māori, healing must occur within this broader relational context. However, attempts to integrate Mātauranga Māori into mental health practice meaningfully remain inconsistent and, at times, tokenistic (Durie, 2001b; Escot & Abraham, 2021).

This thesis explores how clinicians navigate the integration of Mātauranga Māori within their everyday practice. It draws on the experiences of both Māori and non-Māori clinicians to understand the barriers and enablers to working in culturally grounded ways. It also considers how clinical training, service structures, supervision, and leadership influence the ability to engage with Māori knowledge authentically and effectively.

By prioritising clinician voices, this study aims to inform more equitable, culturally safe, and relationship-based approaches to mental health care that uphold Māori self-determination and reflect the richness of Mātauranga Māori. It is grounded in a commitment to decolonising mental health services and amplifying Indigenous knowledges as essential, not supplementary to ethical and effective practice in Aotearoa.

1.1 Problem Statement

Despite a growing policy emphasis on equity and cultural safety in mental health services, Māori continue to experience disproportionately poor outcomes within Aotearoa's mental health system (Came et al., 2019; Durie, 2001b; Haitana et al., 2020; Ministry of Health, 2014, 2015).

These disparities are not only reflected in higher rates of mental distress, suicide, and compulsory treatment but also in experiences of cultural disconnection, systemic racism, and inaccessible services. While the integration of Mātauranga Māori is increasingly acknowledged as vital to improving these outcomes, its practical application within clinical settings remains limited, inconsistent, and often misunderstood (Durie, 2001b; Escot & Abraham, 2021).

Many mainstream mental health services are built upon Western paradigms that prioritise individualism, diagnostic labels, and evidence-based interventions narrowly defined through Eurocentric frameworks. These models can marginalise or pathologise Māori ways of knowing, relating, and healing. As a result, clinicians seeking to work in culturally grounded and responsive ways, particularly Māori ones, often encounter institutional barriers, resource constraints, and professional risks (Came et al., 2020; Cram, 2017; Durie, 2001b).

There is a lack of research that centres the voices of clinicians navigating these tensions on the ground. Little is known about how they interpret, apply, and sustain the use of Mātauranga Māori in practice, or how systemic structures enable or constrain this work. Without this insight, efforts to create culturally safe and equitable mental health services risk remaining aspirational rather than transformative.

This thesis responds to this gap by exploring how clinicians working in Aotearoa's mental health sector understand and engage with Mātauranga Māori, and what structural, professional, and relational conditions are necessary to support its meaningful integration.

1.2 Research Question

Despite ongoing policy efforts to improve mental health equity in Aotearoa, Māori continue to face significant disparities in access, quality, and outcomes of care. These inequities are rooted in the enduring legacies of colonisation and the dominance of Western paradigms that often marginalise or exclude Indigenous knowledge. Within this context, the integration of Mātauranga Māori into mental health care is increasingly recognised as a critical pathway to delivering more culturally safe, effective, and equitable services. However, there remains limited research on how clinicians understand and apply Mātauranga Māori in everyday practice, and what supports or hinders this work.

This research is guided by the following overarching question:

- How do mental health clinicians understand and integrate Mātauranga Māori in their practice, and what are the barriers and enablers to its meaningful application in Aotearoa's mental health services?

Supporting questions include:

- What does integration of Mātauranga Māori look like in everyday clinical contexts?
- How do Māori and non-Māori clinicians navigate issues of cultural safety, ethics, and accountability?
- What structural or policy changes are needed to enable culturally grounded, equitable, and sustainable mental health care?

This study aims to examine how clinicians experience, understand, and engage with Mātauranga Māori in their mental health practice, focusing on identifying both barriers and enabling conditions for its integration.

A qualitative, interpretive methodology was used to address these questions, drawing on *Kaupapa Māori* (Māori approach/customary practice) values and a relational ethic. Data was collected through semi-structured interviews with eight clinicians from various professional backgrounds and service settings across Aotearoa. Thematic analysis followed Braun and Clarke's (2022) six-phase model, enabling a nuanced and reflective exploration of participant experiences. This approach prioritised participant voices and positioned the researcher as a reflexive and engaged collaborator, particularly attuned to the cultural and ethical dimensions of the research.

1.3 Significance of Study

This thesis contributes to a growing body of work that centres Indigenous knowledge and lived experience in mental health practice. By focusing on the perspectives of clinicians actively working to integrate Mātauranga Māori, this research highlights the on-the-ground realities, tensions, and innovations shaping bicultural mental health care in Aotearoa. While policy rhetoric increasingly acknowledges the importance of cultural safety and equity (Came et al., 2020; Durie, 2001b; Haitana et al., 2020), this thesis moves beyond aspirational discourse to examine the meaningful integration of Indigenous knowledge in clinical settings.

The study's significance lies in its focus on lived clinical experience, both Māori and non-Māori practitioners. It offers insight into how they engage with cultural frameworks in the face of systemic constraints. It examines practical strategies, relational dynamics, and institutional challenges and comprehensively explains how cultural safety is enacted, resisted, and sustained in everyday practice. These insights have implications for clinical training and service design, policy development, and workforce support.

The thesis contributes to knowledge by:

- Documenting how clinicians interpret and apply Mātauranga Māori in diverse mental health settings.
- Identifying the barriers and enablers to culturally safe and effective practice.
- Highlighting the emotional labour and structural inequities faced by Māori clinicians.
- Offering clinician-informed recommendations for systemic, educational, and institutional change.

Key assumptions underpinning the study include:

- Clinicians are meaningfully engaging with issues of culture, identity, and power in their work.
- That the voices and insights of practitioners are valid and essential sources of knowledge
- Mātauranga Māori offers a legitimate and valuable foundation for ethical and effective mental health care in Aotearoa.

1.4 Terminology

The following are definitions of key terms that are used throughout this thesis.

Māori. In this thesis, the term Māori refers to the indigenous people of Aotearoa, New Zealand. Māori identity is understood through whakapapa (genealogy), cultural identity and self-identification (Durie, 2001b; Smith, 2012).

Non-Māori. This term is used to describe all other ethnic groups in Aotearoa, following the conventions of the national health research and reporting (Ministry of Health, 2015). While this category is broad and obscures diversity, it reflects how inequities are typically presented in health statistics (Came et al., 2019).

Mātauranga Māori. This thesis describes Mātauranga Māori as the knowledge, values, practices, and worldviews that have been nurtured and handed down across generations. It frames well-being in relational and holistic terms, acknowledging that health cannot be separated from whānau (family),

wairua (spirituality), whenua (land), and whakapapa (genealogy) (Durie, 2001b; Escot & Abraham, 2021; Rangiheuea, 2010).

Mainstream mental health services: Refers to publicly funded and private clinical services in Aotearoa, primarily based on Western biomedical frameworks, as distinct from Kaupapa Māori or Indigenous-led services (Durie, 2001b; Ministry of Health, 2015).

1.5 Thesis Structure

This thesis is structured into six chapters:

- Chapter 1: Introduction
  Introduces the research topic, outlines the problem statement, research question/aims, and significance of the study. It introduces the research questions and provides an overview of the thesis structure.
- Chapter 2: Literature Review
  Examines the historical and current context of mental health care for Māori, including the impact of colonisation, systemic inequities, and the emergence of culturally safe practice. It explores the theoretical and policy frameworks that support the integration of Mātauranga Māori and identifies key gaps in the literature.
- Chapter 3: Methodology
  The research design and methodological approach are described, including the qualitative framework, participant recruitment, data collection through semi-structured interviews, and thematic analysis. Ethical considerations and research positioning are also discussed.
- Chapter 4: Results
  Presents the main themes generated from interviews with clinicians, illustrating how Mātauranga Māori is integrated into practice, the barriers faced, and the strategies clinicians use to navigate systemic constraints. Quotes from participants are used to foreground their experiences and insights.
- Chapter 5: Discussion
  Connects the findings to existing research, offering a critical analysis of how the results extend or challenge current understandings. It highlights the implications for practice, policy, and future research.

- Chapter 6: Conclusions and Recommendations

  Summarises the key findings, outlines recommendations for service improvement and clinician training, and discusses the study's limitations and opportunities for future research.

Chapter Two: Literature Review

"Me haere whakamuri kia haere whakamua "
We must journey back if we want to journey forward.

2.0 Introduction

2.0.1 Overview of Thesis Topic

This literature review explores the integration of Mātauranga Māori, the knowledge, values, and practices unique to Māori worldviews, into mental health care in Aotearoa. Mātauranga Māori encompasses holistic understandings of well-being that are grounded in whakapapa (genealogy), whanaungatanga (relationships), wairua (spirituality), and connection to *te taiao* (the natural world). These foundations offer a rich, relational approach to health and healing that contrasts with dominant Western biomedical frameworks.

The integration of Mātauranga Māori into mental health care is not just a matter of cultural inclusion; it is a pathway to improving outcomes for Māori by making services more meaningful, accessible, and aligned with Māori values. This is particularly important considering persistent mental health inequities, the legacy of colonisation, and the ongoing impact of systemic racism within the health system. The current landscape shows growing recognition of cultural competency and cultural safety but limited practical implementation and support for Māori-led solutions.

This chapter provides a critical examination of the literature related to the integration of Mātauranga Māori in mental health services. It reviews key frameworks, policies, and practices while identifying the opportunities and barriers to transformation within the sector.

2.0.2 Scope of Review

The literature review focuses on three core areas:

1. The benefits of integrating Mātauranga Māori into mental health care, particularly its potential to support healing and reconnection for Māori.
2. The barriers that hinder this integration, including systemic racism, under-resourced training, and policy-level gaps.
3. Current practices and pathways for embedding Mātauranga Māori in clinical and community-based mental health settings.

The review also draws on comparative insights from other Indigenous health systems to situate the discussion within a broader global context. Through this analysis, the chapter aims to clarify where the

gaps lie, what progress has been made, and why a more profound commitment to Mātauranga Māori is essential for achieving equity and transformation in mental health care.

2.1 Historical Context of Mātauranga Māori and Mental Health

2.1.1 Traditional Māori Concepts of Mental Health

Māori are the Indigenous people of Aotearoa (New Zealand), the land's original inhabitants. Every part of New Zealand was occupied by an *iwi* (tribe) or *hapū* (sub-tribe) (Escot & Abraham, 2021; Furness et al., 2016; Love, 2022). Māori lived in communal societies where families lived and worked together, drawing upon the natural environment for shelter, food, clothing, and identity (Durie, 1998).

Mātauranga Māori refers to the body of Māori knowledge passed down through generations. It encompasses holistic understandings of well-being grounded in whakapapa (genealogy), *te reo* (language), wairua (spirituality), whakawhanaungatanga (relationship-building), and whānau (family) (Broughton et al., 2015; Hikuroa, 2017; Mead, 2016). These interconnected concepts provide a relational view of health that links the individual to their ancestors, community, and the natural world (Furness et al., 2023; Durie, 1998).

Historically, the scientific community has often dismissed Mātauranga Māori, perceiving it as mythical or non-empirical. Yet mātauranga is grounded in rigorous methodologies that align with scientific inquiry, while being expressed through the lens of *Te Ao Māori* (the Māori worldview) (Durie, 2001a; Hikuroa, 2017). This epistemological foundation shapes a Māori way of being and engaging with the world that is inherently holistic and relational (Furness et al., 2016).

This worldview contrasts with Western biomedical models, which often separate physical, mental, and social aspects of well-being (Durie, 1998). Whakapapa provides a sense of belonging and identity through ancestral connections, while te reo transmits Mātauranga Māori and cultural values (Broughton et al., 2015; Mead, 2016). Wairua recognises spiritual well-being as central to health (Lindsay et al., 2022), and whānau, extending beyond immediate family, provides a network of care and support (Durie, 1998; Furness et al., 2016) Together, these concepts shape a collective, balanced approach to well-being that remains central to Māori understanding of mental health.

2.1.2 Impact of Colonisation on Mental Health

European contact with Aotearoa began in 1642 with Dutch explorer Abel Tasman. Colonisation intensified in the mid-nineteenth century with the 1840 signing of the Te Tiriti o Waitangi (The Treaty of Waitangi) between the British Crown and various Māori *rangatira* (chiefs) (Boulton et al., 2009; Nairn et al., 2012; Papps & Ramsden, 1996). Although the Treaty was intended to establish a partnership that

would enable Māori and Pākehā to coexist peacefully, in reality, the Crown asserted authority as though full sovereignty had been ceded, undermining Māori *tino rangatiratanga* (self-determination) (Escot & Abraham, 2021; Huygens, 2011).

This breach of partnership disrupted traditional Māori social structures and governance, leading to the widespread acquisition of land, suppression of te reo Māori, and erosion of cultural practices (Escot & Abraham, 2021; Walker, 2004). Although the Treaty sets out three core principles for Māori rights, *kāwanatanga* (governance by the Crown, Article 1), *tino rangatiratanga* (Māori control over lands, resources, and communities, Article 2), and *ōritetanga* (equal rights as citizens, Article 3), these principles have often been disregarded or inconsistently upheld (J. Wilson, 2016).

The cumulative impacts of colonisation have contributed to what is now understood as historical trauma, the intergenerational transmission of emotional and psychological harm (Heart, 2003; Wirihana & Smith, 2014). For Māori, this trauma manifests through cultural disconnection, ongoing land loss, and systemic disadvantage, which continue to influence health outcomes, including elevated rates of psychological distress and suicide (Durie, 2001b; Ministry of Health, 2015). Understanding this historical context is essential for addressing current inequities and supporting culturally appropriate mental health care.

2.2 Colonial Legacies and Health Inequities

2.2.1 Colonial Legacies in the Health System

The colonial disruption of Māori social and cultural systems continues to shape Aotearoa's mental health system today. Under British colonial rule, Māori were systematically excluded from decision-making about their own health and well-being. Traditional healing practices, whānau-based support systems, and Mātauranga Māori were marginalised or actively suppressed in favour of Western clinical models (Durie, 2001b; Rangiheuea, 2010).

These colonial foundations established enduring barriers between Māori and the health system. Māori knowledge was framed as inferior, and assimilation policies promoted Eurocentric medical and psychological frameworks misaligned with Māori values and worldviews (Durie, 2001b; Escot & Abraham, 2021). Consequently, Māori ways of understanding mental health, including the significance of wairua, whakapapa, and whānau, were ignored or devalued (Papps & Ramsden, 1996; Rangiheuea, 2010; D. Wilson et al., 2021).

For many Māori, the health system remains culturally unsafe, linguistically unfamiliar, and disconnected from their identity (Browne et al., 2006; Durie, 2001b). These systemic issues contribute to enduring mistrust and inequities in access and outcomes. Addressing these colonial legacies requires restructuring services to meaningfully embed Māori leadership, Mātauranga Māori, and culturally safe

practices into every level of care (Came et al., 2019; Haitana et al., 2020). These systemic issues have also played a key role in creating the persistent mental health disparities between Māori and non-Māori, which are examined in the following section.

2.2.2 Health Disparities Between Māori and Non-Māori

Establishing accurate trends and patterns in Māori mental health has been challenging due to inconsistent and, at times, unreliable data collection. Early research insights, often drawn from historical and anthropological records, were typically based on anecdotal evidence and lacked rigorous analysis. Many of these accounts were created by non-Māori researchers unfamiliar with cultural contexts, resulting in cultural bias and misinterpretation that distorted clinical assumptions (Kingi, 2017).

These limitations have hindered a complete understanding of the scope and nature of Māori mental health needs. This gap is especially significant given that mental health challenges are often less visible than physical illnesses and are more susceptible to misinterpretation and prejudice. Cultural biases embedded in the definitions of "normal" and "abnormal" behaviour can lead to further misunderstanding when applied across cultural contexts. What is considered typical or acceptable in one culture may not be in another (Kingi, 2017).

Despite these challenges, national data has provided valuable insight into the disparities between Māori and non-Māori mental health outcomes. *Te Rau Hinengaro: The National Health Survey* (2003-2004) remains the most comprehensive national survey. It included 12,992 participants, of whom 2,592 were Māori. The survey found that 50.7% of Māori respondents had experienced at least one mental disorder in their lifetime. As shown in **Table 1**, 29.5% of Māori reported experiencing a mental health disorder within the previous 12 months, and 18.3% within the past month. Anxiety disorders were the most common (31.3%), followed by substance use disorders (26.5%) and mood disorders (24.3%). Eating disorders affected 3.1% of Māori at some point in their lives (Browne et al., 2006).

Table 1: *Lifetime, 12-month and one-month prevalence of mental disorder groups for Māori*

Disorder group[1]	Lifetime prevalence % (95% CI)	Twelve-month prevalence % (95% CI)	One-month prevalence % (95% CI)
Anxiety disorders[2]	31.3 (28.4, 34.3)	19.4 (17.2, 21.8)	13.4 (11.6, 15.4)
Mood disorders	24.3 (22.4, 26.3)	11.4 (10.0, 13.1)	4.1 (3.3, 5.1)
Substance use disorders	26.5 (24.3, 28.7)	8.6 (7.1, 10.4)	4.2 (3.3, 5.4)
Eating disorders[2]	3.1 (2.3, 4.1)	1.0 (0.5, 1.6)	0.5 (0.2, 1.0)
Any disorder[2]	50.7 (47.0, 54.4)	29.5 (26.7, 32.5)	18.3 (16.2, 20.6)

Note. Reprinted from *Te Rau Hinengaro: The New Zealand Mental Health Survey* (p. 150), by M. A. O. Browne, J. E. Wells, & K. M. Scott, 2006, Ministry of Health. Copyright 2006 by the Ministry of Health. Reprinted with permission.

Table 2: *Profile of Māori participants by sociodemographic correlates*

Correlate[1]	Unweighted number	Unweighted %	Weighted %
Area characteristics			
NZDep2001 deciles			
9 and 10 most deprived	1,190	45.9	43.7
7 and 8	527	20.3	21.3
5 and 6	413	15.9	15.7
3 and 4	265	10.2	11.3
1 and 2 least deprived	200	7.7	8.0
Urbanicity			
Main	1,753	67.6	66.8
Secondary	196	7.6	7.6
Minor	361	13.9	14.0
Other (rural)	285	11.0	11.6
Region			
North	930	35.8	34.0
Midland	838	32.3	34.4
Central	507	19.5	18.5
South	320	12.3	13.1

Correlate[1]	Unweighted number	Unweighted %	Weighted %
Individual characteristics			
Sex			
Male	1,048	40.4	46.6
Female	1,547	59.6	53.4
Age group (years)			
16–24	414	16.0	24.5
25–44	1,290	49.7	47.6
45–64	703	27.1	22.4
65 and over	188	7.2	5.6
Educational qualifications			
None	876	33.7	31.8
School or post-school only	1,011	39.0	41.5
Both school and post-school	708	27.3	26.7
Equivalised household income			
Under half of median	892	34.4	31.8
Half median to median	791	30.5	32.2
Median to one and a half times median	502	19.3	19.9
One and a half times median and over	410	15.8	16.1

(Browne et al., 2006, pp. 147–148)

Further analysis of this data reveals significant disparities influenced by social determinants such as income, education, and geographic location. As shown in **Table 2**, Māori participants with lower household incomes or fewer education qualifications had notably higher rates of mental health disorders. Those living in the least deprived areas (deciles 1 and 2) reported the lowest prevalence of mental health issues, highlighting the strong correlation between socioeconomic status and mental

health outcomes. Although minor differences were found between urban and rural populations, these were not statistically significant (Browne et al., 2006).

While Te Rau Hinengaro provides a foundational understanding, more recent population-level data from the Ministry of Health's Tatau Kahukura: Māori Health Chart Book (2015) continues to highlight persistent disparities. Māori continue to experience higher levels of psychological distress. These findings underscore the enduring impact of systematic inequities in Māori mental health.

The New Zealand Health Survey has been conducted annually since 2011. It monitors national health trends and inequities. The current 2023/24 survey indicates that Māori adults are 19.5% more likely to experience high or very high psychological distress than non-Māori, and are 14.7% more likely to report unmet needs for mental health care (Ministry of Health, 2024). This continuous pattern across decades of data reinforces that disparities are not incidental but reflect structural inequities entrenched in the health system.

2.2.3 Racism and Its Impact on Mental Health Care

Systematic and interpersonal racism continues to have a profound influence on the experiences and outcomes of Māori in mental health care. These forms of racism affect not only access to services but also the quality and cultural relevance of care received. Māori, like other racially marginalised groups, experience disproportionately high rates of mental illness when compared to non-Māori groups (Browne et al., 2006; Curtis et al., 2019; Kingi, 2017). Genetic or individual factors alone cannot adequately explain this inequity, but must be understood within the broader context of structural racism and entrenched social disadvantage (Came et al., 2019; Kingi, 2017).

Systemic racism is evident in the overrepresentation of Māori in mental health statistics, including higher rates of severe mental health conditions such as depression, anxiety and psychosis (Browne et al., 2006; Ministry of Health, 2015). Māori are also more likely to be misdiagnosed or underdiagnosed, due to cultural misinterpretations and a lack of cultural competence among practitioners. Clinical frameworks grounded in Western psychological norms may pathologise Māori experiences, particularly when expressions of distress, wairua or tikanga do not align with *Pākehā* (New Zealander of European descent) definitions of 'normal' mental health (Kingi, 2017; Pitama et al., 2017).

Interpersonal racism intensifies these challenges. Experiences of stereotyping, microaggressions, and overt discrimination during clinical encounters can deter Māori from seeking care or engaging meaningfully with providers (Came et al., 2019; D. Wilson & Barton, 2012). These interactions often leave individuals feeling devalued or dismissed, which exacerbates feelings of *whakamā* (shame or

embarrassment) and contributes to the underutilisation of mental health services (Pitama et al., 2017). Recent evidence further illustrates these patterns. Harris et al. (2024) found that experiences of racism directly influenced whether Māori accessed follow-up care, with many reporting disengagement from services after racist encounters. Similarly, Cormack et al. (2024) documented how racism impacts Māori medical students and clinicians, broadly shaping their professional well-being and the cultural safety of health systems.

Compounding these barriers is the ongoing marginalisation of Mātauranga Māori, including traditional healing practices, within mainstream mental health care. Despite long-standing evidence of culturally grounded models like Te Whare Tapa Whā or the Meihana Model, many services continue to privilege Western approaches that are culturally incongruent and have historically been proven ineffective for many Māori (Durie, 2001a; Haitana et al., 2020; Pitama et al., 2017). The failure to meaningfully incorporate Te Ao Māori perspectives into treatment planning reinforces a sense of cultural invalidation and contributes to poorer engagement and outcomes (Curtis et al., 2019; Harris et al., 2024).

Addressing racism in mental health care requires more than increasing Māori representation or offering one-off cultural training. It demands structural change. This includes embedding cultural safety into health policy and practice, supporting Kaupapa Māori approaches, and actively dismantling institutional racism through accountability and ongoing anti-racism efforts (Came et al., 2019; Curtis et al., 2019).

To effectively dismantle these enduring barriers, the mental health system must acknowledge the structural impacts of racism and actively embed Māori cultural values and practices into care pathways. This includes addressing the systemic and interpersonal racism that Māori continue to face within healthcare settings, as well as the institutional marginalisation of Mātauranga Māori (Curtis et al., 2019; Harris et al., 2024). Without deliberate and sustained effort to re-centre Māori perspectives, traditional healing approaches, and cultural frameworks in mental health service delivery, Māori will remain disproportionally represented in negative mental health statistics (Browne et al., 2006; Kingi, 2017). Embedding culturally responsive practices is not only a matter of equity, but a necessary step toward restoring trust and improving outcomes for Māori across the mental health continuum (Pitama et al., 2017).

2.3 Integration of Mātauranga Māori in Mental Health Care

2.3.1 Benefits and Current Practices

Integrating Mātauranga Māori into mental health care offers distinct benefits, particularly when compared to conventional Western psychological approaches. A key advantage lies in the ability to deliver a culturally relevant and holistic care model. Traditional Māori concepts such as whānau, wairua,

and *hinengaro* (mental health) are interwoven, framing well-being as inherently collective and relational. This holistic perspective contrasts with the individualistic focus typical of Western frameworks, which prioritise personal autonomy and psychological well-being separate from social or familial relationships (Durie, 2001b; Hikuroa, 2017; McLachlan et al., 2017).

For example, in Māori frameworks, mental health is not solely an individual's issue but a collective responsibility. Sir Mason Durie's *Te Whare Tapa Whā* model is widely utilised in New Zealand and incorporates four dimensions of health: *taha tinana* (physical health), *taha hinengaro* (mental health), *taha wairua* (spiritual health), and *taha whānau* (family health)(Durie, 1998). This model facilitates a comprehensive understanding of well-being that incorporates community support, spiritual healing, and cultural identity in the therapeutic processes. In contrast, Western psychological models often focus narrowly on individual pathology and rely on standardised assessments that may inadequately account for cultural practices or values (McLachlan et al., 2017).

Building on this foundation, the Meihana model extends Te Whare Tapa Whā to provide a clinically applied framework for assessment and treatment. The Meihana Model retains the four-core dimension of health while adding taiao (the physical environment) and *iwi katoa* (the broader societal context), making explicit the impact of colonisation, racism, and socioeconomic conditions on Māori health outcomes. By integrating these six dimensions, the model equips clinicians with a structured yet culturally grounded tool for practice, which recognises individual and systemic influences on well-being (Curtis et al., 2019; Pitama et al., 2017).

Another influential framework is Durie's *Te Pae Mahutonga* (1999), which uses the constellation of the Southern Cross as a metaphor for Māori health promotion. It identifies six key elements of well-being: *mauriora* (secure cultural identity), *waiora* (environmental protections), *toiora* (healthy lifestyles) and *te oranga* (participation in society), supported by *ngā manukura* (leadership) and *te mana whakahaere* (autonomy). This model highlights that health cannot be separated from socioeconomic, cultural and political contexts. In particular, the dimension of te oranga emphasises the importance of economic participation and equity, reinforcing that Māori depend on access to services and the ability to thrive socially and economically.

The Meihana Model and Te Pae Mahutonga are often used in professional training and service delivery, supporting clinicians to incorporate whānau, wairua and *tikanga* (customs) as integral aspects of therapeutic care. These frameworks provide practical guidance for embedding Māori values into clinical processes, while challenging services to confront structural inequities that undermine Māori health. Haitana et al. (2020) argues that such models enhance clinical engagement and foster equity by centring Te Ao Māori in health care design.

One example of current practice where Mātauranga Māori is successfully integrated is in Māori health services such as *Whānau Ora* initiatives, which centre the family unit in healing and treatment strategies. These approaches acknowledge the importance of a cultural identity, familial support, and holistic treatment, often integrating traditional healing practices such as *Karakia* (prayer) and *Rongoa* Māori (traditional healing) (Pitama et al., 2017).

However, this integration is not without challenges. One key area is the limited formal training for mental health practitioners in Māori mental health models and cultural competency, which impedes the practical application of these frameworks in clinical settings (Pitama et al., 2017).

2.3.2 Barriers to Integration

While there are promising benefits to integrating Mātauranga Māori into mental health services, numerous barriers hinder its comprehensive implementation. One of the primary obstacles is the lack of cultural competency and adequate training among clinicians.

In addition, Western psychology's individualistic approach is often incompatible with the Māori emphasis on collective well-being and whānau involvement. Māori mental health frameworks involve the family or community in the healing process, acknowledging that personal well-being is intimately linked with social and spiritual health (Durie, 1998). Conversely, many Western mental health interventions concentrate predominantly on individual diagnoses, often neglecting the broader social and cultural factors that influence a person's mental health (McLachlan et al., 2017). This disparity between Western models and Māori values can create a sense of alienation and disengagement among Māori clients, resulting in lower treatment adherence and poorer mental health outcomes (Broughton et al., 2015).

Another barrier to integrating Mātauranga Māori is the systemic resistance within healthcare institutions. Many Western-trained clinicians and policymakers continue to view Indigenous knowledge systems as supplementary to Western theories, often labelling them as "alternative" or "complementary" rather than recognising them as essential to effective mental health treatment (Broughton et al., 2015). This marginalisation perpetuates a colonial mindset that devalues Māori cultural practices and privileges Western biomedical frameworks (Came et al., 2019).

Consequently, the healthcare system frequently fails to provide a culturally safe and relevant environment. When Māori mental health care is treated as supplementary rather than foundational, it leads to gaps in service provision, low engagement from Māori communities, and health inequities persist (McLachlan et al., 2017). Policy reform is urgently required to acknowledge the validity and efficacy of Mātauranga Māori and ensure its meaningful integration within mental health services (Came et al., 2019).

In conclusion, while integrating Mātauranga Māori into mental health care presents clear benefits, including improved engagement and more effective treatment for Māori patients, considerable barriers remain. These include insufficient cultural competency training, systemic resistance, and the dominant individualistic focus of Western psychological models. Overcoming these barriers necessitates sustained efforts to dismantle colonial legacies within healthcare systems and implement more inclusive and culturally responsive practices. By embracing the collective, holistic principles of Māori mental health frameworks, the mental health system can be better equipped to meet the needs of Māori communities.

2.4 Cultural Competency and Cultural Safety

2.4.1 Cultural Competency

Migration and globalisation have led to greater cultural diversity in populations globally, highlighting the need for health systems to deliver care that is responsive to a wide range of cultural perspectives (Hark et al., 2009; Lecca et al., 2014). In Aotearoa, this is especially relevant, with census data indicating that 27.4% of the population was born outside of the country (Statistics New Zealand, 2020). As such, culturally responsive healthcare is not just ideal but essential.

The concept of cultural competency emerged in the late 1980s in response to persistent health inequities experienced by racially and ethnically diverse populations (Curtis et al., 2019; Hark et al., 2009). While definitions of cultural competency vary, it is generally understood as the ability of healthcare professionals to deliver effective care to clients whose cultural backgrounds, values and experiences may differ from their own (Boroughs et al., 2015; Curtis et al., 2019). It involves not only awareness of cultural differences but also the knowledge, skills and attitudes required to engage respectfully and appropriately with individuals from diverse communities.

Culture strongly shapes how individuals perceive health, illness, and healing, and therefore plays a critical role in how care is delivered and received. It influences how people think, behave, and make decisions. These factors are particularly essential in mental health care, where understanding cultural context plays a significant role in shaping how distress is experienced, expressed and addressed (Boroughs et al., 2015; Kirmayer, 2012).

‘Whiteness’ refers to systemic processes that reinforce White dominance by treating it as the norm and positioning other cultural identities as secondary or “other” (Ebubedike et al., 2024; Quillin et al., 2024). In Aotearoa, this is closely tied to colonisation, where European settlers embedded their own values, systems and institutions as the default, marginalising Māori worldviews in the process. This legacy continues today, with Western frameworks still often regarded as the standard in health care while

Māori perspectives are viewed as supplementary. These dynamics continue to shape the delivery of services and the experiences of Māori clinicians and clients (Came et al., 2020; Curtis et al., 2019; Durie, 2001b; McNeill, 2009).

As a result, psychological approaches developed within Western frameworks may not translate effectively across cultural contexts and can be ineffective when applied to Māori and other diverse communities (Lee & Khawaja, 2013). Accordingly, mental health training programs are responsible for developing a culturally competent workforce capable of delivering quality, respectful care to individuals from diverse cultural backgrounds (Hark et al., 2009; Quillin et al., 2024; Ridley et al., 2001).

Despite its importance, several barriers impede the effective implementation of cultural competency. Limited access to comprehensive training can lead to miscommunication or misunderstandings with clients from different cultural backgrounds (Hark et al., 2009). Systemic factors, such as institutionalised norms that prioritise 'Whiteness,' further complicate service delivery by perpetuating marginalisation (Ebubedike et al., 2024). Moreover, resource constraints within many healthcare settings may limit access to essential training or culturally adapted services, restricting opportunities for clinicians to develop the skills needed to meet the needs of diverse populations (Lecca et al., 2014). Addressing these barriers is essential for developing a workforce capable of delivering high-quality, culturally competent care across all populations.

2.4.2 Cultural Safety

Cultural safety, much like cultural competency, is a concept with varied interpretations, particularly in addressing systemic power imbalances that impact clinical care. It emerged in response to the health inequities experienced by Māori and other Indigenous populations, emphasising the need for healthcare models that not only acknowledge cultural differences but also actively work to reduce disparities and improve outcomes for marginalised groups (Auger et al., 2019; Cox & Simpson, 2015; Curtis et al., 2019; Papps & Ramsden, 1996)

While cultural competency has traditionally focused on clinicians acquiring knowledge about other cultures, cultural safety goes further by critically examining how power dynamics within healthcare settings influence the quality and experience of care (Auger et al., 2019; Curtis et al., 2019). Rather than simply encouraging knowledge of customs, cultural safety prioritises creating environments where patients feel respected and secure. This includes a commitment to decolonising healthcare, increasing structural inequalities, and engaging in reflective practices that address power imbalances (Auger et al., 2019; Curtis et al., 2019). Importantly, the patient determines whether an interaction is culturally safe, placing their experience at the centre of care.

In practice, cultural safety requires clinicians to reflect on how their cultural background, values and biases might affect clinical interactions. It moves beyond simply learning about others to questioning how clinical spaces, shaped by dominant norms, might disadvantage certain groups. This perspective recognises that awareness alone is not enough; genuine culturally safe care demands critical examination of individual practice and broader systemic conditions (Curtis et al., 2019; Papps & Ramsden, 1996).

While cultural competency might enable a clinician to be familiar with Māori customs, cultural safety involves a more in-depth consideration of how the clinician's worldview and the institutional structures around them may unintentionally perpetuate power imbalances. This emphasis on reflective, patient-centred practice ensures that cultural identity and experiences are respected throughout the care process. Embedding cultural safety into mental health care is essential for improving trust, engagement, and health outcomes for Māori and other indigenous communities. (Auger et al., 2019; Cox & Simpson, 2015; Curtis et al., 2019).

2.4.3 Challenges in Achieving Cultural Competency and Safety

Achieving cultural competency and safety within healthcare settings presents significant challenges, particularly due to the entrenched power imbalances and systemic biases that disproportionately affect Indigenous communities. While cultural competency is valuable, it can risk reducing complex cultural needs to a checklist of behaviours or facts, failing to capture the lived experiences and worldviews of Māori and other Indigenous populations (Curtis et al., 2019; Papps & Ramsden, 1996). In contrast, cultural safety requires a more transformative approach that compels healthcare providers to critically engage with, and actively dismantle the structural inequities that underpin health disparities (Auger et al., 2019; Cox & Simpson, 2015).

A key barrier to achieving cultural safety is healthcare practitioners' ongoing reluctance or lack of preparedness to examine their cultural assumptions and biases. While reflective practice is central to cultural safety, it requires sustained effort, self-awareness, and institutional support to be meaningful and effective (Curtis et al., 2019). Without adequate time, training, or organisational support, clinicians may unintentionally reinforce harmful stereotypes or overlook the cultural needs of Māori patients. In many cases, the absence of robust support structures limits opportunities for practitioners to develop the confidence and competence required to provide care that is both safe and culturally grounded (Came et al., 2019).

At a structural level, the healthcare system has historically prioritised efficiency and standardisation over culturally responsive practise (Came et al., 2020; Curtis et al., 2019; McNeill, 2009; Ministry of

Health, 2015). While consistency in clinical procedures is important, this emphasis can inadvertently marginalise Māori models of care. For instance, culturally significant practises such as *hui* (gatherings) and *karakia* (prayer) are frequently overlooked or excluded from mainstream mental health services, despite their role in fostering trust and connection (Durie, 2001b; Pitama et al., 2017). When uniformity takes precedence, the system risks failing to meet the specific cultural and relational needs of Māori patients. Addressing this requires more than individual goodwill; it demands systemic change that embeds cultural safety into health policy, workforce development, and service delivery at all levels (D. Wilson & Barton, 2012).

In conclusion, while cultural competency and cultural safety are essential for equitable healthcare delivery, cultural safety marks a necessary shift toward patient-centred care that prioritises the experiences and perspectives of Māori and other Indigenous groups. Overcoming the challenges to implementation requires a sustained, system-wide commitment to decolonising healthcare practice and fostering reflective, culturally aware environments where Māori patients feel safe, heard and empowered in their healthcare journeys (Curtis et al., 2019; Robson & Harris, 2007).

2.5 Training and Professional Development for Clinicians Working with Māori

2.5.1 Current Training Programs for Clinicians Working with Māori

Cultural competency and cultural safety have become central components in clinical training programmes aimed at improving mental health for Māori. Across Aotearoa, various initiatives have been introduced to respond to ongoing health inequities affecting Māori. These initiatives ensure clinicians are equipped to meet the increasing demand for culturally responsive services. These programmes are often integrated into broader clinical education. They are designed to equip clinicians with the knowledge, skills, tools and values required to work effectively with Māori, incorporating Māori worldviews, practices, and understandings of well-being (Curtis et al., 2019; Pitama et al., 2017).

One widely recognised initiative is *Te Tohu o Te Whakaruruhau*, a programme that focuses on enhancing cultural competency for clinicians working with Māori and other Indigenous communities. It includes training on Māori models of health, such as Te Whare Tapa Whā, which recognises the interconnected nature of taha tinana (physical), taha hinengaro (mental), taha wairua (spiritual) and taha whānau (family) well-being, and offers a holistic lens through which clinicians can view mental health and healing (Durie, 2001b). By grounding mental health care in these holistic frameworks, clinicians are better positioned to engage respectfully and effectively with Māori clients.

In addition, many training initiatives also include education on Te Tiriti o Waitangi, highlighting clinicians' ethical responsibilities to uphold Māori rights in healthcare settings. *The Code of Ethics for*

Psychologists Working in Aotearoa/New Zealand affirms the profession's commitment to biculturalism and culturally safe practice (The New Zealand Psychological Society, 2002). Such frameworks emphasise the importance of equitable care, respectful engagement, and responsiveness to the diverse cultural identities of clients.

Despite the existence of these programmes, their content and delivery can vary widely. Research suggests that interactive, reflective, and sustained training over time is more likely to shift attitudes and support meaningful changes in clinical behaviour (Came et al., 2019; Curtis et al., 2019). This highlights the importance of moving beyond one-off, tokenistic cultural workshops toward more embedded and transformative learning experiences.

2.5.2 Gaps in Training and Professional Development

Despite the growing emphasis on cultural competency, significant gaps remain in training and professional development opportunities for clinicians working with Māori. One critical issue is that many current programmes only provide a broad overview of Māori culture and history, without adequately addressing the unique needs of Māori in mental health contexts, particularly the impacts of colonisation, systemic racism and intergenerational trauma. (Curtis et al., 2019; Pitama et al., 2017; Robson & Harris, 2007). As a result, clinicians may find themselves ill-equipped to integrate Māori health models of well-being or apply them meaningfully in practice.

Another concern is the limited availability of ongoing professional development. While cultural content may be included in undergraduate training, the absence of structured pathways for continued learning poses a challenge once clinicians are in practice (Lecca et al., 2014). Continuous development is vital to ensure clinicians remain responsive to evolving cultural and clinical contexts, particularly when working to address mental health inequities for Māori.

Moreover, many training programs lack sufficient emphasis on self-reflection and critical examination of bias and power. Cultural safety is not just about knowing the proper protocols; it requires clinicians to reflect on their own biases, beliefs and assumptions, as well as the power dynamics within healthcare settings. (Curtis et al., 2019; Papps & Ramsden, 1996). Without structured opportunities and support for this kind of reflection, clinicians may struggle to move beyond surface-level awareness, limiting their ability to deliver culturally safe and grounded care in genuine partnership with Māori.

2.5.3 Impact on Clinical Outcomes

The quality and depth of training clinicians receive in cultural competency and safety directly impact clinical outcomes for Māori. While many programmes aim to increase awareness of cultural issues, the real challenge lies in translating this awareness into meaningful, culturally responsive practice (Curtis et al., 2019; Ridley et al., 2001). Inadequate training and a lack of focus on Māori-specific needs, such as ongoing effects of colonisation, systemic racism and intergenerational trauma, often result in ineffective communication, misinterpretation, or misdiagnosis in clinical settings. This can lead to culturally misaligned care and, in some cases, harmful (Ebubedike et al., 2024; Ridley et al., 2001).

Research indicates that Māori patients are more likely to disengage with mental health services when care does not reflect their values or support preferred ways of healing (Durie, 2001b; Pitama et al., 2017). Practices such as whānau involvement, karakia, and the use of Māori health models are often overlooked in mainstream mental health services, despite being central to Māori understandings of well-being. When clinicians lack the skills, knowledge, or confidence to incorporate these practices into treatment plans, it undermines the therapeutic relationship and limits the overall effectiveness of care (Lecca et al., 2014; McNeill, 2009; Waitoki et al., 2016).

The consequences of this disconnect are evident in ongoing disparities. Māori continue to experience disproportionately higher rates of mental illness, greater psychological distress, and are more likely to be subjected to coercive interventions, such as seclusion or compulsory treatment orders (Came et al., 2019; Curtis et al., 2019). These inequities are not solely the result of individual clinical practice but reflect broader structural issues, including training gaps, institutional racism, and a healthcare system that continues to privilege Western frameworks for care.

However, evidence suggests that when clinicians engage in robust and ongoing cultural training, particularly programmes that promote self-reflection, partnership with Māori communities, and the integration of Māori health models, there are measurable improvements in engagement, communication and clinical outcomes for Māori (Lecca et al., 2014; Pitama et al., 2017; Ridley et al., 2001; Waitoki et al., 2016). Training that is experiential and relational, rather than purely theoretical, is more likely to shift practice in meaningful ways and contribute to equity in care (Curtis et al., 2019).

In conclusion, training and professional development are critical in shaping the quality of mental healthcare provided to Māori. Without a sustained focus on cultural safety and a deeper understanding of Māori-specific needs, clinicians risk perpetuating inequities rather than addressing them. Improving clinical outcomes requires more than surface-level awareness; it calls for a long-term commitment to

training grounded in partnership, reflection and respect for Mātauranga Māori as it relates to health and healing.

This directly links back to the research question guiding this thesis, 'How do mental health clinicians understand and integrate Mātauranga Māori in their practice, and what are the barriers and enablers to its meaningful application in Aotearoa's mental health services?' The findings in this section demonstrate that the adequacy of clinical training, both its quality and cultural depth, functions as a central enabler or barrier to that integration. When training is robust, relational, and Māori-led, clinicians are more likely to engage in practice that reflects Māori worldviews and improved outcomes. When it is superficial or inconsistent, the opposite occurs, reinforcing inequities and undermining trust.

2.6 Policy and Systemic Changes

2.6.1 Current Health Policies and Their Limitations

In Aotearoa, mental health policies have made some progress in recognising the needs of Māori communities. However, many still fall short of addressing the complex realities that shape Māori mental health. Policies such as *He Korowai Oranga* (the Māori Health Strategy*)* and the Māori Mental Health Framework reflect efforts to include Māori perspectives and priorities within national health policy (Ministry of Health, 2014; Wepa, 2015). Yet the translation of these frameworks into consistent, effective and meaningful practice has been limited. The integration of Mātauranga Māori into mainstream mental health services remains fragmented and, in many cases, superficial or tokenistic, contributing to ongoing gaps in culturally appropriate care for Māori.

A key limitation of current policy is its failure to address the structural and systemic issues perpetuating inequities. While many frameworks acknowledge the importance of culturally responsive care, they are often grounded in a Western biomedical model that marginalises Māori approaches to well-being (Durie, 2001b; Wepa, 2015). The ongoing dominance of this paradigm means that efforts to include Māori knowledge are rarely embedded or transformative. Policy documents may appear inclusive on paper, yet in practice, Māori healing approaches and values are marginalised, and Māori-led initiatives struggle to gain traction within a system that does not fully uphold *tino rangatiratanga* (self-determination) (Boulton et al., 2009).

Further compounding these issues is the failure of some policies to meaningfully address the historical and ongoing impacts of colonisation on Māori mental health. Although the Treaty of Waitangi is acknowledged as a founding document in Aotearoa's health system, the principles of partnership, participation, and protection are not always upheld in policy development or implementation. This results in services that may meet procedural standards but feel culturally unsafe or alienating for Māori patients

(Curtis et al., 2019; Robson & Harris, 2007). Limited access to cultural safety and competency training further exacerbates this problem, leaving many clinicians ill-equipped to work in genuinely responsive ways to Māori health needs.

Structural racism is also evident in the underrepresentation of Māori in health governance and policy-making roles. Māori voices are often excluded from decision-making processes, reducing the potential for policies to reflect the realities and aspirations of Māori communities (Curtis et al., 2019; Pitama et al., 2014; Robson & Harris, 2007). This lack of representation contributes to developing services that continue to centre Western assumptions and priorities, reinforcing a system that many Māori find disempowering or culturally misaligned.

Furthermore, the persistent emphasis on efficiency, standardisation, and cost-effectiveness over cultural safety has led to service delivery that may be procedurally correct but inadequate in meeting the holistic needs of Māori (Pitama et al., 2014). This approach fails to recognise the value of culturally grounded care. It often overlooks the importance of relational, whānau-centred models of healing that are central to Māori understandings of well-being.

A shift is needed from surface-level inclusion to genuine structural transformation to address these issues. This involves not just the integration of Māori cultural practices into existing frameworks, but also a commitment to decolonising the health systems by prioritising Māori leadership, values and aspirations at every level of policy design, governance, and service delivery (Durie, 2001a; Robson & Harris, 2007).

2.6.2 Recommendations for Policy Reform

To create a mental health system that truly supports Māori well-being, policy reform must be both anti-racist and culturally grounded. A foundational step is embedding culturally safe practices within all mental health policy. This includes mandatory cultural safety training for health professionals, with a specific focus on Mātauranga Māori and guided by the ethical principles of Te Tiriti o Waitangi (Curtis et al., 2019; Pitama et al., 2014). Training that fosters reflection, humility and partnership with Māori can help shift clinician attitudes, reduce harmful biases, and improve engagement and trust in services.

Equally critical in ensuring strong Māori representation in health governance. Māori must be involved at every policy development stage, from initial design to implementation and evaluation. Establishing Māori leadership within policy-making bodies ensures that Māori perspectives and aspirations are central to developing mental health services. Māori-led governance creates space for policies that are culturally appropriate, culturally responsive, and uphold tino rangatiratanga (self-determination) in health (Boulton et al., 2009; Curtis et al., 2019). Rather than relying on top-down, one-size-fits-all approaches, genuine power-sharing allows Māori communities to co-design solutions tailored to their

local realities. This kind of inclusion moves beyond tokenism and is essential for redressing historical power imbalances within the health system (Curtis et al., 2019).

Proactive and transparent mechanisms for accountability are also needed. This includes mandated, regular audits of mental health services to assess their responsiveness to Māori and to identify patterns of inequity and institutional racism (Came et al., 2019). Monitoring these outcomes provides insight into whether policies are well-intentioned and effective in reducing disparities. These evaluations should be developed and led in partnership with Māori to ensure they reflect community priorities and experiences.

To better support the integration of Mātauranga Māori into mental health services, policy frameworks must prioritise funding for Māori-led mental health research. This includes dedicated resources to develop, implement, and evaluate culturally grounded interventions aligned with Māori values and practices (Durie, 2001b). Research exploring the role of traditional Māori healing practices, such as whānau-centred care, karakia, and wairua-based approaches, can offer both evidence-based insights and culturally aligned models for broader application within the mental health sector.

Curriculum reform is also essential. Both undergraduate training and continuing professional development for clinicians should incorporate meaningful engagement with Mātauranga Māori, not as an add-on, but as a core component of clinical education. This must go beyond basic cultural awareness to include critical self-reflection and a deep understanding of how colonial histories and structural inequities shape clinical interactions (Pitama et al., 2017) Supporting clinicians in examining their own identities, biases, and power dynamics is a crucial step toward delivering culturally safe and effective care.

Finally, health policy must enable and sustain the growth of community-based, Māori-led mental health services. These services should be developed in partnership with Māori communities and grounded in cultural values, *tikanga* (customs), and local context. Māori-led services offer alternatives to mainstream mental health care that are more accessible, holistic, and culturally safe. Ensuring these services are resourced with sustainable funding and appropriate infrastructure is critical to achieving lasting equity (Boulton et al., 2009).

In conclusion, meaningful policy reform must centre Māori voices, leadership and knowledge systems while actively dismantling systemic racism in health systems. By embedding cultural safety into all aspects of mental health policy, supporting Māori-led research and service delivery, and ensuring Māori are represented at every level of governance, Aotearoa can move toward a more just and culturally responsive mental health system, one that genuinely upholds the well-being and aspirations of Māori.

2.7 Comparative Analysis with Other Indigenous Cultures

2.7.1 Lessons from Other Indigenous Cultures

Mental health inequities among Indigenous peoples globally are deeply rooted in the historical and ongoing impacts of colonisation, systemic discrimination and cultural dislocation. These structural injustices have contributed to high rates of psychological distress, substance abuse, and suicide across many indigenous communities (Denham, 2008; Elias et al., 2012; Hackett et al., 2016). In recent decades, however, Indigenous groups in countries like Canada, Australia, and Hawai'i have taken important steps to reclaim and integrate their knowledge systems into mental health care, offering valuable lessons for Aotearoa.

In Canada, the Indigenous and federal agencies co-developed the First Nations Mental Wellness Continuum Framework to promote a more culturally grounded approach to wellness. This framework centres on Indigenous concepts of well-being, such as balance, belonging, and purpose and is guided by traditional knowledge and community leadership (Health Canada, 2015). It emphasises strengths-based, holistic strategies that address historical trauma and contemporary needs. Research shows that culturally safe, community-driven models, like land-based healing programmes and the inclusion of Elders in care, have led to improved engagement and mental wellness outcomes (First Nations Information Governance Centre (FNIGC), 2012; Restoule et al., 2015).

Similarly, Aboriginal and Torres Strait Islander communities in Australia have advocated for mental health frameworks grounded in culture, identity, and connection to Country. The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Well-being (2021-2031) recognises the interrelationship between mental health and cultural, spiritual, and community well-being. It emphasises Indigenous-led solutions, with a strong focus on healing from trauma and restoring social cohesion (Dudgeon et al., 2014). Programs that embed cultural practices, such as yarning circles, smoking ceremonies, and kinship-based interventions, have been shown to foster resilience and build trust between practitioners and Indigenous clients (Dudgeon et al., 2020).

In Hawaii, Native Hawaiian approaches to mental health draw on the concept of *lokahi* (harmony and balance), recognising the interconnectedness of the physical, emotional, spiritual, and relational dimensions of well-being. Culturally embedded models such as *ho'oponopono* (a traditional form of conflict resolution and healing) are increasingly being integrated into therapeutic settings. Studies show that these practices support individual healing while strengthening family and community ties, particularly when led by respected cultural practitioners (McCubbin & Marsella, 2009).

Across these contexts, a common thread is the reclamation of Indigenous knowledge systems and the shift toward relational, culturally affirming, and community-led models of care. These examples demonstrate the potential of culturally embedded approaches to improve mental health outcomes and restore mana and resilience with Indigenous communities.

For Aotearoa, these international examples offer important insights. While the context is distinct, the shared histories of colonisation and cultural marginalisation point to the value of centring Indigenous voices and knowledge in mental health reform. Investing in Māori-led services, embedding Mātauranga Māori in clinical settings, and recognising whānau, wairua, and whenua as integral to mental well-being are essential steps to building a system that genuinely serves Māori. As these global examples show, transformative change is possible when systems shift from inclusion to true partnership.

2.8 Summary

2.8.1 Summary of Findings

This literature review has critically examined the complex interplay of factors contributing to inequities in Māori mental health outcomes and the responses across clinical, cultural, and systemic levels. The enduring legacy of colonisation, structural racism, and the dominance of Western biomedical frameworks continues to shape Māori experiences within the mental health system. While policy and practice shifts have recognised the need for culturally responsive care, these have not been matched by consistent structural transformation or meaningful inclusion of Māori voices and values.

Central to the literature is the recognition that Mātauranga Māori**,** the body of Māori knowledge encompassing worldviews, values, and healing practices, offers a foundational framework for enhancing mental health care for Māori. Models such as *Te Whare Tapa Whā* (Durie, 2001b) and practices grounded in tikanga, wairua and whānau-centred care demonstrate the importance of approaches that reflect Māori understandings of well-being. Evidence indicates that when Mātauranga Māori is authentically embedded in clinical practice, it improves engagement, strengthens therapeutic relationships, and contributes to better outcomes for Māori clients.

Despite increasing attention to cultural competency and cultural safety, the literature shows that these concepts are often inconsistently applied, under-resourced, or confined to introductory training. Furthermore, the systemic structures in which clinicians operate often limit their ability to fully realise culturally safe and Mātauranga Māori informed care. While some promising examples exist, such as Māori-led services, professional development frameworks, and evolving health policy, their impact remains constrained by institutional barriers and lack of sustained support.

Comparative analysis with other Indigenous communities reveals similar patterns of historical trauma and systemic exclusion but also highlights opportunities to strengthen Māori mental health care through Indigenous-led research, policy reform, and integrated service delivery that privileges Indigenous knowledge systems.

2.8.2 Gaps in Literature

Although there is a growing body of research advocating for the inclusion of Mātauranga Māori in mental health care, significant gaps remain. Much of the literature focuses on the theoretical benefits of culturally grounded approaches, yet there is limited exploration of how Mātauranga Māori is practically operationalised in everyday clinical settings. For example, while models like Te Whare Tapa Whā and the Meihana Model are frequently referenced in health policy and training (Durie, 1998; Pitama et al., 2017), few studies examine how clinicians actually apply these frameworks in routine practice, particularly in mainstream, time-constrained environments. The "how" of integration remains underexplored, leaving practitioners with limited guidance beyond broad theoretical principles.

There is a lack of research that centres the lived experiences and voices of Māori clinicians, cultural advisors, and service users navigating bicultural spaces within mainstream mental health services. Most published work reflects academic policy perspectives, rather than the day-to-day realities of frontline workers and clients. Their insights are essential for understanding what authentic, effective, and culturally safe care looks like in practice. For example, while Kaupapa Māori services have been described as offering holistic and accessible care (Haitana et al., 2020), there are few longitudinal studies tracking client outcomes or the systemic factors that sustain or undermine these models.

Another significant gap lies in evaluation and evidence bases. Western clinical trials and outcomes measures dominate the mental health evidence landscape, meaning Māori-led services and indigenous methodologies are often undervalued or excluded. Long-term evaluations of Māori-led initiatives, such as whānau ora approaches, are rare, despite strong community uptake and anecdotal evidence of success. Without a robust evidence base built on Māori epistemologies, services risk privileging Western success metrics and overlooking outcomes that matter to Māori communities, such as strengthened whānau relationships, restored wairua and increased cultural connection.

Finally, while the literature increasingly critiques structural racism and colonial legacies, there is limited work that goes beyond critique to outline actionable, Indigenous-led policy pathways. For instance, studies highlight barriers created by institutional structures and funding models (Came et al., 2020; Curtis et al., 2019), yet there is little detailed analysis of how policies could be restructured to enable tino rangatiratanga in service governance or shared decision making in iwi and hapū. This lack of

forward-facing policy guidance leaves gaps between recognising inequity and transforming systems in ways led by Māori aspirations and knowledge.

Together, these gaps highlight the need for research grounded in lived experience, attentive to systemic realities, and committed to co-creating practical solutions. By focusing on the voices of clinicians working directly with Māori clients, this study fills this void, offering insight into what genuine integration of Mātauranga Māori looks like, the challenges clinicians face, and the changes required to make practice sustainable.

2.8.3 Justification for Research

This research responds directly to the gaps identified in the literature by exploring how clinicians experience, interpret, and navigate the integration of Mātauranga Māori within contemporary mental health practice. By drawing on the lived realities of those working at the intersection of clinical and cultural worlds, this study seeks to move beyond theoretical advocacy for Māori-centred care and provide grounded insights into what is working, what is missing, and what is needed for meaningful change.

In doing so, this research contributes to the broader efforts to re-centre Mātauranga Māori in mental health care in ways that are relational, ethical, and embedded in practice. It also addresses the need for Indigenous-led scholarship that critiques existing systems and offers pathways toward transformation that uphold the principles of tino rangatiratanga, cultural safety, and equity. Ultimately, this research aims to support clinicians, services, and policy makers in developing approaches that are more responsive to Māori aspirations and grounded in Māori knowledge, values, and ways of healing.

Chapter Three: Methodology

Mā te rongo, ka mōhio; mā te mōhio, ka mārama; mā te mārama, ka mātau; mā te mātau, ka ora.”
Through listening comes knowledge; through knowledge comes understanding; through understanding comes wisdom; through wisdom comes well-being.

3.0 Introduction

The previous chapter explored the intersections between Mātauranga Māori and psychology, establishing a foundation for understanding why integrating indigenous knowledge systems into mental health care is critical. This chapter outlines the methodological framework used to address the research aim. It details the research design, including the qualitative approach adopted, the rationale for participant selection, and the tools used for data collection. It also outlines ethical considerations, data analysis procedures and strategies to ensure research rigour. Reflexive notes on the scope and constraints for the study are included in relevant sections, and the chapter concludes with a summary of the research process.

3.1 Research Design

3.1.1 Qualitative Approach

This study employs a qualitative methodological framework, situated within an interpretive paradigm, to explore clinicians' lived experiences and professional insights. This paradigm recognises that knowledge is socially constructed and that individuals and clinicians interpret and attribute meaning to their professional realities (Gibson & Sullivan, 2012).

Quantitative research, typically associated with objectivity and measurement, often dominates in psychology due to its emphasis on statistical validity (Bryman & Bell, 2015; Gelo et al., 2008; Lakshman et al., 2000). However, qualitative methods provide an alternative lens that prioritises depth, context, and meaning (Mitchell et al., 2007; Povee & Roberts, 2014). These methods are particularly well-suited for exploring the complexities of human experiences, such as how clinicians engage with cultural frameworks like Mātauranga Māori in practice.

The research seeks to uncover recurring patterns in clinicians' narratives through thematic analysis, providing a nuanced understanding of their engagement with Indigenous knowledge systems (Willig, 2019). This approach aligns with the relational and holistic nature of Mātauranga Māori, making it especially relevant for investigating culturally grounded clinical practice.

Epistemologically, this research is informed by an interpretive orientation and a critical realist stance. From a critical realist perspective, social structures, such as colonisation, racism, and institutional

frameworks, are understood to exert real effects on Māori mental health outcomes, even though our knowledge of them is always mediated through cultural and social interpretation (Bhaskar, 1975; Maxwell, 2012). Semi-structured interviews, therefore, enabled meaningful dialogue that both honoured the lived experiences of clinicians and provided insight into the broader systemic conditions that constrain or enable those experiences (Leong, 2022; Sartori et al., 2023; Sibulwa et al., 2019). This dual framing acknowledges that knowledge is co-constructed in interaction, while also recognising the deeper structures that constrain or enable the integration of Mātauranga Māori in practice.

3.1.2 Why Clinicians?

Clinicians were selected as the primary participants in this study due to their central role in delivering mental health care and shaping service experiences. Their perspectives are critical for understanding how Mātauranga Māori is currently being engaged with in practice, as well as identifying barriers and enablers to its meaningful integration (Bush et al., 2019; Walker et al., 2021).

Given their direct engagement with Māori clients and their role in implementing mental health policy at the ground level, clinicians are well-positioned to provide insight into culturally responsive practices (Bush et al., 2019; Walker et al., 2021). Their reflections offer valuable knowledge that can inform training, policy, and service delivery improvements. Focusing on clinicians ensures that the findings of this research are both grounded in practice and applicable to the ongoing development of culturally appropriate mental health care in Aotearoa.

3.1.3 Research Tools

This study used semi-structured interviews as the primary research tool. These interviews were guided by a set of open-ended questions[1] developed in consultation with my Research Supervisor to ensure alignment with the research aims and objectives (Christabel & Prawira, 2023). This collaborative process ensured the questions were both relevant and capable of eliciting rich, meaningful responses.

Semi-structured interviews allow for a flexible and conversational exchange between researcher and participant, supporting in-depth exploration of the issue being studied (Martin et al., 2024; Swain, 2018). While the questions provided structure, the flexible format allowed for adaptation based on participant responses, enabling deeper clarification and elaboration where needed (Kaltenbrunner et al., 2022; Law et al., 2023).

[1] See Appendix D

This method was particularly suited to the relational focus of the study, allowing clinicians the space to reflect openly on their professional experiences, values, and approaches to incorporating Mātauranga Māori into their work. The flexibility of this tool helped uncover not only what clinicians do, but how and why they engage (or struggle to engage) with Indigenous knowledge systems in practice. This approach reflects the Kaupapa of this research, centring Māori knowledge and creating space for meaningful and culturally relevant insights to emerge.

3.2 Researchers Background

In qualitative research, the role of the researcher is not neutral. As the primary instrument of data collection and interpretation, the researcher brings their own experiences, assumptions, biases, and worldview into the research process (Almalik et al., 2010; Gough, 2016). This subjectivity is not a flaw but a recognised feature of qualitative inquiry. The values, beliefs and positionality of both the researcher and participants show how knowledge is constructed and understood (Povee & Roberts, 2014; Tehranineshat et al., 2020).

Acknowledging these influences is a key component of reflexivity, which involves critically examining how one's background may influence the framing of research questions, the interpretation of data, and the overall direction of the study (Frost et al., 2010). Rather than attempting to eliminate bias, qualitative researchers strive to be transparent about their positionality, using this awareness to enhance the depth and authenticity of their analysis.

I identify as Māori. I am an urban Māori woman with whakapapa connections to Ngā Puhi, Ngāti Maniapoto and Ngāti Raukawa. I was raised and educated in both Western and Māori contexts. My personal and professional experiences have deeply shaped my interest in mental health and the integration of Mātauranga Māori into clinical care. Working in the community and experiences with whānau have exposed me to both the strength of our people and the systemic barriers Māori face when accessing mental health services. These experiences have fostered a strong sense of responsibility to contribute to positive changes for Māori through my research.

As a Māori researcher, I hold a dual position, as both an insider with lived experience of the culture and as someone engaging in academic critique systems that impact our communities. This duality requires ongoing reflection and accountability, particularly when working with participants who share aspects of my cultural identity. I recognise the importance of maintaining cultural integrity, upholding tikanga (customary practices), and ensuring that my research aligns with *Kaupapa Māori* (Māori-centred) values such as *whakawhanaungatanga* (building relationships), *manaakitanga* (care and hospitality) and *tino rangatiratanga* (self-determination).

By being open about my background and positioning, I aim to support a more transparent and relational research process. This reflexive stance helps ensure that the voices of participants are honoured and that the research remains grounded in a commitment to equity, cultural safety, and the transformative potential of Mātauranga Māori within mental health.

3.3 Participants

3.3.1 Sample

Data collection is a cornerstone of qualitative research, particularly in psychology, where exploring specific perspectives can provide valuable insights into complex human experiences. This study focuses on clinicians' perspectives on the integration of Mātauranga Māori in mental health care. Purposive sampling was selected as the most appropriate method, as it allows for the intentional recruitment of participants who are not only experienced in mental health practice but also familiar with culturally responsive approaches. This method aligns with the principles of qualitative research, which prioritises the depth, richness and relevance of data over broad generalisability (Tumwakire et al., 2022).

Following consultation with my Research Supervisor, a target of eight participants was established. This sample size was deemed sufficient to explore recurring themes and reach data saturation, where additional interviews are unlikely to yield new insights. Previous research suggests that smaller, targeted samples can generate meaningful findings, especially when investigating nuance, context-specific phenomena such as cultural responsiveness in clinical care (Daliri et al., 2024). This is particularly relevant in mental health settings, where the subjective experiences of clinicians inform how Mātauranga Māori is understood and applied in practice (Clement et al., 2015).

Participants were recruited based on clear inclusion criteria to ensure their relevance to the study. They were required to be actively practising in the mental health care sector and possess some familiarity or experience with Mātauranga Māori. Recruitment occurred through professional networks and a mental health organisation known for its focus on culturally responsive services. Purposive sampling, rather than random or convenience sampling, was essential to ensure data collected remained relevant and aligned with the research aim. This deliberate approach helped generate insights that are both contextually grounded and practice-oriented (Conley et al., 2016; Furida Citra & Aprillia, 2024).

3.3.2 Participant Protection

Researching sensitive topics requires careful ethical consideration, particularly when participants may be reflecting on professional challenges, cultural tensions or personal experiences. In this study, the topic of integrating Mātauranga Māori into mental health care was approached with respect and cultural sensitivity. It was acknowledged that clinicians might encounter systemic or institutional

barriers that could be difficult to discuss. As such, the research environment was designed to be supportive and non-judgmental, encouraging openness while minimising potential discomfort (Rinehart et al., 2017).

Although sensitive topics may present risks, research has shown that participants often find value in reflecting on their experiences, especially when they feel safe and respected (Crowther & Lloyd-Williams, 2012). Rinehart et al. (2017) emphasise that participants are generally resilient and capable of engaging with difficult material when the research process is ethical and relational. In this study, culturally responsive research practice was prioritised throughout. This included being attuned to participants' cultural contexts and maintaining a commitment to *manaakitanga* (caring for others*)*, whakawhanaungatanga, and transparency (Cornejo et al., 2019).

A low-risk notification was applied for and approved by the Massey University Human Ethics Committee, confirming that appropriate safeguards were in place. All participants received information sheets, provided written consent, and retained the right to withdraw at any stage. Interviews were conducted with respect for participants' professional and cultural contexts, and participant identities were protected through pseudonyms and participant codes (e.g., P1, P2, etc.). Further details on ethical approval, consent processes and data protection protocols are outlined in Section 3.6.

3.3.3 Participant Demographics

Participants for this study were recruited through personal and professional networks, with a focus on accessing individuals actively involved in mental health care. I leveraged connections within an organisation specialising in mental health services, which has an extensive network of clinicians and community resources, to identify potential participants. The list of clinicians who participated in the interviews is provided in Table 3. To protect participant anonymity, no identifying information is included, and pseudonym codes (e.g. P1, P2, etc.) have been assigned.

Although gender was not a specific focus of the study, it is worth noting that most interviewees were female. Regarding ethnicity, 62.5% identified as Māori, with the remaining 37.5% coming from other ethnic backgrounds (See Table 4). This sample is not representative of the broader mental health workforce in Aotearoa, which remains predominantly non-Māori. This should be considered when interpreting the findings, as the perspectives of non-Māori are underrepresented in this sample. Participants were selected from a range of sectors, with 50% working in private practice, 25% employed within iwi organisations, and 25% working in the public sector (see Table 5). This diversity of clinical settings contributed to a rich exploration of how Mātauranga Māori is integrated across different

mental health contexts. At the same time, the modest sample size and participant demographics mean the findings are best understood as in-depth, situated insights, rather than representative of the wider mental health workforce.

Table 3

Participants[2] interviewed in research

(Includes pseudonym codes for each participant)

Pseudonym	Speciality	Ethnicity	Gender	Location	Sector
P1	Psychotherapist	European	Female	Auckland	Private
P2	Counselling Psychologist	South African	Male	Auckland	Private
P3	Intern Clinical Psychologist	Māori	Female	Auckland	Iwi
P4	Psychiatrist	Māori	Female	Auckland	Public
P5	General Psychologist	Māori	Female	Northland	Public
P6	Counselling Psychologist	Tongan	Female	Auckland	Private
P7	Clinical Psychologist	Māori	Female	Wellington	Iwi
P8	Clinical Psychologist	Māori	Female	Rotorua	Private

Table 4

Ethnicities of Participants

Ethnicities	# of Participants
Māori	5
South African	1
European	1
Tonga	1

Table 5

Sector of Participants

Sector	# of Participants
Private	4
Public	2
Iwi	2

3.4 Data Collection

This study utilised face-to-face, semi-structured interviews to collect data from clinicians working across various sectors and specialities. Semi-structured interviews were chosen for their ability to balance structure with flexibility (Harrell & Bradley, 2009). This method aligns with the relational approach

[2] Names have been withheld to maintain anonymity of participants

inherent in qualitative research and supports the depth and nuance required to explore how clinicians engaged with Mātauranga Māori in their practice.

Building rapport was a critical part of the data collection process. Establishing a relationship where participants felt safe and respected was essential to encourage open and honest dialogue (Dickson-Swift et al., 2007). A lack of trust or poor communication could have significantly limited the richness of the data collected. When participants feel culturally and relationally safe, they are more likely to share experiences that they may not have otherwise disclosed (Dickson-Swift et al., 2007).

Participants were recruited through both personal and professional networks. These networks were used intentionally, as many of the clinicians had existing connections to the researcher or to organisations known for their focus and culturally responsive mental health care. This approach helped facilitate trust from the outset, consistent with best practices in qualitative research, where trust and relationality are central (Dickson-Swift et al., 2007). Clinicians were initially contacted via email and provided with a copy of the Participant Information Sheet[3] and Consent Form[4]. This ensured that they had sufficient information to make an informed and voluntary decision about participation.

Interviews were arranged via email and scheduled at times convenient for the participants. While both in-person and virtual options were offered, all participants chose to engage virtually, using either Zoom or Microsoft Teams. Each interview lasted approximately 60 minutes.

Interviewing is a powerful method for capturing the voices of participants and understanding how they make meaning of their experiences (Rabionet, 2011). To guide the interview, a list of pre-prepared open-ended questions[5]were developed in consultation with my Research Supervisor. These questions were designed to elicit clinicians' perspectives on the integration of Mātauranga Māori in clinical settings and to identify perceived barriers and enablers to this integration.

At the beginning of each interview, I engaged in whakawhanaungatanga, introducing myself and expressing gratitude for the participant's time. I explained the purpose of the study, reminded them of their right to withdraw at any time and sought verbal permission to record the interview. I also confirmed their anonymity and advised that the data would be used solely for research purposes. Participants were then reminded to return their signed consent if they had not already done so.

As part of whakawhanaungatanga and to model openness, I briefly shared aspects of my background, including my motivations for undertaking this research and my connection to the topic. This helped

[3] See Appendix A
[4] See Appendix B
[5] See Appendix D

establish a relational and respectful space where participants felt comfortable engaging in the interview process.

Before proceeding with the main interview questions, I asked participants to describe their understanding of Mātauranga Māori. This initial question served as a way to gauge their familiarity with the concept and to guide how I framed the remaining questions. Where appropriate, I offered clarification or context to support understanding. The semi-structured format allowed me to follow up on responses, probe for deeper meaning, and clarify points of interest while maintaining alignment with the overall research objectives (Swain, 2018).

All interviews were recorded using the built-in recording features of Zoom and Microsoft Teams. Upon completion of the interviews, I engaged a secure, paid online transcription service to produce verbatim transcripts. These transcripts formed the basis of the subsequent data analysis, as outlined in the following section.

3.5 Researcher Qualification and Positioning

Several factors supported participant recruitment and engagement throughout the research process. I drew on my personal and professional networks to identify and connect with potential participants, which facilitated access to clinicians from a range of sectors and specialities. Some participants were acquaintances or professional colleagues. This existing rapport contributed positively to the research environment, fostering a sense of trust that encouraged open and honest dialogue. Trust is a critical component in qualitative research, especially when engaging in discussions that involve cultural perspectives and professional practice (Dickson-Swift et al., 2007).

Nonetheless, I remained aware that recruiting through my own networks may have limited the diversity of perspectives represented in the study. While this approach created a safe and accessible environment for participants, it may also have influenced who felt comfortable taking part. To address this, I reinforced the voluntary nature of participation, reiterated the value of diverse viewpoints, and maintained confidentiality and anonymity throughout the process. By engaging reflexively with these dynamics, I sought to ensure that the relationships which supported access to participants did not compromise the integrity of the findings.

My familiarity with participants also streamlined logistical aspects of the research, including communication, scheduling, and follow-up. This accessibility contributed to a smooth interview process and enabled the collection of rich, contextually grounded insights. The relationships I held with participants were handled ethically and reflexively, recognising the need to maintain professional boundaries and uphold research integrity at all stages of the study.

3.6 Ethical Considerations

All fieldwork for this study was conducted in accordance with established ethical guidelines. Potential participants were provided with an information sheet[6] outlining the research objectives, their rights, and the voluntary nature of participation. Informed consent was obtained from each participant prior to the commencement of interviews[7]. At the conclusion of each interview, participants were given the opportunity to ask questions and raise concerns.

To ensure confidentiality and anonymity, pseudonyms have been used throughout the thesis. All interview data were securely stored in accordance with Massey University's data protection policies. Transcripts were anonymised before analysis, and only the researcher had access to the original recordings.

The design of the study considered cultural safety, particularly the significance of Mātauranga Māori in both the topic and the participants' professional identities. Interviews were conducted in ways that supported *mana*-enhancing engagement, including whakawhanaungatanga and *kanohi ki te kanohi* (face-to-face or video) interactions. These culturally responsive practices were implemented to foster a respectful and safe environment for sharing insights.

As a researcher connected to Māori and Pasifika communities through both academic and professional experiences, I was mindful of the power dynamics and responsibilities inherent in this work. Reflexivity and transparency were prioritised throughout to ensure ethical alignment with Kaupapa Māori principles.

3.6.1 Low Risk Notification

This study was classified as low risk, as the nature of the interviews posed minimal potential for psychological harm, and the subject matter was deemed unlikely to cause psychological distress. The study involved eight clinicians who work in mental health care, with the focus being on their professional experiences and views on integrating Mātauranga Māori into clinical settings.

In line with Massey University's *Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants* (Massey University, 2017), a low-risk ethics application was submitted and approved prior to data collection (Appendix C). In consultation with my supervisors, the study was confirmed to meet the requirements for low-risk research.

[6] See Appendix A
[7] See Appendix B

The following safeguards were applied:

- Interviews were arranged at times convenient for participants, and participants could choose whether to be audio-recorded.
- All participants received clear information about the research and their rights to withdraw at any point without consequence.
- Cultural considerations were acknowledged, especially where topics intersected with personal or professional identity.
- No harm or discomfort was reported by participants during or after interviews.

These measures ensured the study maintained a high standard of ethical integrity while enabling the collection of meaningful and culturally relevant data, complementing the participant protection strategies described in Section 3.3.2.

3.7 Data Analysis

This study employed reflexive thematic analysis to interpret the data collected through semi-structured interviews, following the approach outlined by Braun and Clarke (2022). Thematic analysis was selected for its flexibility and suitability for exploring complex social phenomena, such as the integration of Mātauranga Māori in mental health care, from the lived experiences of clinicians. This approach allows patterns of meaning to be identified, analysed, and interpreted, while still acknowledging the researcher's active role in knowledge production.

Reflexive thematic analysis is grounded in a constructionist epistemology, which recognises that meaning is co-constructed through language, context, and interaction. This aligns with the interpretive paradigm underpinning this study, as well as with the holistic and relational nature of Mātauranga Māori. Rather than seeking a singular, objective 'truth,' this method embraces multiple realities and values the perspectives of both participants and researchers in the meaning-making process (Braun & Clarke, 2022).

The analysis followed Braun and Clarke's six-phase process:

1. **Familiarisation with the data:** This began with transcribing the interview recordings verbatim, followed by multiple readings of each transcript to immerse myself in the content. During this phase, I also recorded initial reflections and observations.
2. **Generating initial codes:** I systematically coded each transcript using an inductive approach. Codes were applied manually and reflected key concepts, experiences, and patterns in the data.

Attention was given to language that reflected participants' understandings of Mātauranga Māori, cultural responsiveness, and systemic barriers.

3. **Constructing themes:** After coding, I collated the codes into potential themes by identifying meaningful clusters and patterns. Themes were constructed rather than discovered, recognising that my position as a Māori researcher shaped the lens through which I interpreted the data.

4. **Reviewing themes:** The themes were then reviewed for coherence and relevance. I revisited the coded data and full transcripts to ensure that the themes were firmly grounded in participants' narratives and that they reflected the overall dataset. Some themes were refined, combined, or separated during this stage.

5. **Defining and naming themes:** Each theme was then clearly defined, and its scope and focus were articulated. I aimed to ensure the themes captured the complexity of participants' experiences while also relating to the research aim. Theme names were chosen to be both descriptive and meaningful, capturing the essence of each theme.

6. **Producing the report:** In this final phase, I integrated the themes into a coherent narrative to answer the research question. This involved selecting vivid examples from the data and linking the analysis to relevant literature, including scholarship on cultural safety, systemic barriers, and the role of Mātauranga Māori in mental health care.

Throughout the process, reflexivity was a core component. I kept a reflective journal to document my thoughts, assumptions, and decisions during coding and theme development. This practice helped maintain transparency and supported ongoing critical engagement with how my own experiences and identity as a Māori researcher shaped the analytic process.

Using Braun and Clarke's (2022) reflexive thematic analysis enabled a deep engagement with the participants' insights while maintaining the integrity of their voices. The approach also allowed for the cultural grounding necessary to explore the role of Mātauranga Māori in clinical practice, supporting the aim of generating findings that are relevant, respectful, and transformative for Māori mental health care.

3.8 Data Management

Data is a crucial asset in research, and careful management is essential to maintain confidentiality, security, and integrity throughout the study. All digital data, including interview recordings, transcripts, and consent forms, is stored in password-protected folders on a secure university-approved computer. Access to these files is restricted to the researcher and academic supervisors involved in the project.

Hard-copy documents, such as printed transcripts and consent forms, are stored in a locked filing cabinet in the researcher's office. These materials are only accessible to the researcher. All data is stored in accordance with Massey University's data security and privacy protocols. In line with university requirements, the data will be securely retained for the mandated period, then either transferred to the supervisor for archiving or disposed of securely, as outlined in the approved ethics application.

Audio recordings were securely uploaded to a reputable, encrypted transcription service, which complies with ethical standards for confidentiality and data protection. Once transcription was complete and checked for accuracy, the original audio files were archived securely.

In line with university policy, all research data will be retained for five years following the completion of the study. After this period, all digital data will be permanently deleted, and hard-copy materials will be securely shredded.

These procedures ensure that participants' confidentiality is protected and that the data remains accurate and secure throughout the research process.

3.9 Quality Assurance

Reliability and validity are essential components of qualitative research, underpinning the credibility and trustworthiness of research findings (Morrow, 2005). While traditionally associated with quantitative methods, these concepts also play a critical role in qualitative research, though they are understood differently. Reliability in qualitative research is often associated with consistency and transparency in the research process, while validity is referred to as credibility or authenticity, emphasising the extent to which the research accurately represents participants' experiences and perspectives (Golafshani, 2003; Morrow, 2005).

In this study, reliability was supported by maintaining a consistent and transparent data collection and analysis process. All interviews were conducted virtually using Zoom or Microsoft Teams and were recorded with participants' consent. Audio files were then uploaded to a secure, paid transcription service to generate written transcriptions. Each transcript was reviewed against the original recording to ensure accuracy and to capture the nuances of participant responses (Aguinis & Solarino, 2019).

Credibility was reinforced through reflexivity and transparency. A section on my background and positionality was included to acknowledge how my experiences may have shaped the research process and interpretation of findings. This self-awareness contributes to the authenticity of the research and strengthens the ethical foundation of the study (Noble & Smith, 2015).

While generalisability is not the goal of qualitative research, transferability is, which is the extent to which findings may apply to similar contexts (Morrow, 2005; Vuopala et al., 2019). Although this study centres on clinicians working with Māori, the insights shared may resonate with other practitioners working in culturally diverse settings or those seeking to integrate Indigenous knowledge into mental health care more broadly. At the same time, the findings reflect the situated perspectives of a small group of participants and the interpretive lens of the researcher, which means they should be read as contextually grounded insights rather than universally applicable conclusions.

By prioritising methodological rigour, reflexivity, and ethical engagement, this study aims to produce trustworthy findings that honour participants' voices and contribute meaningfully to the discourse on integrating Mātauranga Māori into mental health practice. In preparing this thesis, I used OpenAI's ChatGPT in limited ways to support editing clarity and APA formatting. It was not used as a source of information or analysis, only for editorial-style assistance, and all research, analysis, and conclusions are my own, in line with Massey University's guidelines on AI use.

3.10 Summary

This chapter outlined the research methodology used to explore clinicians' perspectives on integrating Mātauranga Māori into mental health care. A qualitative interpretive approach was adopted to support a deeper understanding of participants' experiences and insights. The research design was grounded in Kaupapa Māori principles and supported through semi-structured interviews, allowing for a balance of structure and flexibility in the conversations.

Participants were selected using purposive sampling, with eight clinicians from a range of backgrounds and sectors contributing to the study. My own background as a Māori researcher was acknowledged and reflected on, recognising how it shaped the research process and supported the development of culturally safe and respectful relationships with participants.

The chapter also outlined the ethical procedures followed, including informed consent, confidentiality, and cultural considerations. Data was collected using Zoom and Teams, transcribed via a secure professional transcription service, and analysed using Braun and Clarke's (2022) thematic analysis. Attention was given to ensuring the quality and trustworthiness of the research through reflexivity, consistency, and transparent processes. Limitations were acknowledged within relevant sections, particularly regarding the sample composition and potential for response bias.

Overall, this methodology chapter provides a clear foundation for understanding how the data was collected, analysed, and interpreted in a way that centres Māori voices, prioritises cultural safety, and seeks to contribute meaningful insights to mental health care in Aotearoa.

Chapter Four: Results

"Ehara taku toa i te toa takitahi, engari he toa takitini."
My strength is not that of an individual, but that of the collective.

4.0 Introduction

This chapter presents findings from semi-structured interviews with eight clinicians working in diverse mental health settings across Aotearoa New Zealand. Using Braun and Clarke's (2022) six-phase thematic analysis framework, the data was analysed to generate main themes that illustrate the lived realities of clinicians navigating the integration of Mātauranga Māori into their practice. The research focused on breaking down systemic and clinical barriers to improve mental health outcomes for Māori clients.

Six overarching themes emerged, each with associated subthemes, and are presented below (see Figure 1). Each theme is supported by quotes from participants to highlight commonalities and distinctions across experiences. The analysis prioritises participant voices and reflects their grounded, real-world insights, while also drawing on relevant literature and frameworks where appropriate to support and contextualise key findings. This chapter seeks to honour the experiences of clinicians navigating bicultural practice and to contribute knowledge that can support transformative and culturally grounded approaches in mental health care.

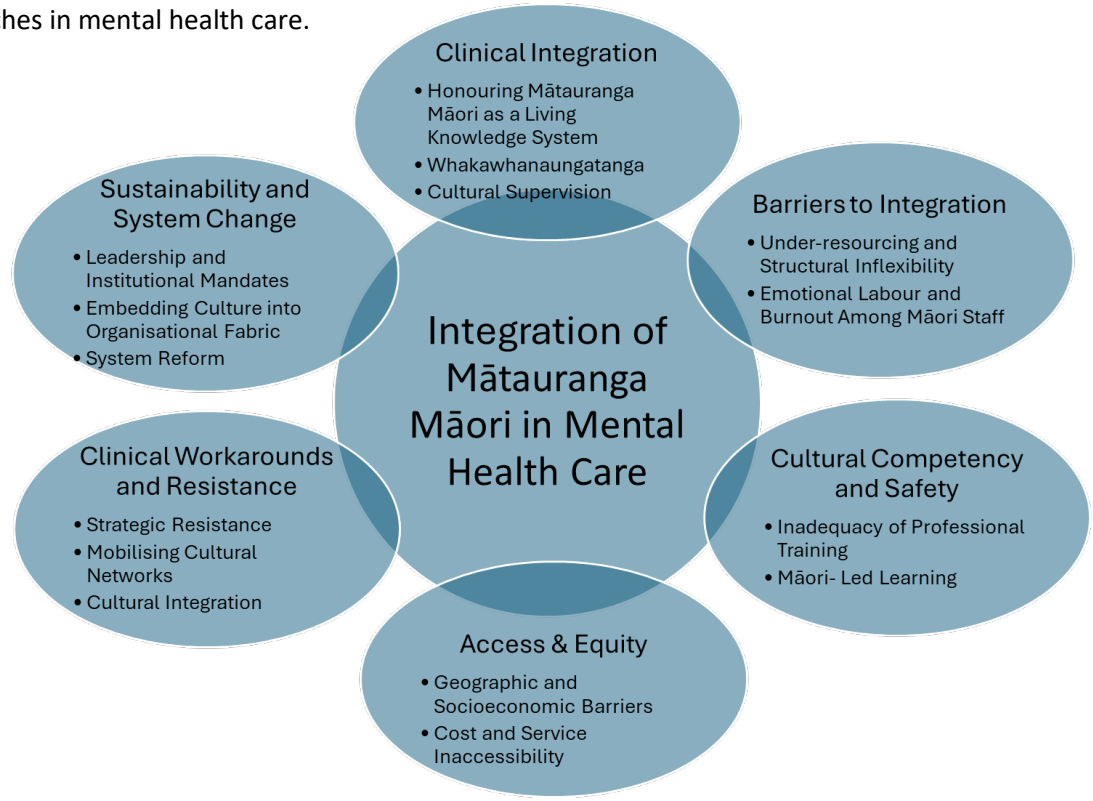

Figure 1: Thematic Map of Main Themes and Subthemes

4.1 Clinical Integration

Participants described a wide range of ways Mātauranga Māori was integrated into their clinical practice. This integration was not uniform and was shaped by clinicians' cultural backgrounds, professional training, workplace support, and community relationships. Within this theme, three subthemes were identified: honouring Mātauranga Māori as a living knowledge system, whakawhanaungatanga as a clinical imperative and strengthening clinical supervision practices. Together, these reflect how clinicians conceptualised and operationalised Mātauranga Māori in their work.

4.1.1 Honouring Mātauranga Māori as a Living Knowledge System

Clinicians described Mātauranga Māori not as a static or confined system to specific tools or frameworks, but as a living, evolving, and relational system that shapes how they work, connect, and support clients. Rather than viewing it as something (to be applied externally, Māori clinicians often described Mātauranga Māori as an intrinsic part of who they are, a worldview embedded in their identity and practice.

P8 emphasised, "It's not a tick-box exercise; it's a way of being. It's in the way you speak, how you relate, your presence." For her, Mātauranga Māori was inseparable from the clinical approach itself. P2 similarly explained, "We use karakia, waiata, whakataukī, and Te Whare Tapa Whā often in our work. It helps centre us and our clients." These accounts reflect how cultural values were not applied formulaically but were woven into the clinician's way of being and relating.

P3 explained that understanding and engaging with Mātauranga Māori meant more than intellectual knowledge: "It's not just knowing about the concepts but being part of them, living them," reinforcing the view that this knowledge is cultivated through whakapapa, whenua, lived experience, and cultural practice, not just academic or professional training.

By contrast, non-Māori clinicians expressed a strong desire to learn and apply Mātauranga Māori respectfully, acknowledging their limitations and positioning themselves as learners. P1 explained, "I'm always learning. I don't claim to know it deeply, but I try to embed what I can through supervision and feedback." Similarly, P6 said, "I'm not an expert, but I try to understand and apply what I can in a way that feels genuine."

What emerged was a clear spectrum of engagement. For Māori clinicians, Mātauranga Māori was central, lived, and identity-based. For non-Māori, it was more aspirational, requiring conscious learning,

cultural humility, and a commitment to relational practice. Across both groups, however, there was a strong consensus that Mātauranga Māori should not be reduced to a set of tools or surface-level practices. Instead, it must be understood as a deeply rooted worldview, grounded in whakapapa, wairua, whanaungatanga, and collective responsibility.

These findings align with existing literature that positions Mātauranga Māori as a holistic and interconnected knowledge system embedded in relationships, community and whenua, a paradigm that challenges dominant Western approaches to mental health (Came et al., 2020; McNeill, 2009; Waitoki et al., 2016). Rather than treating Indigenous knowledge as supplementary, participants reinforced the need to position it as foundational to ethical, culturally safe, and effective mental health care in Aotearoa.

4.1.2 Whakawhanaungatanga as a Clinical Imperative

Whakawhanaungatanga, the process of building meaningful and respectful relationships, emerged as a cornerstone of culturally grounded mental health practice. Clinicians repeatedly described it not as a preliminary step, but as an essential clinical strategy and therapeutic intervention in itself. For many participants, whakawhanaungatanga was the bridge through which trust, connection, and healing were possible, particularly with Māori clients.

P3 explained, “If you don’t build a relationship with someone, especially a Māori client, they’re not going to open up. It doesn’t matter what intervention you’re using if they don’t trust you.” This highlights how therapeutic rapport, when rooted in genuine connection, is culturally situated and cannot be separated from clinical effectiveness.

Several clinicians emphasised that the pace and process of relationship-building often differ when working with Māori clients. P2 noted, “Sometimes, it takes several sessions before we even talk about what brought them in. We might just kōrero, get to know each other first. That’s not wasting time, that’s the work.” This perspective challenges Western clinical timelines that may prioritise rapid assessment and intervention over relational depth.

For Māori clinicians, whakawhanaungatanga was inseparable from identity and tikanga. P8 shared, “It’s part of who we are. You don’t rush into someone’s trauma without first establishing a relationship. That’s not just good practice—it’s respectful.” The act of establishing whānau-like relationships extended to whānau involvement in treatment when appropriate, acknowledging the collective nature of Māori well-being.

Others reinforced that whakawhanaungatanga was far more than rapport building. P6 shared, "It's not just small talk. It's about understanding where they're from, who they are, and showing that you genuinely care." P5 added, "If you skip whakawhanaungatanga, you're not doing therapy, you're doing a transaction."

Whakawhanaungatanga was described not only as a cultural process but also as a therapeutic one, creating safety, reducing stigma, and enhancing therapeutic alliance. Non-Māori clinicians also acknowledged its importance. P1 reflected, "It's been one of the biggest shifts in how I work. I had to slow down, take the time to connect, and that changed everything."

This emphasis on relational practice aligns with literature that positions whakawhanaungatanga as fundamental to culturally safe and effective mental health care. Therapeutic alliances grounded in whakawhanaungatanga foster trust, reduce power imbalances, and enable more meaningful engagement with Māori clients (Waitoki et al., 2016). Reframing connection as a therapeutic outcome challenges dominant models that privilege efficiency over engagement.

Overall, this theme affirms that whakawhanaungatanga is not peripheral but central to ethical and effective practice with Māori. It calls for a shift in clinical expectations and a deeper cultural shift, one that recognises the power of connection as both a method and an outcome of healing.

4.1.3 Strengthening Cultural Supervision Practices

Cultural supervision emerged as a vital support mechanism for clinicians engaging with Mātauranga Māori in their practice. Participants described it as a space for reflexivity, validation, and cultural accountability. It was particularly important for non-Māori clinicians seeking to practice in ways that were respectful and informed, and for Māori clinicians managing the dual responsibilities of clinical work and cultural leadership.

Several clinicians emphasised that cultural supervision created room to explore ethical tensions, identity issues, and culturally grounded ways of working. P1 shared, "Cultural supervision is where I check myself. It helps me make sure I'm not appropriating, but also not shying away from things out of fear." This highlights how cultural supervision was not only about knowledge acquisition but about developing relational and ethical competence.

P3 reflected, "Having cultural supervision helped me reflect more deeply on my practice. It wasn't about ticking boxes but understanding the why behind the what." This points to the role of cultural supervision in fostering deeper critical reflection, beyond compliance, to help clinicians explore the values and intentions underpinning their work.

For Māori clinicians, cultural supervision also served as a source of strength and collective wisdom. P8 shared, “I need that space with other Māori clinicians to breathe, to laugh, to cry if needed. It reminds me I’m not doing this alone.” She also described initiating a "cultural supervision hour" within her organisation, where Māori staff could offer informal guidance to support their colleagues in culturally responsive practice: “We don’t claim to be experts, but we can guide, support, and grow together.” This reflects how cultural supervision, when grounded in reciprocity, can become a powerful tool for both solidarity and collective growth.

Cultural supervision also validated and supported the inclusion of Māori cultural practices within formal clinical settings. P2 noted, “I wasn’t always sure if I could bring in karakia or waiata, especially in formal services. My supervisor helped me understand that these are valid, powerful tools.” This underscores the role of supervision in reinforcing the place of Indigenous knowledges as professionally valid and therapeutically effective.

However, access to quality cultural supervision was inconsistent across services and regions. Some clinicians reported struggling to find qualified cultural supervisors, while others described receiving tokenistic or generic support. P6 shared, “Sometimes it's just a one-off or with someone who doesn’t understand the work. That’s not enough. It needs to be ongoing and grounded in relationship.” The absence of sustained, culturally grounded supervision was seen as a gap that directly impacted the quality and safety of care.

These reflections align with literature emphasising the need for sustained, high-quality cultural supervision as a cornerstone of culturally safe practice (Came et al., 2020; Pitama et al., 2014; Waitoki et al., 2016). Beyond technical guidance, cultural supervision was described as a culturally protective practice, one that upheld mana, enhanced confidence, and enabled deeper engagement with Indigenous knowledge.

Ultimately, cultural supervision was not viewed as optional or supplementary, but as essential. When done well, it supported clinicians to navigate complexity, deepen cultural fluency, and stay grounded in relational ethics. Participants were clear that, to meaningfully integrate Mātauranga Māori into mental health care, robust and relational cultural supervision must be embedded across services.

Clinicians noted that supervision provided a space to reflect on their cultural assumptions, unpack difficult cases, and access community knowledge and guidance. However, some clinicians raised concerns about the limited availability of qualified cultural supervisors and the disproportionate expectations placed on Māori staff to fill this gap.

4.2 Barriers to Integration

Despite a commitment among clinicians to integrate Mātauranga Māori into mental health care, they consistently described profound barriers that constrained their ability to do so effectively. These challenges stemmed not from a lack of will, but from systemic and institutional obstacles that often undermined the very practices they sought to uphold. Within this theme, three subthemes were identified: Under-resourcing and structural inflexibility, emotional labour and burnout among Māori staff, and gatekeeping as a mechanism of systemic racism. Together, these reflect how institutional settings and broader health structures limited the scope and sustainability of culturally grounded practice.

4.2.1 Under-resourcing and Structural Inflexibility

A recurring theme across interviews was the systemic under-resourcing of services that aimed to integrate Mātauranga Māori or provide culturally grounded care. Clinicians described working in environments where time, staffing, and cultural resources were insufficient, undermining their capacity to meet the needs of Māori clients and whānau. These constraints were not simply logistical but were seen as structural reflections of whose knowledge, values, and well-being were prioritised.

P3 reflected, “We’re still trying to do this work in a system that’s colonial in its foundation. It wasn’t made for us or our ways of working.” Others described the pressure to meet clinical targets that did not align with the realities of engaging Māori clients in culturally appropriate ways. P2 described feeling “squeezed from all sides, do more, with less, and faster, while also trying to be culturally safe and responsive.” This conflict between clinical efficiency and cultural integrity was a source of ongoing tension.

Several clinicians described how inadequate resourcing often resulted in clinicians being forced to “bend the rules” or rely on informal strategies to create space for Kaupapa Māori approaches. P8 said, “I have to carve out the space myself. There’s no funding for that. I do it because it’s needed, but it comes at a cost.” These workarounds, while often necessary to honour Māori values and relationships, also reflected burnout risks and the unequal burden placed on those committed to cultural safety.

Under-resourcing was not only financial. It extended to time, emotional energy, cultural guidance, and institutional will. The absence of systemic support was seen as not just inconvenient but actively undermining. P6 explained, “The system will say it values this stuff, but then everything about how it’s structured contradicts that. We’re constantly hitting walls.”

P3 shared, “We don’t have the time, and we don’t have the people. You’re expected to deliver cultural care, but also hit KPIs, complete assessments, meet targets. It’s not designed for Māori ways of working.” This quote highlights the systemic tension between relational, holistic models of care and the time-bound, outcome-driven demands of mainstream mental health services.

The underfunding of Kaupapa Māori services was also highlighted as a critical issue. P2 remarked, “Our Kaupapa Māori service is always on the edge, underfunded, undervalued, and expected to do more with less. Meanwhile, mainstream services have resources we can only dream of.” The inequitable distribution of resources was seen not just as a financial problem but as an expression of institutional bias, where Māori models of care remained marginalised.

Structural inflexibility compounded these issues. Clinicians described rigid service pathways, restrictive assessment tools, and standardised models of care that left little room for cultural adaptation. P6 explained, “You’re given a set number of sessions, a set protocol, and a set of tick boxes. But Māori don’t work like that. Healing doesn’t follow a manual.” The inability to tailor care in culturally meaningful ways was seen as a direct barrier to effective engagement.

Several participants highlighted how structural constraints extended to the physical and relational environment. For example, limited access to kaumātua, lack of Māori leadership, and service policies that restricted the inclusion of whānau all undermined the principles of whakawhanaungatanga, collective healing, and spiritual care.

These accounts reflect wider systemic inequities and support existing literature that critiques the monocultural design of New Zealand’s mental health system. As McNeill (2009) and (2015) Ministry of Health (2015) have argued that the dominance of Western frameworks often crowds out Indigenous ways of healing, despite rhetorical commitments to equity. Participants’ experiences revealed that without significant structural change and investment, the integration of Mātauranga Māori would remain aspirational rather than embedded.

Ultimately, under-resourcing and inflexible systems were not seen as neutral challenges but as active barriers to culturally safe and effective mental health care. As P4 put it, “You can’t expect Māori approaches to thrive in a system that doesn’t value Māori ways of being. We need more than space—we need support, leadership, and proper investment.”

4.2.2 Emotional Labour and Burnout Among Māori Staff

Māori clinicians consistently spoke to the emotional toll of navigating dual responsibilities in their roles, providing mental health care while also shouldering expectations to lead, educate, and advocate for culturally safe practice. This emotional labour was described as both invisible and expected, with Māori staff often positioned as cultural brokers, informal mentors, and the go-to support for anything related to Te Ao Māori. These expectations frequently extended beyond their formal job descriptions, placing additional pressure on Māori clinicians regardless of their official role or position.

P8 captured this dynamic succinctly: “We’re expected to do the cultural stuff on top of everything else—but it’s not in our job description, and it’s not paid. You’re doing it because if you don’t, no one will.” This labour included supporting non-Māori colleagues to engage respectfully with Mātauranga Māori, acting as cultural translators for management, and responding to the specific cultural needs of Māori clients and whānau. While many clinicians saw this as part of their commitment to their people, they also described it as exhausting and unsustainable.

The weight of this responsibility was often compounded by professional isolation and limited access to supportive networks. P3 explained, “You’re one of the only Māori in the service, so everything lands on you. And if you speak up too much, you get labelled as difficult.” The emotional strain was intensified by the need to navigate racism and institutional resistance while protecting their own well-being and integrity. P5 described this role as “invisible work that nobody sees, but everyone relies on,” while P8 explained, “It’s more than burnout, it’s like cultural exhaustion. You’re always holding space for others, but who’s holding it for you?”

Participants spoke of carrying the weight of cultural expectations, community accountability, and systemic change on their shoulders, all while managing high caseloads and limited time. P5 shared, “It’s not just about doing your job. You’re carrying your whānau, your ancestors, your community. That’s not light work.” This sense of carrying collective responsibility was both a source of strength and a cause of burnout, especially when met with inadequate organisational support.

P2 described the internal conflict this created, “You want to be there for your people, but you’re also human. There are days when I feel completely drained, but if I don’t show up, who will?” The tension between commitment and capacity left many Māori clinicians at risk of compassion fatigue, disillusionment, or even leaving the profession. Several participants shared that they were actively considering leaving mainstream mental health services altogether due to the unsustainable demands placed on them.

P3 further noted the lack of structural support, “There’s no infrastructure for Māori staff to be well while doing this mahi. We’re expected to be everything to everyone, therapist, kaimahi, cultural advisor, aunty, activist.” The emotional toll of holding these roles in predominantly Western institutions, where power and decision-making remained Eurocentric, was described as both exhausting and disempowering.

Non-Māori participants also recognised this imbalance. P1 stated, “I’ve seen how much extra gets put on Māori staff, it’s unfair. And it’s not just emotional; it’s spiritual and cultural too.” They went on to acknowledge, “It shouldn’t be that our Māori colleagues are always the ones explaining, leading, fixing. That’s a heavy load, and the rest of us need to do more.” While some workplaces offered informal support, few had formal structures to address this inequity.

These findings align with the literature on the structural burdens placed on Māori health professionals (McNeill, 2009) and align with the Ministry of Health’s (2015) concern about the critical shortage of Māori practitioners and the lack of institutional support for their well-being. The literature is clear that this work is not supplementary but essential and therefore demands shared responsibility and formal support structures.

Despite these challenges, clinicians expressed a deep sense of purpose and pride in their work. However, they were also clear that purpose alone is not a sustainable buffer. As P6 put it, “Loving what you do doesn’t protect you from burning out. We need systems that back us up, not ones that leave us to do it all alone.”

Ultimately, the emotional labour experienced by Māori clinicians is not incidental; it is structural. Until there is collective ownership of cultural responsibilities and tangible support embedded into systems, Māori clinicians will continue to carry a disproportionate burden. Addressing this is essential not only for staff well-being but for delivering equitable, culturally grounded care.

4.2.3 Gatekeeping and Systemic Racism

Many participants described experiencing or witnessing institutional gatekeeping that limited the integration of Mātauranga Māori within mainstream mental health services. This gatekeeping often appeared in the form of rigid clinical protocols, dominant Western frameworks, or management structures that undervalued Indigenous knowledge. Several clinicians noted that even when they wanted to integrate Māori models of health, they were sometimes told “that’s not evidence-based” or “we don’t have time for that” (P3). These kinds of responses were described as dismissive and reflective of a system that privileges Western knowledge while sidelining Indigenous approaches.

Participants spoke powerfully about ongoing experiences of systemic racism, often subtle, institutional, and normalised, that undermined attempts to work in culturally grounded ways. Several described having to "ask for permission" to use Māori models or cultural practices, often facing resistance or dismissal from management. P6 described, "I wanted to bring in kaumātua to support a whānau session, and I was told it wasn't appropriate, that it didn't fit the service model." P3 shared, "It's not just racism in the obvious way. It's being told you need to justify why you want to use a Māori approach. It's that our ways are still seen as optional."

P8 shared frustration about needing to justify the use of karakia and other Māori practices, "If I use a Western tool, no one questions it. But if I bring in something Māori, suddenly I have to defend it." Similarly, P2 explained, "You get told to 'stay in your lane' or that it's not your job to bring culture into the room. But for us, there is no separation." These experiences highlighted the epistemic bias inherent in many clinical systems, where Western knowledge is positioned as neutral and objective, while Māori knowledge is seen as cultural or optional.

Others described institutional rules that indirectly restricted culturally safe care. For example, limitations on session lengths, individualised care plans, or rigid service pathways made it hard to include whānau, practice whakawhanaungatanga, or deliver services in Kaupapa Māori ways. P2 put it plainly: "They say they want equity, but then fight us every step of the way when we try to do things differently. It's gatekeeping, whether they call it that or not." These dynamics were seen not just as logistical frustrations, but as active forms of control over Indigenous knowledge and practice.

Several clinicians pointed to how policies and professional standards can unintentionally reinforce these dynamics. P1 noted, "Even when policies talk about cultural competency, there's no real accountability. It's lip service unless leadership truly values it." This lack of institutional commitment, they argued, contributes to tokenism and places the burden of cultural advocacy on individual staff, often Māori, who are already stretched thin. P6 described this as "death by a thousand cuts, small dismissals that add up over time and wear you down."

Participants also shared how systemic racism intersected with power and resource allocation. P5 stated, "There's funding for evidence-based programmes that don't work for our people, but not for the Kaupapa Māori initiatives that do." This reflects how systemic biases not only shape clinical decision-making but also influence what services are resourced and legitimised.

These findings align with long-established concerns in the literature about the marginalisation of Māori knowledge systems within health structures. Robson and Harris (2007) argue that institutional racism

and structural barriers are key contributors to persistent health inequities for Māori. Clinicians' reflections mirror these systemic realities, highlighting how the need to justify Māori practices or seek approval to include cultural elements represents more than bureaucratic resistance; it reflects colonial power structures that persist within mental health services. McNeill (2009) also notes that Māori models of mental health, grounded in tikanga and relational approaches, are often sidelined by mainstream mental health services, despite their effectiveness for Māori clients. The clinicians' experiences reinforce the urgent need to challenge these systemic norms and re-centre Indigenous frameworks as valid, ethical, and essential to mental health care in Aotearoa.

4.3 Cultural Competency and Safety

Cultural competency and safety were recurring themes across all interviews, with clinicians critiquing current training systems and describing the need for deeper, ongoing, and Indigenous-led learning. Participants expressed frustration with surface-level cultural content in their professional education and emphasised that genuine cultural safety required more than basic knowledge. It demanded reflexivity, humility, and relationship-based practice. Within the same theme, two subthemes were identified: the inadequacy of professional training and advancing Māori-led learning. Together, these highlight clinicians' concerns about existing approaches to cultural competence and their calls for transformative, indigenous-led models of learning that embed cultural meaning in everyday work.

4.3.1 Inadequacy of Professional Training

Many clinicians reflected critically on the limitations of their professional training regarding cultural competency. While most had received some instruction related to working with diverse populations, the content was often described as superficial, generic, and lacking depth in Te Ao Māori. Participants felt underprepared to work in culturally responsive ways with Māori clients and noted that cultural training was frequently tokenistic, treated as a checklist item rather than a meaningful part of clinical development.

P6 shared, "We had one paper on cultural safety, but it was more about general diversity than Te Ao Māori. It didn't prepare me to work in a meaningful way with Māori clients." Others echoed this concern, highlighting that Māori health perspectives were often compartmentalised into single lectures or short modules, rather than being embedded throughout their programmes.

P1 explained, "It was there, but it was never the focus. We'd have a workshop, maybe a guest speaker, but it wasn't woven through our training." P2 added, "A lot of us had to seek out our own learning. If you didn't already come from that world or weren't pushed to go deeper, you could easily miss it."

Some clinicians described feeling ill-equipped and anxious about 'getting it wrong,' due to a lack of guided, reflective spaces to build competence and confidence. Others noted the absence of Māori lecturers or cultural supervisors as a critical gap. Without lived experience and Māori leadership embedded in training institutions, the delivery often lacked authenticity and relational grounding.

This theme aligns with concerns in the literature about the limitations of current training models, which often fail to fully integrate Indigenous knowledge or prepare clinicians to work effectively across cultural boundaries. As McNeill (2009) argues, many mental health training programmes in Aotearoa marginalise Māori worldviews by presenting Western approaches as universal, thereby reinforcing monoculturalism. Waitoki et al. (2016) further highlights the need for culturally embedded curricula and Indigenous-led education as essential to preparing a workforce capable of delivering equitable, culturally safe care.

Clinicians called for a shift from content-based competency toward ongoing, relationship-centred, and reflexive learning. As this research shows, training that positions Mātauranga Māori as peripheral or supplementary falls short of preparing clinicians to meet the needs of Māori clients in a way that upholds mana and fosters trust.

4.3.2 Māori-Led Learning as Transformative

Clinicians consistently expressed that the most impactful learning experiences around cultural safety and Mātauranga Māori came from Māori-led spaces. These included wānanga, supervision, hui, mentorship, and relationships built through community connection, often occurring outside formal training settings. Participants emphasised that transformation didn't come from reading theory alone, but from being guided by those with lived experience and deep cultural grounding.

P3 reflected, "The real learning happened outside the classroom, sitting with kaumātua, being part of the kōrero, watching how tikanga plays out in practice." This relational and experiential style of learning enabled a deeper, more embodied understanding of how to work respectfully within Māori frameworks. P3 also added, "I learned more in one noho marae than in an entire semester of lectures. Being in that space, hearing from people who live it, it changes you." This highlighted how these immersive environments fostered cultural humility and challenged ingrained assumptions.

P8 explained, "Being in spaces where Māori are leading changes everything. It's not just about the content; it's the way it's held, the values underneath it. You feel it, not just learn about it." They went further to say, "When we're taught by our own, it's not just education, it's reclamation. We're reconnecting to things that have been stripped away by colonisation." These reflections point to the

healing and empowering nature of Māori-led learning, not only for individual clinicians but for the broader Kaupapa of reclaiming Indigenous knowledges and leadership.

For P2, Māori-led supervision and teaching helped bridge the gap between cultural intention and clinical action: “You can know about Te Whare Tapa Whā, but unless someone shows you how to use it with wairua and manaakitanga, it’s just a diagram.” This reinforced the idea that cultural models must be embodied and practised relationally, not simply learned as static frameworks.

Non-Māori clinicians also recognised the profound impact of learning from those with lived and cultural experience. P1 shared, “There’s something powerful about learning from someone who walks the talk. It’s not abstract, it’s real.” These moments were often described as turning points in their learning journey, where clinical knowledge and cultural practice finally came together in a way that felt authentic and meaningful.

Many clinicians highlighted the significance of unlearning dominant norms and becoming comfortable with discomfort as part of the process. P6 noted, “Being guided by Māori helped me challenge my own assumptions. I realised how much I’d been taught to lead, to ‘fix.’ This learning flipped that on its head; it became about listening, following, and sitting with not knowing.”

The presence of Māori leadership in teaching and supervisory roles was also tied to feelings of safety, accountability, and collective growth. P5 stated, “When Māori are in leadership positions, it signals to everyone that this knowledge matters, that it belongs here.” Participants who had access to Māori mentors or supervisors expressed greater confidence and clarity in applying cultural knowledge to their practice.

These findings align with literature that highlights Māori-led training and supervision as central to culturally safe practice. Without Māori leadership, cultural learning risks being tokenistic or disconnected from lived realities (Ministry of Health, 2015; Waitoki et al., 2016) . These experiences not only enhanced professional capability but also reshaped clinicians’ understanding of their roles, ethics, and responsibilities within the broader system of care.

Māori-led learning was not seen as a one-off training event but as an ongoing journey. It was about walking alongside Māori communities with humility, being accountable in relationships, and continually reflecting on how to honour and uphold Indigenous knowledges in everyday practice.

4.3.3 Embedding Culture into Everyday Practice

Beyond formal training or supervision, clinicians highlighted the importance of embedding Mātauranga Māori into the everyday rhythm of their work. Rather than reserving cultural practices for isolated events or cultural assessments, participants described how values, tikanga, and Indigenous ways of relating needed to be consistently reflected in their daily interactions with clients and colleagues.

For Māori clinicians, this integration was described as organic and intuitive, something embodied rather than performed. P8 explained, “It’s not something I switch on. It’s just how I move through the world, how I greet people, how I listen, how I hold space.” She described incorporating karaka, waiata, and whakataukī into clinical sessions and team environments, not as performative acts but as authentic expressions of her identity and care. This seamless incorporation of cultural practice into clinical spaces affirmed both Māori presence and values in what are often Pākehā-dominated environments.

Other participants reinforced that cultural safety is shaped just as much by the small, intentional moments as by formal frameworks. P2 shared, “We don’t have to wait for the ‘right’ time to bring in culture. It’s in the small things, asking about their whenua, using te reo, showing respect in the way you sit with someone’s story.” P6 added, “It’s in the little things, how you pronounce names, whether you take time to connect, how you respond to wairua. That tells clients whether they’re safe or not.” These daily practices were seen as critical to building trust and honouring identity.

P2 also challenged the idea that cultural elements should be used selectively, stating, “If you only use Te Whare Tapa Whā on Māori clients or bring out a whakataukī at Matariki, you’re missing the point. It has to be constant, not seasonal.” Others highlighted the importance of incorporating karakia, pepeha, and whakawhanaungatanga into routine clinical interactions, not for performative purposes but to create an environment of cultural safety and belonging.

Non-Māori clinicians also described efforts to embed cultural responsiveness into their daily practice, while being mindful of their own limitations. P1 said, “I try to make it part of my day-to-day, not just something I do when I’m with a Māori client. That’s the shift, it’s not about tailoring something for one group, it’s about changing the culture of care.” P6 echoed this, adding, “Even though I’m not Māori, I want our clients to feel that their ways of being are welcome here. That means I have to think about culture in every interaction, not just when it’s obvious.”

However, embedding culture was not without its challenges. Several clinicians described systemic constraints, rigid service models, brief interventions, and a dominant biomedical paradigm that made it difficult to practise in culturally responsive ways. As P5 explained, “Embedding culture means slowing

down, making space, doing things differently, but the system doesn't always allow for that." They also noted, "I try to bring it in every day, but if the system around you doesn't reflect it, it feels like a fight."

Still, participants shared examples of how they resisted these constraints through everyday acts of cultural practise. P4 described how she routinely began sessions with karakia, not only as a grounding practice but as a way to signal safety and respect. Others talked about involving whānau, using metaphors and narratives grounded in mātauranga, or simply taking the time to connect before diving into clinical tasks. These everyday efforts, while sometimes subtle, were seen as powerful acts of resistance and transformation within a system not always designed for cultural safety.

This theme reinforces the understanding that embedding Mātauranga Māori into everyday practice is not about adding cultural 'extras', it is about shifting the very foundations of how care is delivered. It aligns with literature that argues cultural safety is a lived practice, not a checklist. As the findings show, clinicians who were able to embed culture consistently did so through a combination of lived knowledge, relational ethics, and a strong sense of responsibility to serve Māori in culturally affirming ways.

Ultimately, participants were clear that embedding culture required sustained intention, systemic support, and collective commitment. P6 summarised, "It's not just about adding culture in, it's about changing the way we think about therapy, full stop."

4.4 Access and Equity

Access to culturally safe and effective mental health services was a persistent concern raised by participants. Clinicians described how structural inequities - geographic isolation, poverty, digital divides, and prohibitive costs—continue to limit access for Māori communities, particularly in rural or underserved areas. These barriers were seen as not just logistical but deeply systemic, reinforcing existing inequities in mental health care and undermining efforts to integrate Mātauranga Māori into practice. Within this theme, two subthemes were identified: geographic and socioeconomic barriers and cost and service inaccessibility. Together, these subthemes highlight how structural conditions shape the availability and quality of care for Māori.

4.4.1 Geographic and Socioeconomic Barriers

Clinicians highlighted significant disparities in access to mental health care based on geography and socioeconomic status, barriers that disproportionately affect Māori. Participants described how services

were often centralised in urban areas, leaving rural and remote communities, many with high Māori populations, under-resourced and underserved.

P3 stated, “If you live out in the whop-whops, good luck finding a service that understands Te Ao Māori, let alone one that’s funded or local.” P2 added, “We have kaumātua waiting months just to see someone, by the time they get help, it’s sometimes too late.” These delays were not just logistical frustrations; they were viewed as systemic inequities that put Māori lives and well-being at risk.

Geographic isolation often intersects with broader socioeconomic disadvantage, compounding the difficulty of accessing care. Many whānau lacked reliable transport, affordable childcare, or the ability to take time off work, factors that make attending appointments a logistical challenge. P5 noted, “You’ve got people who don’t have transport, who don’t have internet, who don’t have the luxury to take time off work, and we wonder why they’re not showing up.”

Several clinicians also raised concerns about the digital divide, which became more apparent with the increased reliance on telehealth services. P6 reflected, “Video sessions might work for some, but what if you don’t have Wi-Fi? Or a quiet room? Or even a phone with credit?” While digital services were intended to increase reach, participants warned they may inadvertently exclude those already most marginalised.

These challenges were described as structural, not incidental, deeply embedded in how the health system is funded and delivered. The burden of navigating these barriers often fell on Māori clients and their whānau, reinforcing existing power imbalances.

This reality aligns with McNeill’s (2009) discussion of Māori models of mental health, which emphasise the need for services that are responsive to the real-world contexts of Māori communities. Without meaningful investment in rural infrastructure, culturally grounded local services, and a Māori mental health workforce, clinicians warned that inequities in access would persist.

In sum, participants were clear that improving access for Māori means more than expanding availability; it requires transforming the system to meet people where they are, reflect their lived realities, and uphold the mana of every client, regardless of postcode or income.

4.4.2 Cost and Service Inaccessibility

Clinicians repeatedly emphasised that the cost of mental health care, whether direct or indirect, remains a major barrier to access for many Māori whānau. While some services are publicly funded, participants

noted that eligibility criteria, waitlists, and limited culturally appropriate options often forced clients into the private system, which many could not afford.

P1 shared, “If someone [a Māori client] doesn’t fit the narrow criteria for secondary services, they get bounced. But then the private route is too expensive, so they just don’t get help.” P1 also commented, “A lot of our whānau can’t afford to wait. But they also can’t afford to pay. So, what happens? They go without.” This stark reality led many clinicians to express concern about the widening gap between those who can access care and those who are left behind.

This gap was seen as particularly harmful for Māori, who are more likely to experience financial hardship and systemic barriers to care. P2 observed, “We say it’s free, but if you factor in transport, time off work, or needing to find childcare, it’s not really free at all.”

Clinicians also spoke of inequities in how services were distributed, with more culturally grounded or Kaupapa Māori services often being underfunded or oversubscribed. P6 explained, “The waitlists for Kaupapa Māori services are ridiculous. People want them because they feel safe there, but they’re not resourced to take everyone.” As a result, many Māori clients either disengaged or were forced into mainstream mental health services that did not align with their cultural needs.

P4 added, “The system isn’t set up for Māori, it’s set up for people who already know how to navigate it, who speak the lingo, who can push back.” This mismatch between service design and lived reality left many Māori clients feeling alienated or invisible, particularly when trying to access culturally safe care.

Several participants described working in underfunded community settings where staff were expected to fill in the gaps. P3 said, “Sometimes we’re driving people to appointments, writing letters to WINZ, chasing up housing. That’s not in our job description, but if we don’t do it, who will?” This reflects a system where cost and service design actively reproduce inequity, forcing clinicians to stretch beyond their clinical roles to meet basic needs.

This situation reflects broader systemic inequities in how mental health funding is prioritised and distributed. As Waitoki et al. (2016) note, the mainstream health system often overlooks the layered realities of Māori service users and the importance of whānau-centric, culturally safe care. When funding models fail to support services that align with Māori values and needs, they reinforce existing disparities.

Clinicians expressed frustration at the mismatch between rhetoric and reality, between policy statements promoting equity and the everyday experiences of those trying to access care. P3 stated,

“We keep hearing about equity and access, but I don’t see that reflected in funding. Our communities are paying the price, literally.”

As P8 summarised, “Access isn’t just about getting through the door. It’s about being seen, being heard, and being valued once you’re in.”

Ultimately, participants called for not only more funding, but smarter, more equitable funding, investment that centres Māori providers, eliminates unnecessary barriers, and ensures services are truly accessible for the communities they are meant to serve.

4.5 Clinical Workarounds and Resistance

In the face of systemic constraints, clinicians described a range of adaptive strategies used to uphold culturally safe care. These included acts of quiet resistance, drawing on community and cultural networks, and reimagining practice to better align with Māori values. While these efforts were often unsupported by formal systems, they represented powerful acts of commitment and creativity. Within this theme, three subthemes were identified: strategic resistance, mobilising cultural networks and everyday cultural integration. Together, these themes capture the ways clinicians resisted systemic limitations and actively worked to centre Mātauranga Māori in their daily practice.

4.5.1 Strategic Resistance

Clinicians frequently described acts of strategic resistance as essential to delivering culturally safe care in systems not designed with Māori in mind. This resistance was not about defiance for its own sake but emerged from a deep sense of ethical responsibility and cultural commitment. Participants spoke of intentionally bending rules, working around rigid policies, or taking initiative outside formal guidelines to meet the needs of Māori clients and whānau.

P2 explained, “Sometimes you just do what needs to be done. If that means shifting a session to a whānau home or using karakia even if it’s not policy, then you do it. Because that’s what’s right for the client.” This type of workaround reflected clinicians’ unwavering prioritisation of relational and cultural integrity over procedural compliance.

P8 similarly noted, “I’ve stopped asking for permission. If I know something is safe and culturally needed, I’ll just do it. Waiting for the system to catch up means people miss out.” For many, such actions were framed not as rebellious but as necessary acts of care and accountability to whānau and to Kaupapa Māori.

Strategic resistance also took the form of challenging deficit-based narratives and advocating for the legitimacy of Māori models. P3 shared, “We’re constantly having to prove that our ways work. That they’re not just cultural extras. I push back, because if we don’t, who will?” This highlights how acts of resistance were not only operational but discursive, asserting the value of Indigenous knowledge within systems that often marginalised or misunderstood it.

Several participants described how these acts of resistance were often performed quietly, under the radar, and without institutional support. P6 commented, “Sometimes you just make it happen. If I waited for policy to change, I'd never be able to work in a way that’s right for my clients.” Others noted the emotional weight of having to continually advocate, justify, or translate cultural practices into clinical language to gain approval.

This form of quiet, relational resistance, doing what was right despite constraints, was described by many as the only way to uphold both professional and cultural obligations. It allowed clinicians to remain connected to their values and to deliver care that felt authentic, despite the limitations of the system. P4 summarised, “It’s about choosing who you’re accountable to. For me, that’s my people, not just my employer.”

These findings reinforce research that highlights the ethical tensions Māori and culturally responsive clinicians face in navigating dominant clinical models while remaining true to Indigenous principles (McNeill, 2009; Ministry of Health, 2015). Strategic resistance was not framed as adversarial but as necessary and protective, a quiet reclamation of space, voice, and tino rangatiratanga within clinical systems.

4.5.2 Mobilising Cultural Networks

In the face of systemic gaps and institutional resistance, many clinicians described turning to their own cultural networks as a vital source of strength, guidance, and practical support. These networks included kaumātua, whānau, community leaders, Māori clinicians, and cultural advisors who provided not only knowledge but also affirmation, encouragement, and a sense of shared responsibility.

For Māori clinicians, these networks served as lifelines, offering cultural sustenance, space for healing, and critical reflection. P8 explained, “When the work gets heavy, it’s my people I lean on. Sometimes that’s aunties, sometimes it’s other Māori in the field. They remind me why I do this.” These relationships allowed clinicians to feel grounded in collective values, even when isolated within their organisations.

Mobilising cultural networks was not just about emotional support; it also functioned as an informal but powerful extension of clinical care. P2 described, “There are times I’ll call on a kaumātua to support a session or reach out to a marae for help with a client. That’s not part of the service contract, but it’s what makes the difference.” These collaborative approaches blurred the boundaries between clinical and community, recognising that healing often requires a village, not just a therapist.

P5 explained, “Sometimes the best thing I can do for a client isn’t counselling, it’s calling in a kuia who they trust. That connection can shift things in a way I never could alone.” These networks were seen as forms of community resilience and relational healing, reminders that well-being is collective, not individual.

Several clinicians described acting as cultural connectors themselves, linking clients to Kaupapa Māori services, navigating iwi support systems, or facilitating access to traditional healing practices. P6 said, “I see part of my job as making sure people don’t fall through the cracks. If that means calling Whānau Ora or helping someone reconnect with their marae, I’ll do it.” These actions were rarely written into job descriptions but were seen as essential to honouring Māori models of health and well-being.

Non-Māori clinicians also acknowledged the significance of Māori-led networks, often positioning themselves as learners within these spaces. P1 reflected, “The more I connected with Māori colleagues and community, the more I realised how much I didn’t know, and how much I needed to step back and listen.” P1 further noted, “I try to connect with people who know more than me, because I know I can’t hold this work alone. It’s not mine to lead.” This awareness of positionality and the value of shared responsibility was echoed throughout the interviews.

This theme reflects the importance of collective practice and cultural relationality in sustaining ethical and effective care. While institutional systems often operated in siloed and individualistic ways, clinicians described cultural networks as holistic, expansive, and rooted in whakapapa. Mobilising these networks was not seen as a workaround but as the rightful centre of care, a reclamation of Māori ways of doing, knowing, and healing.

These findings align with existing literature that emphasises the role of Indigenous knowledge holders and relational networks in improving mental health outcomes (McNeill, 2009; Ministry of Health, 2015). They underscore that sustainable, culturally grounded care is not the sole responsibility of individual clinicians but requires strong, well-resourced connections between services and the community.

Clinicians described a range of ways they actively integrated Māori cultural values, practices, and frameworks into their everyday therapeutic work, not as additions or modifications, but as core components of care. This process of cultural integration was often deliberate, values-driven, and grounded in relationship, reflexivity, and clinical creativity.

P3 explained, “You don’t just use Te Whare Tapa Whā when it’s convenient. It should guide the whole approach; not just be a box you tick on an assessment form.” For them, cultural integration meant aligning practice with Māori worldviews at every stage, from assessment to treatment planning, to whakawhanaungatanga and discharge. This approach challenged the assumption that cultural practice could be compartmentalised or selectively applied.

P2 similarly emphasised, “If you only use Te Whare Tapa Whā on Māori clients or bring out a whakataukī at Matariki, you’re missing the point. It has to be constant, not seasonal.” Others highlighted the importance of incorporating karakia, pepeha, and whanaungatanga into routine clinical interactions, not for performative purposes but to create an environment of cultural safety and connection.

P6 added, “It’s in the little things, how you pronounce names, whether you take time to connect, how you respond to wairua. That tells clients whether they’re safe or not.” These daily practices were seen as critical to building trust and honouring identity, especially in services where Māori clients were navigating historical and contemporary experiences of discrimination.

Some clinicians shared examples of more collective and Kaupapa Māori approaches to cultural integration. P6 explained, “We’ve created a wānanga-style group that runs over several weeks. It’s not therapy in the Western sense, but it’s deeply therapeutic for those who attend. It’s grounded in tikanga, whanaungatanga, and collective healing.” Such initiatives reflected what some referred to as ‘quiet transformation’, change driven from within, often under the radar, but deeply impactful.

P8 shared, “I don’t wait for someone to say it’s okay to bring karakia into a session. If I know it’s needed, I’ll do it. Because that’s part of what healing looks like for us.” Their approach reflected a broader assertion of Māori authority in defining what safe and effective care looks like.

Participants also reflected that cultural integration required system-level support. Without leadership backing and structural alignment, individual efforts could feel isolating or tokenistic. P5 explained, “I try to bring it in every day, but if the system around you doesn’t reflect it, it feels like a constant battle.” P4 reinforced this point: “It can’t just be the Māori staff carrying this. If the whole team’s not on board, if management doesn’t back it, it won’t last.” Many clinicians shared that genuine cultural integration was only possible when the wider service upheld and resourced Indigenous ways of working.

Non-Māori clinicians expressed that cultural integration required humility, self-awareness, and a willingness to challenge dominant paradigms. P1 shared, “It’s not just about learning the practices, it’s about shifting your mindset. Asking yourself, whose knowledge is centred here? Whose values are shaping this interaction?” This reflective stance was seen as critical to avoiding tokenism and building genuine, culturally responsive care.

Ultimately, clinicians described cultural integration not as a fixed endpoint but as a continuous process, one that required internal commitment, external support, and collective accountability. As one participant put it, “It’s not about getting it perfect. It’s about showing up with respect, learning as you go, and doing the work in a way that uplifts everyone.”

These findings reinforce the literature that positions cultural integration as essential to equity, not as an optional add-on (McNeill, 2009; Ministry of Health, 2015; Waitoki et al., 2016). For many participants, embedding culture into clinical practice was not just a professional obligation, but a moral and relational commitment to Māori clients, to community, and a more just and culturally honouring system of care.

4.6 Sustainability and System Change

Participants emphasised that meaningful and sustained integration of Mātauranga Māori requires system-wide transformation. Clinicians were clear that the responsibility for bicultural practice could not rest solely on individuals or isolated initiatives. Instead, change must be embedded through leadership, structural reform, and institutional culture. Within his theme, three subthemes were identified: leadership and institutional mandates, embedding culture into organisational practice, and system reform for equity and inclusion. Together, these subthemes illustrate how clinicians envision a future where culturally grounded practice is not only supported but normalised and resourced across the sector.

4.6.1 Leadership and Institutional Mandates

Across interviews, participants stressed that meaningful, sustainable integration of Mātauranga Māori into mental health practice requires strong, visible, and values-based leadership. Without clear institutional mandates and accountability structures, efforts to work in culturally grounded ways were often left to individual clinicians, particularly Māori staff, leading to inconsistent practice and burnout.

P2 stated, “When leadership gets it, everything flows better. You don’t have to fight to be Māori. You can just be.” This succinctly captured a sentiment echoed across interviews, that culturally capable

leadership creates safety and momentum, enabling Māori clinicians to work authentically without having to constantly justify their approaches.

P4 similarly stated, “Leadership sets the tone. If they don’t walk the talk, then cultural safety becomes optional, not expected.” P5 expanded on this idea, sharing, “Good leaders don’t just approve things, they model them. They create space and expectation for others to follow.” Clinicians described how leadership influenced not just policy but the everyday culture of services, shaping whether Indigenous knowledge was embedded or marginalised.

Participants noted that even where organisational values espoused equity and biculturalism, this did not always translate into concrete action. P2 reflected, “It’s easy to put a whakataukī on the wall or open a meeting with karakia. But unless those values show up in budgets, policies, and who holds power, then it’s just branding.” Many stressed that lip service to cultural values without structural follow-through created disillusionment and undermined trust.

Clinicians emphasised the need for tangible mechanisms of accountability. As P3 explained, “You can have all the vision statements in the world, but if no one’s held accountable, nothing really changes.” Participants called for cultural performance indicators, mandatory supervision structures, and funding models that reflect Māori priorities, not just Western clinical outcomes.

In the absence of such leadership, some clinicians described having to advocate alone, often at great personal cost. P6 noted, “If the people at the top don’t prioritise it, it ends up being optional. And culture isn’t optional, it’s essential.” This lack of support contributed to burnout and constrained innovation.

Māori clinicians in particular were attuned to the symbolic and practical power of Māori leadership. P8 noted, “When Māori are in leadership, it changes the whole culture of a service. It says our ways are valid, not just tolerated.” Participants described how even a single Māori leader in a position of influence could shift organisational culture, legitimise Indigenous practice, and foster safer environments for both staff and clients.

However, they also cautioned that placing a few Māori individuals in leadership without wider structural change could be tokenistic and unsustainable. P3 explained, “We don’t just need Māori faces at the top, we need the whole system to shift. Otherwise, we’re just plugging holes while the waka’s still leaking.” The emphasis was on collective responsibility and systemic realignment, not cultural leadership by proxy.

Some participants pointed to positive examples of culturally grounded leadership where values were backed by action. P6 described a workplace where leadership championed transformation by creating roles for kaumātua, embedding cultural supervision, and linking equity goals to performance reviews: “It wasn’t just lip service. They made it part of how the whole service ran.” These examples illustrate the potential for leadership to foster structural shifts that legitimise Indigenous knowledge systems and empower clinicians to practise in culturally aligned ways.

These findings align with the literature that underscores the importance of leadership in embedding cultural safety and enabling systemic transformation in health care (Ministry of Health, 2015; Waitoki et al., 2016). Effective leadership is not only about vision but about operationalising cultural values through policy, practice, and power-sharing.

Ultimately, participants made clear that leadership is not peripheral to equity; it is foundational. Without top-down support, bottom-up innovation is limited in reach and sustainability. But where leadership mandates cultural safety, empowers Māori voices, and drives structural alignment, services are better positioned to deliver mental health care that honours, reflects, and uplifts Te Ao Māori.

4.6.2 Embedding Culture into Organisational Fabric

Participants strongly emphasised that embedding culture must go beyond isolated initiatives or symbolic gestures; it requires systemic alignment across all levels of an organisation. Māori models, values, and practices need to be interwoven into the day-to-day operations, policies, and structures of mental health services, rather than being positioned as supplementary or optional.

P5 explained, “Embedding culture doesn’t mean doing a pōwhiri once a year. It means rethinking how we do everything, how we train, who we hire, how we measure success.” For many clinicians, embedding Mātauranga Māori was not just about incorporating specific practices like karakia or whakawhanaungatanga, but about redesigning systems around Māori worldviews and collective well-being.

P1 shared, “Culture shouldn’t be a side project. It should be baked into how we do things, our assessments, our supervision, our HR policies.” Others spoke about rethinking clinical pathways to better accommodate collective approaches and relational engagement. P8 explained, “Whānau involvement isn’t just a nice-to-have. For us, it’s part of healing. That should be recognised in how services are designed.”

Clinicians pointed to existing examples of cultural integration, such as including kaumātua on clinical teams, developing Kaupapa Māori supervision pathways, and designing services based on models like Te Whare Tapa Whā or Te Wheke. However, these initiatives were often fragile, relying on a few passionate staff members rather than being structurally protected. As P4 noted, “The risk is that it all disappears when key people leave. If it’s not in the fabric, it’s not going to last.”

Hiring and representation were also key areas of concern. P4 said, “We need more of us in the room, not just to tick a box, but to shift the whole energy of a service. When we’re there, things change.” This shift was not only about presence but about power, having Māori clinicians, leaders, and advisors positioned to influence decision-making, service design, and evaluation.

Organisational culture was shaped by who held power and how decisions were made. Participants highlighted the need for Māori leadership at all levels, not just in advisory or consultative roles, but in positions of influence. P3 commented, “If Māori aren’t in the room where decisions happen, then it’s not real partnership, it’s consultation at best.”

Several clinicians noted the importance of aligning organisational values with resourcing and accountability. P6 stated, “It’s not enough to say culture is important. Show me the budget. Show me the KPIs. That’s when I’ll believe it.” For many, the absence of tangible investment in cultural initiatives signalled a lack of genuine commitment.

The role of physical space and environment was also mentioned, with some services incorporating Māori design elements, reo Māori signage, and inclusive service names. While these changes were appreciated, participants were clear that they must be accompanied by changes to relational practices and institutional power structures. P2 observed, “You can’t just decorate a space with Māori stuff and call it culturally safe. If the practice doesn’t match the aesthetic, people feel it.”

Embedding culture also required time, flexibility, and trust. P8 explained, “You can’t do this properly if everything is about rushing people through. Culturally grounded care takes time, time to connect, time to heal.” They noted that services structured around Western timelines and individualised care often undermined collective and relational approaches central to Māori well-being.

Some participants described feeling hopeful as more services began to invest in dedicated Māori teams, cultural governance groups, and partnerships with iwi and hapū. However, others cautioned that without deep system shifts, these moves could become siloed or tokenistic. P1 stated, “We can’t just bolt Māori things onto Pākehā systems. The foundation has to change.”

These perspectives align with literature emphasising the need for Indigenous knowledges to be embedded into the DNA of health systems, across policy, service delivery, training, funding, and evaluation (McNeill, 2009; Ministry of Health, 2015). Without structural commitment, cultural responsiveness risks becoming a surface-level performance rather than a transformative shift.

In summary, embedding Mātauranga Māori into organisational fabric requires intentional redesign of systems, not just cultural competence training or symbolic gestures. It demands a redistribution of power, sustained investment, and a reorientation of mental health services toward Māori values, tikanga, and collective well-being. For many clinicians, this work was not just about improving outcomes; it was about restoring balance and honouring Te Tiriti-based partnership in action.

4.6.3 Structural Reform

Clinicians were clear that isolated interventions or superficial inclusion of culture were not enough; what was needed was structural reform. Participants repeatedly emphasised that the foundations of the current mental health system in Aotearoa were shaped by Western ideologies and institutional racism, which continue to marginalise Māori ways of knowing, healing, and being.

P3 stated, “This system was never built with us in mind. It was built to treat individuals, not whānau. To assess symptoms, not whakapapa. So, if we’re serious about equity, we need to rebuild it, not just tweak it.” P3 further argued, “You can’t just tweak the system. You have to question the whole foundation, who it was built for, whose voices it values.” This sentiment captured the widespread view that transformation requires more than inclusion; it demands reimagining the system itself.

Structural reform, as described by participants, involved shifting power, resources, and decision-making to Māori communities and leaders. P8 emphasised, “We need our own spaces, our own models, led by our people. Not just co-design, co-governance. Co-leadership.” Several clinicians called for shared governance with iwi, community-led service design, and dedicated funding for Kaupapa Māori services. P7 said, “If we want equity, we need equity in decision-making. Māori need to be at the table, not just consulted after the fact.”

Others spoke about redirecting resources to better support community-based and preventative approaches, rather than reactive, crisis-driven care. P6 reflected, “We keep pouring money into ambulances at the bottom of the cliff. What if we funded the marae, the whānau, the people doing the work before it gets to crisis?”

Clinicians spoke to the need for reform across multiple levels: funding, policy, education, workforce development, and governance. P2 explained, “You can’t embed culture without changing how services are funded. If you want Māori approaches, you need to fund time, whānau involvement, tikanga. Otherwise, it’s just lip service.” Many highlighted that structural barriers, such as rigid service criteria, tick-box audits, and short-term contracts, actively disincentivised culturally grounded care.

P6 noted, “We’re always being told to do more cultural stuff, but with no extra time, no training, no supervision. That’s not reform. That’s setting us up to fail.” This dissonance between rhetoric and resourcing was described as one of the biggest barriers to meaningful system change.

Several participants advocated for increased Māori leadership at every level of the health system, including at the Ministry, in DHBs and their successors, and within mainstream mental health services. P5 shared, “You can’t decolonise a system if the same people are holding the power. We need more of us making decisions, not just giving advice.” This was closely linked to calls for structural accountability, including cultural performance indicators and binding commitments to equity under Te Tiriti o Waitangi.

Education and workforce pipelines were also seen as critical sites for reform. P4 pointed out, “We don’t just need more Māori psychologists, we need training programmes that are built around Māori values from the start. Otherwise, we’re just slotting people into a broken system.” Others suggested revisiting accreditation standards and supervision models to ensure they were aligned with Māori health aspirations.

Importantly, structural reform was not only about correcting injustice but about restoring mana and ensuring the sustainability of Māori-led healing. P1 commented, “We have the solutions. We just need the system to step back and trust us.” The recognition of Indigenous sovereignty in mental health was seen as central to creating a future where Māori can thrive, not just survive.

These calls for reform were underpinned by a belief that the health system must fundamentally reorient itself towards partnership, justice, and relational care. Clinicians stressed that this is not just a cultural issue, but a matter of health equity and human rights. As P2 stated, “Until the system changes, we’ll keep having to work around it. But we’re not giving up, we’re building something better, from the inside and the outside.”

These reflections are supported by calls in the literature for structural transformation grounded in tino rangatiratanga and Te Tiriti-based partnership (McNeill, 2009; Ministry of Health, 2015). Without a shift

in who holds power, whose knowledge is centred, and how success is defined, equity remains unattainable.

In conclusion, participants were unequivocal that culturally responsive care cannot exist without structural reform. This reform must be systemic, sustained, and led by Māori, not simply guided by well-intentioned policy. It requires rethinking not only what services look like, but whose voices shape them, whose knowledge defines them, and whose well-being they are truly designed to serve.

4.7 Summary

This chapter has presented the voices of eight clinicians working across diverse mental health settings in Aotearoa, each navigating the integration of Mātauranga Māori into their practice in a system not originally designed to hold it. Through thematic analysis, a rich tapestry of lived experience emerged, one that speaks to both the promise and the profound challenges of bicultural mental health care.

Clinicians described Mātauranga Māori as a living, relational knowledge system, one not simply applied but lived and embodied. This theme of clinical integration was often rooted in whakawhanaungatanga, cultural supervision, and community connection, all of which were identified as essential to culturally safe care. Māori clinicians brought deep insight and lived cultural wisdom but also carried a disproportionate burden, expected to lead, teach, advocate, and heal, often without institutional recognition or support.

The barriers to integration were described not as abstract concepts but as daily realities, ranging from racism and under-resourcing to rigid service structures. These systemic pressures undermined cultural safety and clinical integrity, leading to experiences of burnout and cultural taxation, particularly for Māori clinicians. Concerns about cultural competency and safety were also widespread, with participants critiquing surface-level training and calling for deeper, Māori-led learning that is reflexive, relational, and ongoing.

Issues of access and equity were highlighted, with clinicians pointing to geographic isolation, poverty, digital divides, and prohibitive costs as persistent barriers to services, especially in rural and underserved communities. In response, many spoke of clinical workarounds and resistance, developing creative strategies, drawing on cultural networks, and embedding tikanga in daily practice as acts of quiet but powerful commitment to whānau and Kaupapa Māori values.

Finally, participants emphasised the importance of sustainability and system change. They were clear that lasting transformation cannot rest on individuals alone but requires leadership, institutional

mandates, structural reform, and investment in Māori-led solutions. Only then can culturally grounded practice be normalised and resourced across the sector.

Together, these six themes affirm what the literature has long made clear: equity will not come through surface-level inclusion or isolated training efforts. It will require a reimagining of the health system itself, grounded in Te Tiriti o Waitangi, led by Māori, and centred on relationships, wairua, and collective well-being. The next chapter will consider how these findings speak to the broader questions of systemic change and what it will take to create a mental health system that truly serves Māori.

Chapter Five: Discussion

"He iwi kē koutou, he iwi kē matou, engari i tenei wa, tatou, tatou e."
You are different, we are different, but we are able to work together.

5.0 Introduction

This chapter discusses the key findings presented in Chapter 4 and considers them in relation to the existing literature, the central research question, and the broader context of mental health care in Aotearoa. It explores how clinicians understand and integrate Mātauranga Māori into their practice, and what helps or hinders that process. The discussion draws on both participant insights and scholarly literature on Indigenous mental health, cultural safety, and systemic transformation to examine what these findings mean for current practice, professional training, and institutional change.

This chapter addresses the primary research question:

> How do mental health clinicians understand and integrate Mātauranga Māori in their practice, and what are the barriers and enablers to its meaningful application in Aotearoa's mental health services?

It also considers the following aims:

- What does integration of Mātauranga Māori look like in everyday clinical contexts?
- How do Māori and non-Māori clinicians navigate issues of cultural safety, ethics, and accountability?
- What structural or policy changes are needed to enable culturally grounded, equitable, and sustainable mental health care?

While many clinicians, both Māori and non-Māori, expressed strong commitments to culturally responsive practice, they often work within systems that were not built to support Indigenous approaches to well-being. This tension between clinical expectations and cultural integrity shaped much of the day-to-day work described by participants. At the same time, the findings revealed areas of innovation, resistance, and hope, examples of what's possible when culture is centred and valued.

The discussion is organised around seven key areas that respond directly to the research questions and expand on the themes identified in Chapter 4:

- Relational practice as a clinical imperative
- Systemic barriers to integration
- Reclaiming cultural knowledge and leadership

- Embedding culture into everyday practice
- Access and equity
- Clinical workarounds and resistance
- System change and sustainability

Together, these sections highlight not only the barriers clinicians face but also the possibilities for embedding Mātauranga Māori more meaningfully and sustainably into mental health care in Aotearoa. A final section of this chapter (5.8) reflects on the strengths and limitations of the study and how these relate to the findings.

5.1 Relational Practice as a Clinical Imperative

A central finding of this research was the importance of relational practice as a foundation for culturally grounded mental health care. For both Māori and non-Māori clinicians, whakawhanaungatanga was described not as an optional or preliminary gesture, but as an essential part of the therapeutic process. This emphasis on connection, trust-building, and shared humanity shaped the way clinicians approached assessment, intervention, and recovery.

Participants consistently spoke about the need to build meaningful relationships with clients, not only to enhance engagement, but because relationality itself was therapeutic. This was especially important for Māori clients, many of whom have experienced intergenerational trauma, institutional racism, and cultural disconnection. As P5 explained, “If you skip whakawhanaungatanga, you’re not doing therapy – you’re doing a transaction.” This framing of relationship as a clinical imperative reflects a Māori worldview where well-being is not individualised, but held collectively through whakapapa, wairua, and whānau ties.

This emphasis on interconnectedness, wairua, and collective well-being aligns with established Māori health models that view wellness as holistic and relational (Durie, 1998; McNeill, 2009). These frameworks challenge Western paradigms that often separate mental, physical, and spiritual health, and that centre the clinician as expert. Instead, they highlight the value of relational ethics, cultural humility, and shared responsibility.

For non-Māori clinicians, learning to work in more relational ways often required unlearning professional habits shaped by Western clinical training. Several described the shift from “fixing” to “listening,” from leading to walking alongside. P1 reflected, “I had to slow down, take the time to connect, and that changed everything.” These changes were not just interpersonal; they involved a deeper shift in orientation toward practice, identity, and power.

The literature supports the idea that authentic relationship-building is a cornerstone of culturally safe care. Wilson et al. (2021) In his review of Māori health models, argues that whakawhanaungatanga is not a cultural "add-on," but a core element of therapeutic engagement that can reduce stigma, increase access, and enhance outcomes for Māori clients. When clinicians were supported to prioritise relationships, they reported deeper trust, stronger alliances, and more meaningful outcomes.

However, participants also described the challenges of relational practice within time-pressured, target-driven services. When appointment slots were limited or clinical outcomes narrowly defined, taking the time to build relationships could be seen as inefficient or outside the scope of "real" therapy. This created tensions for clinicians who were trying to work in culturally grounded ways but felt constrained by organisational expectations.

Despite these pressures, many clinicians continued to centre whakawhanaungatanga in their work, drawing strength from cultural values and professional ethics. This speaks to the deep commitment of practitioners to relational approaches, even when systems do not fully support them. It also signals the need for services to better align with Indigenous relational frameworks if they are serious about equity and cultural safety.

5.2 Systemic Barriers to Integration

Despite strong commitments by many clinicians to work in culturally responsive ways, participants described persistent systemic barriers that undermined their efforts to integrate Mātauranga Māori into everyday practice. These barriers were not only logistical or procedural but deeply structural, rooted in a mental health system that was seen by many as fundamentally shaped by colonial assumptions and Western biomedical models.

P3 reflected, "We're still trying to do this work in a system that's colonial in its foundation. It wasn't made for us or our ways of working." This sentiment was echoed across interviews, with clinicians highlighting the ways that institutional structures often prioritised efficiency, individualised care, and standardised interventions that did not reflect Māori worldviews or lived realities.

Participants described the tension between trying to deliver culturally safe care and being pressured to meet performance targets, manage high caseloads, and follow rigid service pathways. P2 described feeling "squeezed from all sides—do more, with less, and faster—while also trying to be culturally safe and responsive." These pressures often forced clinicians to "bend the rules" or use their own time and resources to make space for whānau-centred and tikanga-aligned approaches. As P8 shared, "I have to

carve out the space myself. There's no funding for that. I do it because it's needed, but it comes at a cost."

Under-resourcing was a central theme, not only in terms of funding but also time, emotional capacity, cultural guidance, and institutional will. P6 explained, "The system will say it values this stuff, but then everything about how it's structured contradicts that. We're constantly hitting walls." These accounts resonate with the literature that critiques the failure of health systems to shift beyond rhetorical commitments to equity and actually reconfigure their operations to support Māori-led care (McNeill, 2009; Ministry of Health, 2014).

Participants also noted that even when policies existed to support cultural safety, they were often inconsistently applied, poorly understood, or lacked the teeth to drive meaningful change. This created environments where cultural practice was often seen as optional, secondary, or something to be "fit in" rather than embedded. Such contradictions have long been acknowledged in national health policy. The Ministry of Health's *Guide to He Korowai Oranga* (2014) affirms the importance of partnership, protection, and participation under Te Tiriti o Waitangi but offers limited direction on how to restructure mainstream mental health services to uphold these principles in practice.

For Māori clinicians in particular, these systemic conditions were experienced not just as barriers but as ongoing sites of resistance. Many described working within services that failed to reflect their values, having to justify or explain the use of Māori frameworks, and encountering subtle and overt forms of racism. These findings reflect broader critiques that the system often upholds a monocultural status quo, despite decades of evidence and advocacy for change (McNeill, 2009).

Ultimately, participants made it clear that integration of Mātauranga Māori cannot be left to the discretion of individual practitioners; it requires structural shifts, including investment, leadership, and genuine power-sharing. They emphasised that this must also be supported by meaningful change in health policy, ensuring that cultural safety is embedded at every level of service design and delivery. Without these changes, the risk remains that cultural safety will continue to be treated as a supplementary concern rather than a core responsibility of ethical and effective care. At the same time, participants noted that shifts in policy and funding priorities have the potential to further strengthen Kaupapa Māori health services, helping to grow models of care that are grounded in indigenous knowledge and leadership.

5.3 Reclaiming Cultural Knowledge and Leadership

A recurring theme across participant interviews was the need to reclaim and centre Māori knowledge, leadership, and authority within mental health services. Clinicians spoke of both the importance and the struggle of working in ways that reflect Te Ao Māori, often in systems where such approaches are marginalised or treated as optional.

Many described how Māori models of health and healing, such as *Te Whare Tapa Whā* and Kaupapa Māori approaches, are still not treated with equal value to Western clinical frameworks. They shared experiences of having to "justify" the use of Māori approaches or being expected to provide evidence in Western terms before such practices would be accepted. P3 explained, "We're constantly having to prove that our ways work. That they're not just cultural extras." This pressure to validate Indigenous knowledge using Western standards reflects a wider dynamic where Māori worldviews continue to be sidelined in clinical practice. Māori knowledge remains undervalued in many settings, treated as an "add-on" rather than a legitimate and essential foundation for well-being.

This marginalisation is often subtle and structural, embedded in systemic norms, policies, and decision-making processes that default to Eurocentric models. Several Māori clinicians described feeling unsupported or undermined when trying to integrate culturally grounded approaches into their roles. P2 stated, "They say they want equity, but then fight us every step of the way when we try to do things differently." These experiences speak to a broader pattern where Māori voices and leadership are frequently excluded from the design and direction of mental health services, despite being central to cultural safety and equity.

Māori clinicians also described being over-relied on for cultural knowledge and leadership, even when not formally recognised or resourced for it. P5 described this as "invisible work that nobody sees, but everyone relies on," while P3 explained, "We're expected to be everything to everyone, therapist, kaimahi, cultural advisor, aunty, activist." These roles are often taken on out of cultural commitment, but they come at a cost, leading to burnout, emotional exhaustion, and what participants described as cultural taxation, where Māori staff are expected to carry disproportionate responsibility without recognition or support. Over time, this inequity can undermine well-being, contribute to high turnover, and limit the sustainability of a Māori workforce within mainstream mental health services. These findings echo concerns raised in the literature about the burden of cultural taxation and the systemic undervaluing of indigenous health professionals (Came et al., 2020; Pitama et al., 2017).

The presence of Māori leadership was seen as both symbolically and practically transformative. P5 shared, "When Māori are in leadership positions, it signals to everyone that this knowledge matters,

that it belongs here." This aligns with Durie's (1998) emphasis on tino rangatiratanga (self-determination) as a foundation for Māori health advancement. Māori leadership helped shape service culture, clinical priorities, and staff accountability, fostering environments where culturally grounded care was more possible. P1 noted, "There's something powerful about learning from someone who walks the talk. It's not abstract, it's real." P4 added, "It can't just be the Māori staff carrying this. If the whole team's not on board, if management doesn't back it, it won't last."

These insights reflect the importance of rebalancing power and responsibility within mental health systems. As McNeill (2009) discusses, Māori practitioners often carry additional cultural and relational labour, navigating between worlds without adequate institutional support. Without shared ownership and structural change, the work of cultural leadership remains unsustainable.

Ultimately, reclaiming and embedding Māori knowledge and leadership requires more than inclusion; it demands a fundamental shift in how services value, prioritise, and support Indigenous expertise. Mātauranga Māori should not be relegated to the margins, but recognised as central to clinical care, staff development, and system transformation. This means backing Māori clinicians with the authority, resourcing, and institutional recognition they need to lead, without being left to carry the burden alone.

5.4 Embedding Culture into Everyday Practice

While high-level commitments to equity and cultural safety are now common across many mental health organisations, participants stressed that these values must be lived out in the daily rhythms of clinical work, not confined to policy statements or occasional cultural events. Clinicians repeatedly emphasised that culture cannot be separated from care; for many Māori clients, healing happens through practices, values, and relationships that reflect Te Ao Māori. As P8 explained, "Whānau involvement isn't just a nice-to-have. For us, it's part of healing. That should be recognised in how services are designed."

Participants described efforts to embed cultural values through their clinical relationships, assessments, supervision, and group work. These efforts were often creative, intentional, and locally informed. P6 shared, "We've created a wānanga-style group that runs over several weeks. It's not therapy in the Western sense, but it's deeply therapeutic for those who attend. It's grounded in tikanga, whanaungatanga, and collective healing." Such approaches were seen as powerful forms of culturally grounded care, often developed from the ground up by committed clinicians.

At the same time, many noted that these efforts often relied on the passion and unpaid labour of Māori staff and were rarely supported or sustained by formal structures. P4 put it simply, "It can't just be the

Māori staff carrying this. If the whole team's not on board, if management doesn't back it, it won't last." This underscored the need for collective responsibility and structural backing, so that cultural values are embedded not only in therapeutic interactions but also in service design, supervision models, and team culture.

Clinicians emphasised that embedding culture requires organisations to shift how they operate at all levels. P1 shared, "Culture shouldn't be a side project. It should be baked into how we do things, our assessments, our supervision, our HR policies." Several clinicians talked about rethinking clinical pathways to better align with collective and relational approaches to healing, moving away from narrowly defined clinical outcomes and toward more holistic, whānau-centred definitions of well-being.

Hiring more Māori staff and investing in their development was also identified as a critical part of embedding culture into the fabric of services. P4 said, "We need more of us in the room, not just to tick a box, but to shift the whole energy of a service. When we're there, things change." This echoes calls within the literature for Māori workforce development, equity in leadership roles, and culturally safe work environments (McNeill, 2009; Ministry of Health, 2014)

Overall, participants stressed that embedding culture is not just the job of Māori staff. True integration requires collective commitment, backed by policies, funding and leadership. When culture is valued across the entire team and resourced institutionally, it becomes a living part of the service, not an optional extra. These findings highlight that cultural safety is not just about what happens in the therapy room, but about the systems, structures, and relationships that shape that room. Embedding culture into everyday practice is both a clinical and institutional responsibility, essential to improving engagement, outcomes, and equity for Māori. This is also a matter of honouring Te Tiriti o Waitangi, which establishes partnership, protection and participation as obligations for health services (Ministry of Health, 2014). Embedding culture, there is not only a best practice but also a Treaty-based responsibility.

5.5 Access and Equity

Equity in access to mental health care remains a major concern for clinicians working with Māori whānau. Despite policy commitments to equity and cultural safety, participants described a system that often fails to meet people where they are, both literally and figuratively. Structural barriers such as cost, location, service design, and institutional bias were seen to disproportionately affect Māori, particularly those in rural areas or with limited financial means.

Clinicians consistently raised the issue of socioeconomic hardship as a key barrier to care. P1 commented, "A lot of our whānau can't afford to wait. But they also can't afford to pay. So, what

happens? They go without." This stark reality led many participants to express concern about the widening gap between those who can access timely, appropriate care and those who are left behind.

Several clinicians described working in underfunded or overstretched services where they were expected to fill in the gaps left by the system. P3 explained, "Sometimes we're driving people to appointments, writing letters to WINZ, chasing up housing. That's not in our job description, but if we don't do it, who will?" These acts of care, while necessary, reflect a system that places an unsustainable burden on clinicians while failing to address the social determinants of mental health.

Service design was another major concern. Participants spoke about how current systems are often not set up for Māori realities. P4 noted, "The system isn't set up for Māori, it's set up for people who already know how to navigate it, who speak the lingo, who can push back." This mismatch between service expectations and lived experience means that even when services are technically "available," they are not always accessible in a meaningful sense.

Access was also described as relational and cultural, not just logistical. As P8 summarised, "Access isn't just about getting through the door. It's about being seen, being heard, and being valued once you're in." This aligns with the literature on Indigenous mental health, which emphasises that accessibility must include cultural safety, trust, and relevance to the communities being served (Durie, 1998; McNeill, 2009).

Geographic access, particularly in rural areas, was another pressing issue. Participants working in regional settings described challenges with clinician shortages, long travel distances, and limited-service options. These limitations disproportionately impact Māori communities, many of whom live outside major urban centres. Without consistent investment in rural services and the Māori health workforce, these inequities are likely to persist.

The need for equity in access was also reflected in participants' calls for more Kaupapa Māori services and culturally grounded models of care. However, many noted that such services are under-resourced and stretched beyond capacity. As one participant pointed out, the scarcity of Kaupapa Māori services means Māori clients are often forced to choose between cultural fit and timely care, an unfair and avoidable compromise.

These insights echo long-standing findings from reports such as *Tatau Kahukura: Māori Health Chart Book* (Ministry of Health, 2015), which highlights the ongoing disparities in service access and outcomes for Māori. They also reinforce the argument that addressing access is not simply about increasing

availability but about rethinking service models to reflect the realities, needs, and aspirations of Māori whānau.

These findings also resonate with Durie's Te Pae Mahutonga model of Māori health, introduced in Chapter 2, particularly the dimension of te oranga (participation in society), which emphasises socio-economic well-being as central to health. Clinicians' accounts of whānau struggling with poverty, housing, and access barriers reflect precisely the kinds of inequities Durie highlights, where lack of economic security undermines health outcomes. As he argues, equity requires more than accessible services; it depends on enabling Māori to develop the economic skills and opportunities necessary to participate fully in society (Durie, 1999).

In sum, equity of access is not just about opening more doors; it's about redesigning the house. Without structural changes that address cost, location, service design, and cultural relevance, Māori will continue to face barriers that limit their ability to access mental health care on their own terms. As participants made clear, true equity requires systems that are not only open but also welcoming, affirming, and responsive.

5.6 Implications for Practice and Policy

In the absence of system-wide support for the integration of Mātauranga Māori, many clinicians described developing their own informal strategies to uphold culturally safe practice. These "workarounds" were not acts of rebellion, but deliberate, values-driven responses to the gaps and limitations within the mainstream mental health system. They reflected clinicians' deep ethical commitment to their clients and to working in ways that honour Te Ao Māori.

Participants shared that they often needed to "bend the rules" or stretch the scope of their roles in order to respond to the real needs of Māori clients and whānau. P2 explained, "Sometimes you just do what needs to be done. If that means shifting a session to a whānau home or using karakia even if it's not policy, then you do it. Because that's what's right for the client." For many, this type of everyday resistance was necessary to uphold cultural integrity and maintain therapeutic relationships.

Several clinicians spoke about consciously stepping outside of rigid clinical frameworks to prioritise relational care. P8 noted, "I've stopped asking for permission. If I know something is safe and culturally needed, I'll just do it. Waiting for the system to catch up means people miss out." This sentiment was echoed across the dataset; clinicians were often forced to choose between what was professionally sanctioned and what was culturally necessary.

This form of strategic resistance was not limited to practice alone; it also extended to advocacy and discourse. P3 shared, “We’re constantly having to prove that our ways work. That they’re not just cultural extras. I push back, because if we don’t, who will?” Challenging deficit-based narratives and asserting the legitimacy of Māori approaches was seen as part of the work, even if it came with personal or professional risk.

These actions reflect what the literature describes as culturally responsive resistance, where Indigenous and allied practitioners disrupt dominant clinical norms to uphold equity and cultural safety (McNeill, 2009). Rather than abandoning their professional roles, clinicians were reimagining them in ways that better aligned with the lived realities of Māori communities.

Non-Māori clinicians also engaged in forms of resistance, particularly those who had built strong relationships with Māori colleagues or cultural mentors. These participants described using their positions to back Māori leadership, challenge inappropriate practices, or advocate for more inclusive models of care. While often less visible, these acts of support were crucial in shifting organisational culture from within.

Despite their impact, these workarounds also came at a cost. Clinicians described the emotional labour of constantly navigating systemic resistance, and the pressure of having to “fix” structural problems through individual action. As previous sections have shown, this burden often fell most heavily on Māori staff, who were already stretched thin by dual expectations.

Ultimately, these workarounds reflect both the limitations and the potential of the current system. On one hand, they expose the rigidity and cultural inadequacy of dominant models of care. On the other hand, they show the ingenuity, courage, and commitment of practitioners who are finding ways to uphold mana-enhancing, culturally grounded practice, often in spite of, rather than because of, the system.

5.7 System Change and Sustainability

Across the interviews, clinicians were clear that without system-level change, the integration of Mātauranga Māori in mental health services will remain fragile, inconsistent, and overly reliant on individual effort. While participants demonstrated a strong commitment to culturally grounded practice, they also expressed frustration at the lack of institutional structures to support, sustain, and scale this work. Many described a sense of swimming against the current, working with heart and integrity, but without the backing needed to make lasting change.

Participants identified several areas where system transformation is urgently needed. One key theme was the importance of leadership that understands and actively supports the integration of Te Ao Māori within health services. P2 stated, “When leadership gets it, everything flows better. You don’t have to fight to be Māori. You can just be.” Others emphasised that cultural safety must be embedded into organisational strategy, not left to individual champions. As P5 put it, “Good leaders don’t just approve things, they model them. They create space and expectation for others to follow.” This aligns with the Ministry of Health’s (2014) He Korowai Oranga framework, which outlines the need for leadership that reflects and upholds Māori values at every level of service delivery.

Participants also highlighted the need to embed Mātauranga Māori into the organisational fabric of mental health services, across policies, supervision, workforce development, and funding decisions. P1 shared, “Culture shouldn’t be a side project. It should be baked into how we do things, our assessments, our supervision, our HR policies.” P8 similarly emphasised that whānau involvement and collective healing approaches should be designed into the service model, not treated as optional extras.

The presence of Māori leadership was seen as both symbolically and practically transformative. P5 noted, “When Māori are in leadership positions, it signals to everyone that this knowledge matters, that it belongs here.” However, several participants reported being undermined or unsupported in their attempts to lead change. P2 stated, “They say they want equity, but then fight us every step of the way when we try to do things differently.” These experiences reflect a broader pattern of institutional resistance to Māori leadership, despite policy commitments to equity and Te Tiriti o Waitangi.

To create sustainable change, clinicians argued that shared governance, equitable resource distribution, and structural reform are needed. P3 argued, “You can’t just tweak the system. You have to question the whole foundation who it was built for, whose voices it values.” Participants called for community-led design processes, Kaupapa Māori service models, and dedicated funding for Māori-led initiatives. P7 put it simply: “If we want equity, we need equity in decision-making. Māori need to be at the table, not just consulted after the fact.”

Clinicians also pushed for a shift away from reactive, crisis-driven care toward preventative, community-based approaches. P6 reflected, “We keep pouring money into ambulances at the bottom of the cliff. What if we funded the marae, the whānau, the people doing the work before it gets to crisis?” These calls reflect what McNeill (2009) describes as the need for a reorientation of services towards Indigenous worldviews that prioritise collective well-being, early intervention, and long-term healing.

Ultimately, participants viewed system change as a matter of equity, justice, and human rights, not just cultural inclusion. As P2 stated, “Until the system changes, we’ll keep having to work around it. But we’re not giving up, we’re building something better, from the inside and the outside.”

5.8 Strengths and Limitations

This study has a number of strengths that contribute to its value. It offers insight into the perspectives of practising clinicians, many of whom work closely with Māori and Pasifika communities. Their experiences provide an important view of how Mātauranga Māori is, or could be, integrated into mental health care. The use of semi-structured interviews allowed participants to share their stories in depth while keeping the conversations focused on the research questions. Thematic analysis, guided by Braun and Clarke (2022), supported a careful and reflexive interpretation of the data, while attention to cultural safety helped ensure that the research process was mana-enhancing. In addition, the relationships the researcher held with some participants helped foster trust and openness, which encouraged honest and reflective dialogue.

At the same time, the study has several limitations that should be acknowledged when interpreting the findings. The sample was small, with eight participants, and cannot be taken as representative of the broader mental health workforce. The majority of participants were Māori, meaning the perspectives of non-Māori clinicians are less visible in this study. Recruitment through my own professional and personal networks also shaped who took part and may have limited the diversity of views. While this facilitated access and trust, it also carried the risk of response bias, where participants might have felt inclined to provide answers that aligned with my own values or expectations. Finally, as with all qualitative research, the findings are interpretive and situated within a particular context. They should be read as in-depth insights into clinicians’ experiences rather than as universally generalisable conclusions.

Despite these limitations, the study makes a meaningful contribution by centring Māori knowledge and voices in conversations about mental health care. The findings highlight both challenges and possibilities, offering a foundation for future work that can build on and extend what has been learned here.

5.9 Summary

This chapter has explored how mental health clinicians understand and engage with Mātauranga Māori in their everyday practice, and the conditions that help or hinder its integration within Aotearoa’s

mental health system. Drawing on participant insights and existing literature, the discussion examined the relational foundations of culturally grounded care, the structural and systemic barriers that clinicians face, and the critical role of Māori leadership and knowledge in transforming practice.

While clinicians described a deep commitment to culturally responsive and relational ways of working, they often operate within systems that are misaligned with these values. Barriers such as institutional racism, policy constraints, and under-resourcing were shown to undermine both cultural safety and clinical integrity. At the same time, the findings revealed spaces of innovation, resistance, and quiet transformation, where clinicians are drawing on Māori knowledge, networks, and relational approaches to create more meaningful, whānau-centered care.

The chapter highlighted that sustainable change requires more than individual effort. It calls for structural reform, shared leadership, and the embedding of culture at all levels of service design and delivery. These insights directly inform the conclusions and recommendations presented in the following chapter.

Chapter Six: Conclusions and Recommendations

"Kia whakatōmuri te haere whakamua."
I walk backwards into the future with my eyes fixed on the past.

6.0 Introduction

This final chapter brings together the key insights from the research and outlines the conclusions, recommendations, and implications arising from the study. Building on the findings discussed in Chapters 4 and 5, this chapter revisits the central research question, how clinicians understand and integrate Mātauranga Māori in their practice, and considers what is needed to support its meaningful application within mental health care in Aotearoa.

The chapter begins by summarising the study's key findings and their contribution to the field. It then presents a set of recommendations for policy, training, and service delivery that are grounded in the voices of clinicians and aligned with existing literature. The limitations of the research are also acknowledged, along with suggestions for future research. The chapter concludes with final reflections on the significance of this work for moving toward a more culturally grounded and equitable mental health system.

6.1 Conclusion of Key Findings

This study set out to explore how mental health clinicians understand and integrate Mātauranga Māori in their everyday practice, and what helps or hinders that process. Through the voices of both Māori and non-Māori clinicians working across different regions and services, the findings provide a grounded and nuanced picture of what it means to deliver culturally responsive care within a system that is not always set up to support it.

One of the clearest findings was the importance of whakawhanaungatanga as a clinical imperative rather than a cultural add-on. Clinicians emphasised that building trust, acknowledging wairua, and centring connection are not just helpful, but essential to effective care for Māori. This reflects a broader understanding of well-being as collective and spiritual, not only psychological or individual.

However, many participants described significant systemic barriers that made it difficult to practice in ways that reflect Te Ao Māori. These included time pressures, policy constraints, underfunding, and performance targets that prioritised throughput over relationships. Māori clinicians spoke of carrying an unsustainable load, expected to be cultural leaders, mentors, and advocates, often without formal

recognition or resourcing. While their work is vital, it is often invisible and unsupported by the structures around them.

Despite these challenges, clinicians described a range of creative and courageous strategies for integrating Mātauranga Māori into practice. These included drawing on whānau networks, adapting service delivery to include wānanga and karakia, and forming alliances with kaumātua, iwi, and community leaders. Some described this as “quiet resistance”, deliberate choices to honour cultural values even when systems did not. Others spoke of the need for shared responsibility and stronger leadership to embed culture into the organisational fabric, not just rely on individuals to carry the load.

Participants also pointed to the critical need for structural change. This includes rethinking leadership, funding, policy settings, and the way services measure success. Many called for Māori-led governance, equity in decision-making, and sustained investment in Kaupapa Māori services. Clinicians were clear that meaningful change requires more than good intentions; it demands accountability, resourcing, and a genuine willingness to shift power.

Taken together, these findings show that the integration of Mātauranga Māori in mental health care is not only possible, it is already happening. But it is happening in pockets, often despite the system rather than because of it. The challenge ahead is to build on these efforts, remove the barriers, and ensure that culture is not treated as optional, but as foundational to the way we understand, deliver, and sustain mental health care in Aotearoa.

6.2 Recommendations

The findings of this study point to several actionable recommendations for improving the integration of Mātauranga Māori within Aotearoa’s mental health system. These recommendations reflect the insights and experiences of clinicians working at the interface of cultural knowledge and clinical practice, and aim to support culturally safe, equitable, and sustainable care.

6.2.1 Recognise Whakawhanaungatanga as Essential Clinical Practice

Whakawhanaungatanga should not be treated as a cultural extra; it is a must. Building trust and connection is not supplementary to care; it is foundational to healing, particularly for Māori clients. Time for whakawhanaungatanga should be protected and prioritised as part of core practice. This approach needs to be embedded into clinical training, service delivery, funding models and supervision frameworks. It is not just about engagement; it is about healing. Training programmes and workplaces must support clinicians to work relationally, reflect critically on power and identity, and prioritise connection as core to effective care.

6.2.2. Strengthen Māori Leadership and Workforce Development

Māori leadership must be visible, supported, resourced and empowered to guide service development, clinical practice, and workforce well-being. This includes leadership at the governance level, management, within clinical teams, and in training institutions. This includes creating pathways for Māori clinicians to lead service design, clinical innovation, and cultural strategy, without being expected to carry the burden alone. Investment in Māori workforce development should be ongoing, with attention to retention, mentorship, and well-being. When Māori are in decision-making roles, it sends a clear message that Te Ao Māori and Mātauranga Māori are central to the way services should operate, not peripheral.

6.2.3 Growing the Māori Clinical Psychology Workforce Must Be an Intentional, Well-resourced Priority

Many Māori students struggle to access and navigate psychology pathways, often facing cultural disconnection, academic pressure, and limited mentorship. Without clear, culturally safe progression pathways, many are lost before reaching registration. This contributes to the ongoing shortage of Māori clinicians and places unsustainable pressure on those already in the field.

Supporting Māori into, through, and beyond clinical training requires collaboration across tertiary institutions, funders, and mental health services. This includes culturally safe recruitment, academic and pastoral support, paid placements, mentoring, and transparent progression pathways. Universities, professional bodies, and services must work together to ensure Māori students are not only recruited, but also retained, supported, and empowered to thrive.

6.2.4 Reform Institutional Structures to Support Cultural Integration, Not Just Inclusion

Institutional change must go beyond surface-level acknowledgements of Māori culture or symbolic inclusion. Mātauranga Māori should not be treated as an optional or supplementary component, but as a legitimate and essential foundation for service delivery. This means embedding cultural frameworks and Māori knowledge into all aspects of mental health care, including assessment processes, clinical documentation, outcome measures, supervision models, organisational policies, and funding structures.

Cultural integration requires more than the goodwill of individual clinicians. It must be backed by sustained leadership, resourcing, and institutional accountability. This includes creating governance structures that enable shared decision-making with Māori, auditing organisational practices for cultural responsiveness, and establishing clear performance indicators for cultural safety and equity. Services

must also build internal capability through cultural supervision, reflective practice, and ongoing training that centres Te Ao Māori, not as a workshop, but as a way of working.

Without structural reform, the burden of cultural integration will continue to fall disproportionately on Māori clinicians, many of whom are already stretched thin. True integration requires organisations to actively shift power, reconfigure priorities, and hold themselves accountable to Te Tiriti o Waitangi obligations and to the communities they serve. Only then can cultural safety move from aspiration to reality.

Cultural integration must be accompanied by clear accountability measures, including cultural audits, mandatory cultural supervision, and regular reporting aligned with Te Tiriti o Waitangi.

Collectively, these recommendations call for a shift in how we understand and enact cultural safety, not as a checklist or policy add-on, but as a way of being that must be reflected in people, systems, and structures. If we are serious about equity for Māori in mental health care, then Māori ways of knowing, relating, and healing must sit at the centre, not the margins, of our clinical practice and institutional design.

6.3 Limitations of the Study

While this study offers meaningful insights into how clinicians engage with Mātauranga Māori in mental health care, it also has several limitations that are important to acknowledge:

- The sample was relatively small and made up of selected participants who were already engaged with or interested in culturally responsive practice. This may have influenced the findings, as those who took part were likely more motivated or confident in their ability to speak to the topic. Clinicians with limited exposure to Mātauranga Māori or who felt unsure about their cultural competence may have opted out, which means some perspectives, particularly those involving resistance or uncertainty, may be underrepresented.
- The cultural makeup of the sample, while inclusive of both Māori and non-Māori clinicians, was not fully representative of the wider clinical workforce in Aotearoa. For example, the voices of Pasifika, Asian, or other ethnic groups working in mental health were not explored in depth. This limits the generalisability of the findings across the full diversity of cultural perspectives and experiences within the sector.
- The study focused on the clinicians' experiences rather than clients or whānau. While it was valuable to explore what integration looks like from the provider’s side, future research should

also include the voices of Māori service users to understand how these practices are experienced and what effective care looks like from their perspective.

- Most interviews were based on or connected to mainstream mental health services, even if some had dual roles or relationships with Kaupapa Māori contexts. As a result, the findings may not fully capture the depth of Māori-led practice or the unique strengths and innovations emerging from Kaupapa Māori services.
- I acknowledge my position as the researcher. My cultural background, professional experiences, and personal worldview shaped how I engaged with participants, interpreted their kōrero, and presented the findings. I approached this research with cultural humility, self-awareness, and a strong sense of responsibility to honour the Kaupapa. At the same time, I recognise that all research is influenced by the lens we bring, our experiences, assumptions, and position within the work.

6.4 Recommendations for Future Research

This study highlights several areas that warrant further exploration. While it offers insight into the lived experiences of clinicians integrating Mātauranga Māori into mental health practice, it also raises questions that lie beyond its scope. Future research could build on these findings in the following ways:

- Include the voices of whaiora and whānau. This study focused on clinician perspectives. To develop a more complete understanding of what culturally safe, effective mental health care looks like, it is essential to centre the lived experiences of Māori clients and their whānau. Future research should explore how these groups perceive and experience the integration of Mātauranga Māori in care.
- Investigate the perspectives of service managers and policy makers. Many clinicians described tensions between their cultural commitments and the systems they work within. Understanding how leadership and policy-level decisions influence the integration of Mātauranga Māori would offer valuable insights for systemic reform.
- Examine differences across settings and professions. This study focused primarily on mental health clinicians, but future research could compare how cultural integration plays out in different regions (e.g., urban vs. rural), clinical disciplines (e.g., psychiatry, nursing, psychology), and service models (Kaupapa Māori vs. mainstream).
- Explore long-term impacts of culturally grounded practice. Longitudinal research could investigate how sustained integration of Mātauranga Māori influences outcomes for both

clients and clinicians over time. This may include impacts on well-being, therapeutic relationships, clinician burnout, and service responsiveness.

- Assess training models and workforce pathways. Given the concerns raised about the accessibility of psychology training for Māori students, research is needed to evaluate what models of recruitment, training, and mentoring are most effective in supporting Māori into and through the profession.
- Examine how services honour Te Tiriti o Waitangi in planning, policy development, and implementation. Future research could investigate how Treaty obligations are enacted (or neglected) at a service level, particularly in relation to partnership, participation, and protection. This would highlight the extent to which current systems align with the principles of tino rangatiratanga and equity and identify pathways for embedding Treaty commitments into everyday practice.

These recommendations reflect the need for further inquiry that is not only academically rigorous but also responsive to the needs and aspirations of Māori communities. Future research must be led by, or undertaken in genuine partnership with, Māori, grounded in Kaupapa Māori principles, and committed to transforming mental health care in ways that uphold Te Tiriti o Waitangi, tino rangatiratanga and equity.

6.5 Concluding Remarks

This study set out to explore how mental health clinicians engage with Mātauranga Māori in their everyday practice, and what helps or hinders that process. Clinicians across a range of roles and backgrounds spoke openly about their experiences at the interface of culture and care. They described the challenges of practising within systems that were not designed with Māori in mind, and the pressures of upholding cultural integrity in environments that often marginalise it. Yet, alongside these frustrations, they shared powerful examples of innovation, relational healing, and quiet transformation, demonstrating what is possible when Mātauranga Māori is genuinely valued and embedded.

The findings reinforce what many Māori have long asserted: culturally grounded care is not a ‘nice-to-have’; it is essential. When clinicians are supported to work in ways that centre whakawhanaungatanga, uphold tikanga, and reflect the lived realities of Māori, better outcomes become possible, not only for Māori, but for all. Transforming mental health care in Aotearoa is complex work. It requires more than policy tweaks or cultural workshops. It demands deep systemic change: shifting power, rethinking priorities, and embedding Māori leadership, knowledge, and values into every layer of practice and decision-making.

This thesis offers a small contribution to that wider Kaupapa. While it does not claim to represent all experiences, it amplifies the voices of those working to enact change from within the system. Their insights deserve not only to be heard, but to inform the way we design, deliver, and resource mental health care into the future. This is also a matter of honouring Te Tiriti o Waitangi, which establishes partnership, protection, and participation as obligations for health services. Embedding Mātauranga Māori into mental health care is therefore not only best practice, but a Treaty-based responsibility. The challenge now is to ensure these responsibilities are not symbolic but enacted in practice.

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Appendices

Appendix A: Participant Information Sheet

"Mātauranga Māori in Mental Health Care: Breaking Down Barriers for Better Outcomes"

Kia Ora, my name is Ariel Wetere, and I am currently studying towards a Master of Arts (Psychology) at Massey University Auckland campus.

You are being invited to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Ask questions if anything you read is not clear or if you would like more information. Take time to decide whether to take part. Thank you for reading this.

Colonization has entrenched inequities between Māori and non-Māori populations, which continue to affect current generations. Māori people have suffered political, economic, and social marginalization resulting in lower life expectancy, poorer educational and health outcomes, and stigmatization within healthcare. Despite initiatives aimed at improving Māori health, many may not be effectively implemented in practice.

The aim for this is to investigate how clinicians understand and incorporate Mātauranga Māori (Māori knowledge) into mainstream mental healthcare for Māori, as well as the barriers that impede the integration of Mātauranga Māori into practice. The ultimate goal is to identify strategies to overcome these barriers and promote better mental health outcomes for the Māori population. To achieve this, semi-structured interviews will be conducted with 6-8 clinicians, including private, public, and iwi providers, who work with Māori. Clinicians are being targeted for this research because they play a critical role in delivering mental health services to Māori, and their understanding and incorporation of Mātauranga Māori can significantly impact the effectiveness of mental healthcare for this population.

It is envisaged that this research will add to the existing body of indigenous mental health knowledge and the development of strategies to overcome identified barriers and promote the use of Mātauranga Māori in mental health care. This in turn will impact on the following:

- Government policy and practice
- Inform the development of cultural competency training for clinicians working with Māori.
- Enhance cultural safety of mental health services for Māori.
- Increase awareness of the importance of Mātauranga Māori in mental healthcare among clinicians, policy makers, and the wider community
- Contribute to the decolonization of mental health services.

Overall, this research has the potential to promote better health outcomes for Māori and contribute to the development of more culturally responsive and effective mental health services for indigenous populations globally.

You are being invited to take part in this research project as you have been identified as a clinician in one of the identified sectors and work with Māori. Your insights and knowledge on this matter are important and we value your experiences and views. It is up to you to decide whether to take part. If you do decide to take part, you can indicate your agreement by signing the consent form provided. You can withdraw at any time. You do not have to give a reason. Taking part in this research will involve you being interviewed. The interview will last approximately one hour and will be audio-recorded for research purposes.

The data will be anonymized and will not be used in any way which would enable identification of your individual responses (unless agreed to by participant). Data will be stored securely on a password-protected computer. Data will not be shared with any third parties. Signed consent forms and original audio recordings will be retained in digital format in a password protected file until after my degree has been conferred. A transcript of interviews in which all identified information has been removed will be retained for a further two years after this. Under the freedom of information legislation, you are entitled to access the information you provided at any time. There are no other commitments or lifestyle restrictions associated with participating. Participating in the research is not anticipated to cause you any disadvantages or discomfort. The potential physical and/or psychological harm or distress will be the same as any experienced in everyday life.

Results of the research will be published. You will not be identified in any report or publication. Your institution will not be identified in any report or publication. If you wish to be given a copy of any reports resulting from the research, please advise.

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer a question.
- withdraw from the study.
- ask questions about the study at any time during participation.
- provide information on the understanding that your name will not be used unless you give permission to the researcher.
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

If you have any questions about the study, please feel free to contact me at arielwetere@gmail.com. Alternatively, if you are concerned about any aspect of this study, you may contact Associate Professor Mathew Shepherd M.Shepherd1@massey.ac.nz – lead Supervisor of this study, or Professor Christine Kenney C.Kenney@massey.ac.nz.

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Prof Craig Johnson, Director, Research Ethics, telephone 06 356 9099 x 85271, email humanethics@massey.ac.nz".

Thank you for taking the time to consider this invitation.

Appendix B: Research Consent Form

"Mātauranga Māori in Mental Health Care: Breaking Down Barriers for Better Outcomes"

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read, or have had read to me in my first language, and I understand the Information Sheet attached as Appendix I. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded.
2. I agree/do not agree to the interview being image recorded.
3. I wish/do not wish to have my recordings returned to me.
4. I wish/do not wish to have data placed in an official archive.
5. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____hereby consent to take part in this study.

(Print name here)

Signature: _____ Date: _____

Appendix C: Low Risk Notification Letter

Dear:

Thank you for submitting a low risk notification for your research/teaching/evaluation.

This email is to acknowledge receipt of the low risk notification and to inform you that the details of your project have been recorded in our database for inclusion in the annual reports to the Health Research Council Ethics Committee (HRCEC) and the Massey University Research Committee (URC).

You may proceed with your research, though it is advisable to provide a couple of weeks before commencing, as all low risk notifications are checked for completeness and clarity by a Research Ethics Advisor. You may be contacted if your application is incomplete and/or further clarification is required.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis.

If a sponsoring organisation, funding authority (e.g., the Health Research Council) or a journal require evidence of ethical approval from a Human Ethics Committee (with an approval number), you need to complete a full Massey University Human Ethics application to be reviewed and approved by one of our Human Ethics Committees. Applications must be submitted and approved prior to the commencement of the research.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice- Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

If you have any concerns about the conduct of this research that you want to raise with someone other than the researcher(s), please contact the Research Ethics Office, email humanethics@massey.ac.nz. "

Please include the following statement on all public documents (e.g., information sheet, consent form) related to your project:

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.

If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

I wish you all the best in your research, teaching or evaluation activities and appreciate your thoughtful consideration of ethics principles and practices.

Ngā mihi nui,

Dr Brian Finch Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise

Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand T 06 951 6841; 06 951 6840 E humanethics@massey.ac.nz; animalethics@massey.ac.nz; gtc@massey.ac.nz

Appendix D: Interview Questions

Project Title: Mātauranga Māori in Mental Health Care: Breaking Down Barriers for Better Outcomes

Research Question: What are the barriers to incorporating Mātauranga Māori into mainstream mental health, and how can these barriers be overcome to promote better mental well-being outcomes for Māori individuals.

Questions:

1. What are the current mental health outcomes for Māori individuals in New Zealand, and how do they compare to non-Māori individuals?
2. How have historical and ongoing colonisation, racism, and discrimination impacted the mental health of Māori individuals and communities, and how can incorporating Mātauranga Māori into mental health care address these issues?
3. What is Mātauranga Māori, and how is it different from Western approaches to mental health care?
4. How do you, or how have you seen Mātauranga Māori incorporated into clinical practise?
5. What are the existing barriers to incorporating Mātauranga Māori into mainstream mental health care, and how have these barriers been addressed in the past?
6. How have Māori individuals and communities been involved in the development and implementation of mental health care services in New Zealand?
7. What are some examples of successful collaborations between Western mental health care providers and Māori healers or cultural practitioners?
8. What are the potential benefits and challenges of incorporating Mātauranga Māori into mainstream mental health care?
9. How can mental health care providers be better trained and equipped to incorporate Mātauranga Māori into their practice?
10. How can policy and funding support the integration of Mātauranga Māori into mainstream mental health care?
11. How can the incorporation of Mātauranga Māori into mental health care be sustained over time, and what are the key factors that contribute to long-term success and impact
12. How can the success of Mātauranga Māori integration into mainstream mental health care be measured and evaluated?
13. What are the next steps for promoting better mental well-being outcomes for Māori individuals through the incorporation of Mātauranga Māori into mainstream mental health care?
14. How can the incorporation of Mātauranga Māori into mainstream mental health care be adapted to meet the diverse needs of Māori communities across Aotearoa New Zealand, including those living in rural or remote areas?