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HE ARA KI TE AO MĀRAMA

A pathway to understanding the facilitation of taha
wairua in mental health services

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**Whānau-ā-Kai, Ngāti Kahungunu, Whakatōhea,
Ngāti Porou**

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Abstract

This research is about the facilitation of taha wairua (spirituality) in mental health services.

This research has been guided by kaupapa Māori frameworks and aimed to answer three questions:

- Whether taha wairua, supported by mātauranga Māori can be verified as a valid concept for use in mental health services
- How Māori cultural and clinical workers facilitate taha wairua within a kaupapa Māori approach, and,
- How the use and influence of taha wairua facilitates the inclusion of mātauranga Māori.

The increasing acceptability of alternative and holistic approaches to healing often with a spiritual component deserves serious consideration, especially within the area of mental health services.

The literature shows that indigenous views of health and healing are valid and deserve recognition and acceptance in mental health services. The Treaty of Waitangi, the founding document of New Zealand, underpins Māori rights to the facilitation of taha wairua practices in Western health systems. Current New Zealand mental health policy and legislation provide strategies to progress the facilitation of Māori healing interventions in mental health services. It is noticeable, however, that these strategies are not built on the Treaty of Waitangi but are built on health disparities. The literature also supports the concept that there is a place in the recovery process for both spirituality and religious beliefs, and Western and cultural interventions. The data illustrate how tikanga Māori either practised solely in its natural form or within the framework of Māori models of health is beneficial to

health outcomes for tangata whai ora and whānau when supported by the facilitation of taha wairua.

The research data provided the foundation for components that can produce a framework for the facilitation of the concept of taha wairua within the scopes of practice of kaimahi Māori in mental health services. Some standards for best practice in supporting taha wairua within the cultural component of all Māori working in mental health have also been proposed.

Māori do not have the critical mass to achieve all that has been raised in this research, and the principle of collective responsibility needs to be applied to provide the necessary resources and support to achieve implementation of Māori healing frameworks to facilitate taha wairua in mental health services.

It is hoped the knowledge gained from this research will be useful to policy makers and managers in gaining insight into the benefits of healing for tangata whaiora, whānau and kaimahi Māori through the provision of appropriate cultural interventions and in providing an appropriate environment to enable physical and spiritual healing to take place. It is also hoped Māori too will find this research of benefit, particularly to inform scopes of practice, thereby providing potential for new ways to achieve best practice cultural and clinical practice.

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Papakupu/Glossary of Terms

Ahi-kā	symbolic phrase for ‘home fires kept burning’
Āhuru mōwai	safe environment
Ārangī	unsettled, anxious
Ārangirangi	listlessness, idle
Aroha	love
Hapū	sub-tribe
Harirū	shake hands
Hauora	health
Haurangi	someone who is intoxicated, mad
Hinengaro	mental
Hōngī	pressing of noses
Hui	meeting, gathering
Io Matua Kore	highest spiritual (God) being
Iwi	tribe
Kaimahi Māori	Māori worker
Kaimanaaki	social worker
Kaitautoko	support worker
Karakia	prayer, incantations
Karanga	call
Kaumātua	respected tribal elder (male or female)
Kaupapa	purpose
Kaupapa Māori	for Māori, by Māori
Kāwanatanga	right to govern
Koha	gift of appreciation
Kōrero	talk
Kōrero pūrākau	traditional Māori stories
Kotahitanga	oneness, united

Mahitahi	co-operativeness
Mahi whakairo	Māori carving arts
Mākutu	illness attributed to a cultural violation
Mana	control, prestige, influence
Manaaki	caring in a reciprocal manner
Manuhiri	visitors
Marae	symbol of cultural identity
Māramatanga	enlightenment
Matakite	seer
Mātauranga Māori	Māori knowledge
Mate Māori	Māori illness
Mauri	life principle (essence)
Mihimihi	introductions
Mirimiri	massage
Moemoeā	dreams, future goal, vision
Motu	island
Ngā mahi matarua	a person performing two significant roles
Ngā mahi tōtika	best practice standards
Ngā umanga Māori	roles in facilitating taha wairua
Ngā taonga tuku iho	cultural treasures, knowledge, handed down
Noa	safe
Ora	well-being
Oranga	facilitate complete well-being
Ōritetanga	equality
Pākehā	European
Pakeke	adult
Pōrangi	headstrong, the mind fully occupied, out of one's mind, wandering, seeking
Poutama	denotes pathways to higher learning and skills
Pōwhiri	welcome ceremony
Pūmanawa	personal traits, characteristics
Punga	fern
Rangatahi	youth
Rangatiratanga	chieftainship

Rangi (nui)	sky father
Rau	leaf
Rongoā	traditional medicines, remedies
Rongo maraeroa	atua – god of peace
Rōpū	group
Tangata whai ora	a person seeking health
Te whare tapa whā	four cornerstones of health
Taha wairua	spiritual dimension
Tangata kainga	people belonging to a local area
Tangata whenua	people of the land
Tangihanga	funeral
Tapu	a state subject to risk, address with caution
Te ao Māori	the Māori world
Te ao tawhito	the old world
Te hunga mate	ancestors
Te hunga ora	the living
Teina	younger sibling
Te reo Māori	the Māori language
Te reo mihi	language of acknowledging
Tikanga	custom, protocols, procedures
Tinana	physical
Tino rangatiratanga	self-determination, autonomy
Tohunga Puna Ora	Māori traditional healer
Tuakana	older sibling
Tūmatauenga	atua – god of war
Tūrangawaewae	place where one stands
Uara	values, principles
Wahine	woman
Waiata	song
Wairangi	overly excited, infatuated, foolish
Whaikōrero	formal speeches
Whakamā	deep sense of embarrassment, shyness
Whakamomori	great sense of sadness
Whānau	family

Whanaungatanga	relationships
Whakapapa	genealogy
Whakataukī	proverbial saying
Whakawhanaungatanga	affirmation of bonds
Whenua	land

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Mai i te Kore ki te Pō, mai i te Pō ki te Ao Mārama, Tihei Mauri Ora!

CHAPTER ONE

Introduction

The increasing acceptability of alternative and holistic approaches to healing (Armstrong & McBride, 1995; Mental Health Commission [MHC], 1998), often with a spiritual component, deserve serious consideration especially within the area of mental health services. Growth in literature about the exploration of indigenous knowledge also added credence to pursuing this topic (Lukoff, Lu & Turner, 1992; Sims, 1994; Crossley, 1995, Turbott, 1996).

In New Zealand, pressures have arisen from what has been called the Māori cultural renaissance (Walker, 1992) and from the New Zealand's governmental policy of biculturalism, which has been defined as an 'adherence to the principles of the Treaty of Waitangi' (Orange, 1987) and its basic concepts of equity and partnership between Māori and the Crown (Durie, 1998a). He Korowai Oranga (2002), the New Zealand Government's most recent Māori Health Strategy, has four main strategic pathways. Pathway one recognises and values Māori models of health and traditional healing, which are holistic in their approach, and acknowledges te taha wairua, the spiritual dimension in health care. For Māori, the unseen elements (spiritual, mental and emotional) are as important as the seen or physical elements (Ministry of Health [MOH], 2002). Māori traditional healing is based on indigenous knowledge – it encompasses te ao Māori and a Māori view of being.

This thesis explores the concept of taha wairua and its role in clinical practice with a group of Māori cultural workers and clinicians working in Māori Mental Health services. There were three points of interest embedded in this investigation: whether te taha wairua is supported by mātauranga Māori (Māori knowledge) and

is legitimated within clinical practice; how Māori clinical and cultural workers facilitate taha wairua within a kaupapa Māori approach; to elucidate an understanding of how the use and influence of taha wairua facilitates the inclusion of mātauranga Māori. Ultimately it is hoped the knowledge gained from this research will add to the developing body of knowledge on kaupapa Māori theory and will inform practice, thereby providing new ways to enhance best cultural standards of professional practice, particularly for Māori, along with clinical best practice.

The International Context

This section provides an overview of international organisations that support indigenous peoples and their access to appropriate mental health services. Two major players internationally support Māori rights in the development of mental health services and inform the New Zealand Government's health policy in setting appropriate direction: the World Health Organisation (WHO) and the Working Group on Indigenous Populations (WGIP). As one of the 192 member states' belonging to the United Nations New Zealand is able to participate in these two organisations and their initiatives. The United Nations was set up after the Second World War with a specific focus on human rights.

World Health Organisation (WHO)

The World Health Organisation, established in 1948 under the General Assembly of the United Nations, is a specialised agency for health, responsible for providing worldwide information, counsel and assistance in the field of health; promoting cooperation among scientific and professional groups that contribute to the advancement of health; and advancing work in the prevention and control of international spread of diseases (World Health Organisation (1948), <http://policy.who.int>).

One of the World Health Organisation's constitutional principles states, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". The Organisation views health as "a state of complete physical, mental and social well-being and not merely the absence of

disease or infirmity” (Cohen, 1999: iv). While Māori also view health broadly and support the general thrust of the World Health Organisation’s definition, they have challenged the Organisation to broaden its view of health and to recognize also the importance of wairua (spirituality) and the whānau (Dyall, 1988). Other indigenous peoples, such as North American Native Indians, also have healing beliefs that involve spirituality (Lamberg, 2000). A commitment by the World Health Organisation to recognize ‘spirituality’ within its view of health would help confirm governments’ work in progressing appropriate health care services for their indigenous populations.

Working Group on Indigenous Populations (WGIP)

This Working Group is an auxiliary arm of the Sub-Commission on the Prevention of Discrimination and Protection of Minorities, itself an auxiliary of the United Nations Commission on Human Rights. The Group was established in 1982 to:

- bring about dialogue between governments and indigenous people
- review national developments in the protection of human rights and fundamental freedoms of indigenous people, and
- develop international standards on the rights of indigenous people (Te Puni Kōkiri, 1994).

Of specific interest to Māori is the development of the draft Declaration on the Rights of Indigenous Peoples, which was completed in 1993 and is currently undergoing critique and a negotiation process by governments. The process so far has taken several years and it is expected the text will undergo further changes as governments discuss it in the United Nations. The Declaration, once adopted, will not be a treaty and will not be legally binding on United Nations members; it will, however, be a very solemn document and countries will be expected to comply with it fully (Te Puni Kōkiri, 1994).

The draft Declaration on the Rights of Indigenous Peoples and the Treaty of Waitangi

The draft Declaration on the Rights of Indigenous Peoples articulates many principles recognised in the Treaty of Waitangi and by Māori as essential in the development of Māori mental health services. The Treaty of Waitangi, signed in 1840, was designed to protect the traditional possessions of Māori (Spoonley,

1988). In 1992, the New Zealand Government, in response to Māori issues in the health sector, stated: “the Government regards The Treaty of Waitangi as the founding document of New Zealand, and acknowledges that it must meet the health needs of Māori and help address the improvement of their health status”. In a further statement the Government added that services must “recognise the special needs and cultural values of Māori” (Department of Health 1992:8).

The Government’s further commitment to the Treaty and to Māori health in respect to legislation is acknowledged in section 4 of the New Zealand Public Health and Disability Act 2000¹ and is also evident in the New Zealand Health Strategy (MOH, 2000) and He Korowai Oranga: the Māori Health Strategy (MOH 2002). The Treaty of Waitangi has four articles: the first provides for the responsibility to govern; the second, the responsibility to protect Māori interests and where necessary to redress grievances; the third, the responsibility to ensure Māori people enjoy all the rights and privileges of citizenship; and the fourth article, not often alluded to in national documents but very relevant to this thesis topic, provides both parties with the right to control their own spiritual beliefs (Durie, 1998a; Turbott 1996). For policy makers to incorporate the Treaty of Waitangi into policy, it was necessary to define key principles. Brookfield (1999) comments, “principles are the underlying mutual obligations and responsibilities which the Treaty places on the parties. They reflect the intent of the Treaty as a whole and include, but are not confined to, the express terms of the Treaty” (p. 153).

Key bodies that have identified the principles of the Treaty, which are important for discussions on Māori mental health, include the Waitangi Tribunal², the Royal Commission on Social Policy³ and the New Zealand Government (Durie, 1998a).

¹ Part 1, section 4 of this Act contains specific reference to the Treaty of Waitangi. This clause states that “in order to recognise and respect the principles of the Treaty of Waitangi and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decision making on, and to participate in the delivery of, health and disability services”.

² The Labour Government under the Treaty of Waitangi Act 1975 set up the Waitangi Tribunal. The Tribunal’s effectiveness was increased in 1985, when the Treaty of Waitangi Amendments Act was passed, giving the Tribunal power to look at claims dating from the time of the 1840 signing of the Treaty (Barlow, 1991:154)

³ The New Zealand Government set up the Royal Commission on Social Policy in October 1986. (RCSP, 1988 Government Printer Wellington)

Table 1.1: Principles of the Treaty of Waitangi

	Waitangi Tribunal	Royal Commission On Social Policy	Crown Principles for Action on Treaty Issues
Main Principles	Partnership Rangatiratanga Active Protection	Partnership Participation Protection Options	Kāwanatanga (govern) Rangatiratanga (autonomy) Ōritetanga (equality) Redress

Source: Durie, 1998:90; 2001:260

I note a few relevant examples of key principles, drawn from earlier reports of the aforementioned Government strategies that are applicable to Māori mental health and that align to some of the articles in the draft Declaration on Indigenous Peoples Rights:

- Tino rangatiratanga, the principle of *autonomy* is defined as ‘the right for Māori to manage their own policies, resources and affairs (within the rules necessary for the operation of the State)’ (Durie, 1994:175) and,
 - Article 3 of the draft Declaration states: “indigenous peoples have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.
- The principle of *options*⁴ gives Māori a choice to join the culture and lifestyles of the mainstream, or to continue to live according to tikanga Māori or to ‘walk in two worlds’ while,
 - Article 9 declares: “indigenous peoples and individuals have the right to belong to an indigenous community or nation, in accordance with the traditions and customs of the community or nation concerned. No disadvantage of any kind may arise from the exercise of such right”, and,
 - Article 24 provides for indigenous peoples to “have the right to access, without any discrimination, to all medical institutions, health services and medical care”.

⁴ Derived from the Waitangi Tribunal (1988), *Muriwhenua Fishing Report* (Wai22), Waitangi Tribunal, Wellington p.195

- The principles of *participation* and *partnership* as defined by the Royal Commission on Social Policy (1988) outline the processes whereby Māori and the Government or its agencies are equal partners and anticipates that Māori and Pākehā (European) are partners and that Māori participate in all levels of society, including decision-making arenas and in the delivery of services (Durie, 2001).
 - Article 23 provides opportunity for indigenous peoples, to “have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to determine and develop all health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions”
- *Active Protection* is a principle that encourages the Crown (government) to actively protect the interests of Māori. Durie (2001) expands this to include social, cultural, spiritual and physical assets and also in the reduction of disparities between Māori and Pākehā.
 - Articles 12 and 13 provide indigenous peoples with rights to “practise and revitalize their cultural traditions and customs” and...”to manifest, practise, develop and teach their spiritual and religious traditions, customs and ceremonies”.
 - Article 24 offers protection in “the right to their traditional medicines and health practices, including the right to the protection of vital medicinal plants, animals and minerals.

Another important part of the United Nations Commission on Human Rights has been to formulate an accepted and responsive definition of what makes a people indigenous. Moana Jackson, a Māori representative at the 1996 IWGIA June Conference, argued that attempts by some to assume a right to define indigenous peoples was “to further deny their right to self-determination, since there can be no more fundamental expression of that right than the ability to determine who one is through self-identification” (IWGIA, 1996:251).

Definition of Indigenous People

How to define indigenous people remains a significant issue. The World Health Organisation report (Cohen, 1999) on the mental health of indigenous peoples presents several definitions for consideration. Previous to this report the definition was, “those peoples established and living on lands prior to European contact, such as those living in North and South America before colonization began in the late 15th century and those living in Oceania, the aboriginal groups in Australia and the Māori in New Zealand” (Cohen, 1999:4).

Following that, however, the most widely used definition comes from the International Labour Organization’s Convention No. 169 of 1989, which defines two broad categories of indigenous peoples, and covers ethnic diversity:

- those tribal peoples “whose social, cultural and economic conditions distinguish them from other sections of the national community and whose status is regulated wholly or partially by their own customs or traditions or by special laws or regulations” and,
- “peoples in independent countries who are regarded as indigenous on account of their descent from populations which inhabited the country, or a geographical region to which the country belongs, at the time of conquest or colonization or the establishment of present state boundaries and who, irrespective of their legal status, retain some or all of their own, social, economic, cultural and political institutions” (Cohen, 1999:5).

Again, although the above definition is the one more commonly used, the WHO 1999 report then presents a pragmatic approach as taken by the World Bank based on research of poverty among the indigenous peoples of Latin America and identifies and relies on three variables – language, self-perception, and geographical concentration (Psacharopoulos & Patrinos, 1994).

All the above definitions, however, do not consider the sense of the relationship of indigenous peoples to their actual state of life style and the influence of political forces. Maybury-Lewis, a longtime advocate for the rights of indigenous peoples, believes a key feature of the term ‘indigenous’ is the sense it carries of

marginality. In essence, his view includes the impact that colonization has on groups who have been conquered by those peoples racially, ethnically or culturally different from themselves and who are marginalized by conditions created by those who may claim jurisdiction over them (Maybury-Lewis, 1997). Subsequently, the issue of migration must be taken into account, for those groups who move from rural (traditional lands) to urban areas in search of economic opportunities, as has happened for example with Native Americans and with Māori (Somervell, Manson & Shore, 1995; Durie, 1997). It would seem therefore that an ‘ironclad’ definition of the term ‘indigenous peoples’ fails to convey an adequate sense of their diversity. The draft Declaration in article 8 has been further interpreted in that “indigenous peoples have the collective and individual right to maintain and develop their distinct identities and characteristics, including the right to identify themselves as indigenous and to be identified as such” (Te Puni Kōkiri, 1994:21). Consequently, the WHO 1999 report (in line with Moana Jackson’s view) recommends that in relation to mental health a more appropriate definition of ‘indigenous peoples’ must include as key elements:

- self-identification
- self-perception
- language (culture) and,
- relationship to the land (Cohen, 1999:6).

All the above characteristics have, in the experience of Māori, either been positive or negative contributors to mental illness or well-being, dependent on the individual’s and the whānau’s level of access and exposure to traditional cultural resources as well as on other socio-economic indicators.

Indigenous peoples and mental health – a comparison with Māori

To put this within an international perspective, I will briefly outline the experience of indigenous peoples, their beliefs and attitudes concerning mental health, and how these values may compare with the indigenous people of New Zealand, the tangata whenua (people of the land) known more commonly as Māori. In particular I will focus on indigenous concepts of spirituality, both broadly and within mental health.

The WHO 1999 report (Cohen, 1999) provides illustrations of challenges to and repression of culture through colonization tactics such as war, development and forced dislocation from ancestral lands, waterways and forests, all of which not only served to oppress and repress indigenous culture and limit or sever access to traditional resources but also generated loss of economic self-sufficiency and opportunity, and good health. Other examples included American Navajos and Hopis of the Southwest United States, relocated so that mineral resources could be developed in northern Arizona, and Australian Aborigines driven off their lands by cattle ranchers (Cohen, 1999). It is now well documented in Māori history, that there was large-scale confiscation of millions of acres of Māori land under the guise of Government policy during the land wars. These included the New Zealand Settlements Act 1863 for the confiscation of land from tribes ‘deemed to be in rebellion’, and the Suppression of Rebellion Act 1863, which suspended habeas corpus (Orange, 1987; Walker, 1996).

Māori and their historical colonial experience have much in common with other indigenous peoples such as the American Indians; so too with their experience of mental illness. It is worth examining here how one neuropsychiatric disorder, depression, may be misdiagnosed. Over two decades ago, Kleinman (1977) wrote, “the depressive syndrome represents a small fraction of the entire field of depressive phenomena. It is a cultural category constructed by psychiatrists in the West to yield a homogenous group of patients” (p. 3).

A recent review of the literature on the interrelationships between culture and depression concluded that a better understanding of the phenomenology of depression must also take into consideration the social contexts and cultural forces that shape one’s everyday world, that give meaning to interpersonal relationships and life events (Durie, 1994; Manson 1995). Furthermore it is widely believed the manifestation of depression in indigenous populations tends to take the form of somatic symptoms rather than psychological ones, and current tools for diagnosing psychiatric illness, such as the Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSMIV, 1994), limit the use of cultural explanations and understandings to ensure appropriate diagnosis (Kleinman, 1988).

There are some similarities for Māori and American Indians in their presentation to mental health services. Manson, Shore and Bloom's (1985) research amongst American Indians noted that depression was the most frequently reported problem for those who present at mental health treatment facilities, and is easily misdiagnosed. They also reported that its relationships to other conditions such as alcoholism, antisocial behaviour, physical illness, and grief, are not well understood. This research found that major depression was secondary to an alcoholic condition in every male subject. Other research has also examined the problems inherent in the investigation of psychiatric disorders, as well as the relationship between depression and problem drinking among American Indians (O'Neill 1989; 1993). The findings from this research emphasised the importance of native understandings of psychiatric illness in the attempt to arrive at better explanations of mental illness among these peoples. Two common psychiatric conditions that were manifested and displayed the psychiatric significance of 'flat affect' were 'hallucinations involving spirits' and 'prolonged mourning', all of which were reported as more frequent among American Indians. These manifestations have been treated as symptoms of serious disturbance. O'Neill (1993) concluded from this investigation of drinking and depression at the Flathead Reservation in the United States that while these behaviors might indicate psychopathology, depression and drinking, they might also have positive connotations:

Depression...can be a positive expression of belonging... To be sad is to be aware of human interdependence and the gravity of historical, tribal, familial and personal loss. To be depressed, and that includes tearfulness and sleep and appetite disturbances, is to demonstrate maturity and connectedness to the Indian world. A carefree attitude is often thought of as indicative immaturity. (O'Neill, 1993:461)

This research highlights the similarities amongst indigenous peoples experiencing mental unwellness. There is a general understanding that other variables such as social and economic conditions must be taken into account and are well known in relation to the deterioration of mental well-being (Alderete, 1998). Poor health has been related to living conditions, lifestyle, socio-economic disadvantage, smoking, alcohol, food and nutrition (Durie, 1994). Dislocation, poverty and repression of

culture are also common factors shared by indigenous peoples experiencing poor health outcomes (Psacharopoulos & Patrinos, 1994).

The American Indian examples are not unlike those for the Māori experience. Definitions of psychiatric illness used by mental health services in New Zealand as provided for in the 'DSMIV' do not reflect cultural concepts such as *mate Māori*⁵ (illness attributed to a violation of an indigenous spiritual tradition or belief) and this non-recognition can become a barrier to appropriate assessment and treatment and a further barrier to early intervention. Like the North American Indian experience, alcohol-related admissions for Māori males is the leading cause of admission and the second most common cause for Māori women (Te Puni Kōkiri, 1998). Admissions for non-psychotic illnesses such as depression are declining for Māori as these problems are now being cared for on an outpatient basis or in community-based services (Dyall, 1997). This researcher's belief is that most Māori would not agree in their understanding that depression and drinking may also have positive implications. While psychotic illness is present in every culture, the point of entry to that diagnosis for Māori seems to be a group of illnesses that have no counterpart in traditional Māori society, namely drug and alcohol disorders (Te Puni Kōkiri, 1996). Depression is a predominantly Western illness and there are no terms in Māori culture that relate simply to this illness. *Whakamomori* is a Māori term and one meaning, defined by *kaumātua*, describes it as 'a great feeling of sadness due to the loss of land' (Te Puni Kōkiri, 1996). The reality for the majority of Māori dispossessed from their traditional resources is their inability to regain those resources because of the permanence of the dispossession. Most Māori could only hope for 'possible' access to those resources. There are positives, though, within the dimension of 'hearing voices' and 'prolonged or deep grief'. For Māori, experiencing such phenomena can bring an awareness of their connectedness to the Māori world. More so if culturally appropriate assessment, treatment and interventions are in place in mental health services.

⁵ See Mauri Ora, Durie (2001:24) for a more detailed description

Mental Health Services in New Zealand

Māori, the indigenous people of New Zealand, represent 15 percent of the population and are over-represented in health statistics (MHC, 1998). Mental health services in New Zealand had their roots in a system of law and order rather than health. This type of ‘institutionalized’ mental health system was modeled on that of the old colonial British regime. The first asylum was established in 1844, in Wellington, and was attached to a prison. This was 4 years after the Treaty of Waitangi laid the foundations for the development of a bi-cultural society. Abbott and Haines (1985) report that psychiatric institutions were not established to meet the needs of Māori but rather to provide asylums for new settlers who were considered mentally disturbed. Although mental health services in New Zealand have undergone some radical changes, particularly over the past 3 decades, with a greater emphasis on community delivery and a parallel reduction in the number of hospital beds, Māori would question whether the change has been radical enough. Presently, “Māori are more likely to be admitted at the instigation of a welfare or justice service and when this happens, the admission is to a mainstream service” (MOH, 1997:9). There has also been a shift in balance between clinical interventions and community approaches to care and rehabilitation. Since that time, however, questions have arisen about the extent of adequate funding to facilitate these changes, i.e. essential skilled workforce numbers; appropriate accommodations; effective whānau support and community support systems. Making New Zealand Health services relevant to the people who use them has been an ongoing challenge for policy makers and managers. The universal approach to social policy at least as it had been practised in New Zealand relied on excessive reference to the norms of the majority and fell well short of being able to locate Māori at the centre of the exercise or even to seriously incorporate Māori needs (Durie, 1998a).

Major Health Reforms

Since 1991 some major changes have occurred in the health system. In 1991 under the National Government, four Regional Health Authorities were established to undertake the purchaser roles that had previously been carried out by Area Health Boards; most of the large hospitals (Crown Health Enterprises) would operate more along business-market ideologies (National Health Committee,

2002). This change was significant in that the political environment in New Zealand once renowned for its State Welfare provision ‘from the cradle to the grave’ now introduced ‘user pays’ system for medical care (Ashton, 1992; Crowe, 1997). A change to a Labour Government in the late 1990s saw the introduction of another structural change with the disbandment of the Regional Health Authorities and the devolution of health care purchasing to a single, central purchasing agency, the Health Funding Authority, in 1998 (National Health Committee, 2002). More recently, we have seen a devolution of funding back to the regions, with 21 District Health Boards⁶ (DHBs) now responsible for purchasing most government-funded health care services for the population within specific geographic districts (National Health Committee, 2002). The National Health Committee sees that potential benefits for Māori could include more effective relationships with iwi (Māori tribes) and other Māori groups thereby creating increased participation on all levels in regards to health policy and service development and delivery and an increase of mental health services for Māori by Māori. The Committee also sees there are potential risks in that Māori may be underrepresented at governance level, participation of Māori within the sector may continue to be inadequate, and the existence of 21 DHBs may allow unacceptable regional variability to develop that could threaten present Māori health gains and limit future Māori health development.

Current Policy Direction

The New Zealand Government’s commitment to improving Māori health status and reducing inequalities has been defined through a number of goals and objectives outlined in:

- The New Zealand Strategy (MOH, 2000)
- He Korowai Oranga: Māori health Strategy (MOH, 2002)
- Building on Strengths: A Guide for Action. A new approach to promoting mental health in New Zealand/Aotearoa (MOH, 2002a)

The key strategic trends include: the shift to population health approaches (MOH, 2000); the integration of Māori models of health into the health care system and

⁶ For more information about DHBs and their role in supporting Māori health gain see “Improving Māori Health Policy, National health Committee, June 2002 (pp. 19 –25).

the expansion of perspective beyond individual health needs and problems to encompass whānau ora (family well-being) and strength-based approaches; building on the Māori provider and workforce development of the 1980s and supporting rangatiratanga with avenues for Māori to determine priorities, directions and service delivery for Māori health (MOH, 2002); and a new focus on ‘public’ mental health including prevention, promotion and intersectoral action that address the wider socio-economic determinants of mental health and mental health inequalities as well as treatment (MOH, 2002a).

Key Government policy documents to progress the improvement of Māori mental health status are: Looking Forward: Strategic directions for mental health service (MOH, 1994); Moving Forward: The national mental health plan for more and better services (MOH, 1997); Blueprint for Mental Health Services in New Zealand: How things need to be (Mental Health Commission, 1998); and Te Puāwaitanga: Māori Mental Health National Strategic Framework (MOH, 2002b).

The underlying objective of all these strategic documents is to produce *more* and *better* mental health services inclusive of Māori mental health services and Alcohol and Other Drug services. There are two main goals for mental health services: to decrease the prevalence of mental illness and mental health problems within the community, and to increase the health status of and reduce the impact of mental disorders on tangata whai ora⁷ (Māori consumers), whānau, caregivers and the general community. There are seven strategic directions – more mental health services; more and better services for Māori; better mental health services; balancing personal rights with protection of the public; developing and implementing the national drug policy; developing the mental health infrastructure; and strengthening promotion and prevention.

This means the Government’s strategy is about both the quantity and quality of services. The strategy aims to increase mental health services so they are able to meet the needs of 3% of the adult population and 5% of the child and youth

⁷Tangata whai ora means ‘a person seeking health’ and refers to a person who is the subject of care, assessment and treatment processes in mental health – acknowledgements to Professor Mason Durie. Tangata whai ora is frequently written as tangata whaiora, the former term is used throughout this research on the basis of advice given to the Ministry of Health by Te Taura Whiri i Te Reo Māori, who indicate that whai ora means ‘in search of well-being’ whereas whaiora means ‘who has well-being’. (MOH 2000a)

population by 2004. The Blueprint (MHC 1998) focuses on the ‘more and better’ services needed to achieve these access objectives and takes a recovery approach to mental health service delivery with a particular emphasis on meeting the mental health needs of Māori. Based on need and to reduce disparity, the Blueprint suggests the target for access to mental health services for Māori should be double that of the general population, i.e. “6 % rather than 3 %” (MHC, 1998:57).

The new environment created by this change has seen more opportunities for mental health services for Māori to be delivered by Māori and mainstream. In 1999 there were approximately 125 providers contracted to provide Māori mental health services, compared with a total of 82 in 1997 (MHC, 2001). Of critical importance in the new environment created by these changes will be the ways in which Government objectives are interpreted and met.

Te Puāwaitanga (MOH, 2002b), the Māori mental health strategy, aims to ensure national consistency in planning and delivering mental health services for tangata whai ora and their whānau. The framework comes under the umbrella of the national mental health strategy of ‘more’ and ‘better’ services for the 3% of people experiencing serious mental health disorders, including “more and better services for Māori”. It includes five goals specifically for District Health Boards, reflecting their statutory responsibilities for improving Māori health outcomes and reducing Māori inequalities through planning, funding and delivering services. The framework has the following 5-year goals:

- to provide comprehensive clinical, cultural and support services to at least 3% of Māori, focused on those who have the greatest mental health needs
- to ensure active participation by Māori in the planning and delivery of mental health services reflects Māori models of health and Māori measures of mental health outcomes
- to ensure 50% of Māori adult tangata whai ora will have a choice of mainstream or kaupapa Māori community mental health service
- to increase the number of Māori mental health workers, including clinicians, by 50% over 1998 levels, and

- to maximize opportunities for intra- and intersectoral co-operation.

The framework provides specific actions that DHBs can adopt over a 1-, 3- and 5-year period, enables the Ministry of Health to monitor achievement of the goals, and also contains guiding principles that support Māori health development and health gains. These guiding principles are that:

- all mental health services covered by the Te Puāwaitanga strategy will actively acknowledge the special relationship between the Crown and tangata whenua under the Treaty of Waitangi
- the services should reflect Māori realities and Māori priorities
- the services must protect and enhance the cultural and personal safety of tangata whai ora and their whānau
- improved effectiveness requires better specification of Māori mental health services and consistently applied standards
- Māori models of well-being require mental health initiatives to occur in an inclusive and integrated manner
- capacity building of Māori service providers is a priority
- intersectoral and intrasectoral collaboration is essential to implement holistic models of care and well-being.

The Treaty of Waitangi and its relevance to Māori Mental Health

Turbott (1996) states:

in the context of spirituality, mental health and mental disorder are treaty guarantees. Article two of the Māori version of the Treaty incorporated social and cultural guarantees – Māori control over things Māori and not exclusively property, as narrowly and improperly defined within the English version of the Treaty and article four of the same version guarantees to both parties the right to control their own spiritual beliefs. (p. 722)

As treaty partners, Māori have the right to access mainstream and/or kaupapa Māori services as they choose. There are currently insufficient kaupapa Māori

services available, and as mainstream services are not capable of catering adequately for the needs of Māori (Durie, 1998b), Māori communities are developing various initiatives and reconfiguration of services to meet tangata whai ora rather than organisational need. More importantly, Māori communities continue to develop tikanga models of practice – Te Whare Tapa Whā, for example, recognises traditional cultural practices based in whanaungatanga – so they may be versed within a contemporary environment.

Māori ill health has been attributed (by Māori) to changes that have occurred in Māori culture since colonization; key factors include alienation from the land and the loss of spirituality, loss of traditional group support (whānau and hapū), mana⁸, and identity (Rankin, 1986; Durie, 1998b). Kaupapa Māori mental health services are a recent development, and much of the burden for their development has weighed heavily on a few⁹ within the Māori health community. Like the Treaty of Waitangi, the services are ill defined in relation to clinical practice. In the absence of practical cultural standards, questions have arisen about the clinical validity of Kaupapa Māori Mental Health services, making it sometimes difficult to implement cultural interventions within mental health services (Dyall, 1997). The holistic and whānau, hapū, iwi focus on health is often marginalized by the assumptions of the Western psychiatric tradition which is individualized and symptom based (Durie, 1998b). Durie, (1985) and Turbott (1996) assert that notions of health, especially of mental health, are bound by culture and time, and that any consideration of Māori mental health must acknowledge the unique cultural heritage and cultural reality in which Māori people live. Government documents such as the Ministry of Health's *Looking Forward* (1994) and *Moving Forward Strategic Directions for the Mental Health Services* (1997), state that mental health services in the future will need to be culturally safe and able to provide treatment at a spiritual, physical, emotional and cultural level. This applies to both mainstream mental health services and any services managed and delivered by Māori themselves (MOH, 1997). In an attempt to achieve this goal it

⁸ "Mana as a concept is beyond translation from the Māori language. Its meaning is multi-form and includes psychic influence, control, prestige, power, vested and acquired, authority and influence, being influential or binding over others, and that quality of the person that others know she or he has!" (Pere, 1997)

⁹ Lack of a skilled Māori workforce in the New Zealand Mental Health Services has historically placed the burden on the shoulders of a 'few'.

is important to acknowledge that essential characteristics of a Māori health service must be identified according to health objectives rather than political objectives (Durie, 1996). In this respect four characteristics are of special interest:

- A cultural context that makes sense to tangata whai ora and their whānau
- Clinical inputs that are consistent with the best possible outcomes
- Outcome measures that make sense to tangata whai ora and their whānau and are tangata whai ora focused
- The integration of the health service with other aspects of positive Māori development.

Services must also integrate clinical treatment with Māori development. Durie, Gillies, Kingi, Ratima, Waldon, Morrison and Allan (1995) lists five principles for funding culturally effective services.

Table 1.2: Principles for Funding Culturally Effective Services

Principle	Focus
Choice	The need for a range of services so that options for different types of services are available
Relevance	Services that are culturally meaningful and able to address actual needs
Integration	Mental health services should not exist in isolation from other health services and intersectoral connections should be made
Quality	In any service, high standards of care and treatment are necessary and this should be reflected in outcomes
Cost effectiveness	Services must give value for money and limited resources make economies of scale important

Source: Durie et al., 1995:18

More recently, Durie (2001) has also recommended five strategies for mental health named after the ‘five fingers’ tree, called the Puāhou plan:

- Access to a secure identity
- Active participation in society and the economy
- Alignment of health services
- Accelerated workforce development
- Autonomy and control.

Underlying these strategies are themes of Māori centred values and beliefs, intersectoral collaboration, positive Māori development and the need to link health with the broader arenas of cultural enhancement and socio-economic advancement

(Durie 2001). The Puahou plan is built on a philosophy that good health equates with active participation, strong communities and an appropriate mix of clinical and cultural skills

Relevant legislation

A major piece of legislation that underpins the welfare and care of the mentally unwell is the Mental Health (Compulsory Assessment and Treatment) Act 1992. This Act replaces the Mental Health Act 1969 and redefines the approach and conditions in which a person may be assessed for treatment. The 1992 Act (MOH, 2000a) currently impacts most on mental health policy for patients who are not voluntary, and who are admitted into psychiatric wards or hospitals today in New Zealand. Dyll (1997) reports that research shows compulsory admissions account for a third of all admissions for Māori men, which include those under both the 1992 Mental Health Act and the Criminal Justice Act 1985. She also notes that the rate for involuntary admission is 154 % higher for Māori men than for Pākehā men, and 55 % higher for Māori women than Pākehā women. Te Puni Kōkiri's (1996) review of the pattern of Māori first admissions and re-admissions to mental health services agree with these research findings and add that re-admission rates for Māori are 40% higher than that for non-Māori, and that Māori access mental health services at a later stage of the illness and consequently are more likely to be seriously ill by the time they present to the service.

The 1992 Act is significant in that it aims to have mental health services recognise the importance of cultural need and identity and provides a legal framework that fosters the patient's rights (Bailey & Coates, 1992). This cultural emphasis in treatment is found in section 5.65 of the Act, which states:

every person is entitled to be dealt within a manner which accords proper respect to that person's cultural and ethnic identity, language and religious or ethical beliefs and with proper recognition of the importance and significance to the person of the person's ties with his of her family, whānau, hapū, iwi and family group; with proper recognition of the contribution those ties make to the person's well-being. (MH (CAT) Guidelines 2000:20)

Section 7 (a) of the 1999 Amendment also states that: “a practitioner must consult the family or whānau of the proposed patient or patient and in deciding whether or not consultation with the family or whānau is in the best interests of a proposed patient or patient, the practitioner must consult the proposed patient or patient” (MH (CAT) Guidelines, MOH, 2000a:22). These two sections are important because they recognise the significance of cultural identity and beliefs and incorporate the inclusion of whānau hapū and iwi, which promotes whanaungatanga, and strives to ensure meaningful participation. Another important policy is the application of the Medicines Act 1981 to the preparation, dispensing and labelling of rongoā¹⁰ in the Ministry of Health’s Standards for Traditional Māori Healing (MOH, 1999). Recognition of Māori concepts, values and approaches to healing in policy is fundamental to enabling Māori clinical and cultural workers to facilitate te taha wairua within their scopes of practice.

While the current mental health policy and legislation provide strategies to progress indigenous knowledge through the facilitation of Māori models of health and Māori traditional healing, it is argued these strategies would be strengthened by the use of a Treaty of Waitangi based framework (National Health Committee, 2002). Many people in the Māori health sector believe the Ministry of Health has failed to ensure implementation of Māori health policies by provider organisations and groups. As a result, some providers have failed to deliver effective services to Māori and some services are not consistent with the Treaty of Waitangi or the principles derived from the Treaty (Ferguson, 2000). Ten years ago Durie (1998) noted that the drive towards action on Māori health was based on concern about high mortality and morbidity rates, he commented that, “...a recognition of Māori interests in social policy legislation appears to arise from a concern about cultural values or disparities in Māori/non-Māori standards rather than from any sense of a Treaty-based obligation or rights quite apart from equity issues” (Durie, 1998:92), and this comment is still valid.

¹⁰ Traditional Māori Healing practices, including medicines or remedies – see Standards for Traditional Māori Healing, June 1999:11, Ministry of Health, Wellington.

Māori strategies for health

National advancement of appropriate health strategies is not new to Māori. The current deficiency of not having a Treaty of Waitangi based framework does not deter Māori in their aspirations for Māori health and well-being as a nation or as individuals, whānau, hapū and iwi. Māori aspirations for self-determination in all aspects of their political and social lives have been ongoing and may at times seem fruitless. The most dramatic and enduring example is that of the demise/survival of the Māori race. Predicted in the national newspaper (the New Zealand Herald) as early as 1874 to be a dying race (Durie, 1999), by 1896 Māori population numbers had decreased to 42,000 (Pool, 1991). Contrary to these predictions the end of the Māori race did not occur – the 1996 census saw 579,714 New Zealanders claim Māori descent (Durie, 1999). Amidst all this seeming doom and gloom, tribute must be made to the strong leadership, commitment and dedication of Māori to vigorously pursue opportunities to assure the well-being of the race. Sir Apirana Ngata, Māori leader and New Zealand statesman, played a major role in turning the tide for Māori health. In the early 1900s Ngata recognised that major gains in health would not come only from health services, but from meaningful jobs, security of income, good education, decent housing, and a strong cultural identity (Durie, 1998). It was Ngata who, through the Māori Councils Act 1900, helped draft the by-laws for village councils – e.g., wooden floors in meeting houses, unless chimneys were installed, and proper arrangements for the disposal of refuse (Walker, 1990). With the establishment of the Department of Public Health in 1900, Maui Pomare, the first Māori medical officer appointed, saw merit in the Māori councils and chose to work alongside council members to promote positive health practices, disease prevention and data collection. Within 2 years this type of health model showed gains, Māori census returns improved and a 70 % vaccination uptake by the entire Māori population were attributed to the work of the Councils (Durie, 1998b).

Māori community health workers

In 1903, the Māori councils passed a resolution to appoint competent inspectors for native villages, and, according to Durie (1998b), a new category of health worker emerged. Mostly male and leaders in their own right, they were the first generation of Māori community health workers and reputedly played a major part

in improving housing, sanitation, and water supplies. Not unlike the community health worker today, they were selected on their understanding of health issues, their capability to be trained, and their acceptance by or support from within their own communities. Although this initiative was short-lived (6 years later there was a policy change and their positions were disestablished), a foundation had been established for future Māori workforce development to acknowledge and value cultural skills and expertise in Māori approaches to health. Māori health professionals like Pomare and Te Rangihiroa recognised the value of community-based health workers and the inclusion of local Māori leaders to achieve health goals.

Māori approaches to healing

As has been common in Māori iwi and hapū history, in seeking to lead and self-manage all facets of their lives, i.e. economic, education, housing, employment and health, social and economic government policies have tended to favor universalism, where one law suits all. Due to dedicated effort and commitment by stalwart organisations, led and driven by wahine Māori, such as the Women's Health League/Te Rōpu o te Ora and the Māori Women's League, Māori approaches to health have remained a key focus, coupled with principles of public health (Durie, 1998b). Te Rōpu o te Ora chose to maintain a strong local presence, and remains active today. The Māori Women's League is a national independent voice and has a reputation as the champion of Māori women. Its link with health has seen the League advocate for the establishment of accessible and culturally relevant health clinics (Metge, 1967). Māori nurses played a significant role when Māori perspectives were being formulated and incorporated into conventional nursing practice (Durie, 1998b).

Two decades of Māori development

A crucial point in Māori development was the Hui Taumata, the Māori Economic Development Summit Conference held in 1984. The main points of discussion at this conference were self-sufficiency, the strengthening of the tribal base, and new environments for shaping social and economic initiatives for Māori (Te Puni Kōkiri, 1994a). Another key contributor, particularly in the area of health development, was the Hui Whakaoranga, a Māori Health Planning Workshop,

hosted by the Department of Health at Hoani Waititi Marae, Auckland that same year. This hui gave Māori an opportunity to articulate basic concepts and philosophy of Māori health. According to Durie (1984), Hui Whakaoranga was very significant, signalling a departure from an apologetic and pessimistic viewpoint to a positive self-assured one. Hui Whakaoranga is important for this thesis because it was from this Planning Workshop that the following concept of Māori health emerged:

To achieve health requires a sense of wairua (spiritual), hinengaro (mental) and tinana (physical) well-being which depends on the security of one's self in relation to one's whānau (family) and community, as well as the knowledge and comfort from one's roots and cultural background. (Dept of Health 1984:12)

It was also at this hui that Māori traditional practices were acknowledged as a valuable contribution to support the healing of Māori within mental health services. Ten years later, in March 1994, the next major national Māori health hui, Te Ara Ahu Whakamua, was held. This was a time to reflect on health developments since Hui Whakaoranga, particularly on the increase of primary health care service delivery by Māori for Māori; and on the continued commitment to tino rangatiratanga, and Māori taking control and management of things Māori. It was also at this hui that the principle of collective responsibility was reinforced, in that the mainstream health sector needed to commit to providing appropriate and responsive health care to Māori to support Māori health gain (Te Puni Kōkiri, 1994a). Strategic directions set at Te Ara Ahu Whakamua were aimed at purchasers of health services to assist in the development of Māori providers and to provide options for Māori involvement including partnerships and joint ventures in budget holding and service delivery. These national hui forged the way for local Māori initiatives to move ahead in their own communities. The strategic directions as set and implemented during these past two decades have had a positive impact on government policy when one considers those aspirations and current policy gains. This research would not have been as credible without the tremendous contributions made by Māoridom, not just over the past 20 years or so but over the past 100 years.

Overview of thesis chapters

This chapter has provided the foundation for this thesis by outlining the intent of the researcher towards taha wairua and its use in mental health services, and the legitimisation of taha wairua in clinical practice and the support it receives from mātauranga Māori. Key organisations and strategic directions that support indigenous peoples and Māori to access culturally appropriate mental health services have been presented in an international and national context. A comparison has been made between the Māori and the Native American Navajo tribal experiences accessing Western mental health services. The Treaty of Waitangi has been shown to underpin Māori rights to the facilitation of taha wairua practices in Western health systems.

Appropriate cultural interventions are one positive way to address the poor health status of Māori (Dyall, 1997). Research and statistics continue to confirm that mental health problems are the number one health concern for Māori and that there are disproportionate numbers of Māori in crisis, acute inpatient and forensic services (MHC, 1998). The Blueprint (MHC, 1998) recognises that healing for Māori is not found solely in the physical remedies offered but draws on cultural and philosophical principles and embraces a holistic approach with the inclusion of the individual, the whānau, the hapū, the iwi and the spiritual realms of te ao Māori. Although the use of Māori concepts and tikanga practices are not new to Māori, it would be fair to say that only over the past decade have Māori centred approaches been more widely used in mental health services. Principles for purchasing and providing culturally effective services have been outlined and acknowledgment has been made of Māori leaders and organisations that have advanced appropriate and relevant health strategies for Māori over the last century.

Chapter Two outlines Western, Indigenous Peoples and Māori notions of spirituality. A comparison of definitions of what constitutes spirituality and religion is made, with clear indications that these definitions do not share the same meaning. The literature also shows that Māori have distinctive beliefs about spirituality, which is significantly influenced by Māori cultural concepts, beliefs and practices. The limitations Western medical models of health impose on the concept of spirituality restrict opportunities for spirituality to be an accepted and

integral part of indigenous and Māori health practices in mental health services. Regardless, current research attests to the benefits of the use of spirituality in positive health outcomes for clients/consumers/tangata whai ora. The foundations of Māori traditional health practices, which have their roots in Te Ao Tawhito¹¹ where systems of social control were governed by lore of tapu, are traced. Examples will be shared of the adaptation of the concepts of tapu and noa and other tikanga concepts and practices that form the basis for Māori models of health that are currently used by Māori who work in mental health services.

Chapter Three outlines and discusses the methodology used for this research. Differences and similarities between a Māori centred and a Kaupapa Māori approach are defined and discussed. Mātauranga Māori, in a traditional and a contemporary sense, is acknowledged, and differences between te ao Māori and Western world cultures in the obtaining and the sharing of mātauranga Māori are explained.

By establishing whakapapa links and consulting with the researcher's own 'whānau of interest' and 'whānau of supervisors' the ground was prepared not only in defining the research question and initially moving the research forward but also in maintaining an integral kaupapa Māori approach. Having as the primary, 'seven ethical responsibilities'¹², Smith (1999) in establishing the process to guide this researcher's behaviour as interviews were set up and arranged gave added value to a kaupapa Māori framework. The knowledge and experiences shared by the researcher, her supervisors and participants reinforced the belief that participatory practice in a Māori context addresses the power and control issues fundamental to research that have contributed to the robustness of the study findings.

Chapter Four is the first of the two data analysis chapters. Examples of how tikanga practices and Māori models of health support the facilitation of taha wairua in Māori mental health clinical and cultural practice are provided. The

¹¹ The old Māori world.

¹² See Chapter Three under subtitle, 'Ethical Considerations' for a description of these seven ethical responsibilities.

influence of taha wairua on the Māori clinical and cultural workers and in the recovery process for tangata whai ora is a constant theme in this chapter. The research demonstrates how taha wairua influenced practice and how it benefits tangata whai ora and whānau. Recovery principles of hope, personal meaning and responsibility, self-advocacy, education and support, along with empowerment, strengthened identity and raised self-esteem underpin these benefits. Analysis in this chapter identifies a number of principles and concepts that support best-practice standards for the cultural worker role (these are discussed further in chapter six, along with chapter five's analysis of research findings).

Chapter Five outlines the characteristics, principles, skills and competencies that help define best-practice standards for cultural worker roles. Furthermore, for the consistency and sustainability of those cultural practices that facilitate taha wairua in mental health services, a fitting environment needs to be fostered and maintained. This environment needs to contain physical and spiritual components, such as suitable buildings; effective cultural training to promote competency; proficient leadership; more funding for more staff resource; a valuing of Māori human resource, better access to services for Māori and a positive but much needed change in attitude from Western ideas to appreciate Māori cultural ways. What is apparent throughout the experiences shared is the commitment of kaimahi Māori to tikanga practices that promote and enable taha wairua to influence their scopes of practice with tangata whai ora and whānau. Kaimahi Māori were also able to articulate the issues that created barriers for the facilitation of taha wairua.

Chapter Six contains the findings and the conclusions drawn from the analysis of the data. This chapter also provides the foundation for the components that can make up a framework for the facilitation of the concept of taha wairua in the scopes of practice of kaimahi Māori in mental health services. Recommendations and resource requirements for the framework are suggested, and strengths and limitations of the framework are discussed. The findings from this research cannot be applied to the Māori mental health workforce in general; they represent the views of a small sample of workers, and therefore opportunities for future research are also suggested.

CHAPTER TWO

Notions of Spirituality (Literature Review)

Spirituality has always been an intrinsic part of ‘being’ Māori. For Māori, ‘being’ has four dimensions physical, mental, emotional and spiritual (Durie, 1994). Koenig (2000:1708) believed that, “ignoring any of these aspects could leave a person feeling incomplete and may even interfere with healing”, and continued, “spirituality is an important part of wholeness”. This chapter looks at spirituality from a Western and a Māori perspective. According to Koenig (2000), the vast majority of Americans do not make a distinction between the concepts of religion and spirituality, and most research linking spirituality to health has measured religious beliefs and practices (Mitchell & Romans, 2002). Studies over the last decade, however, have broadened, with others investigating the link between spirituality and health (McEwen 2003; Corrigan, McCorkle, Schell, & Kidder, 2003). As noted in Chapter One, mainstream acceptance of a holistic view of health for Māori emerged from the 1984 Hui Whakaoranga (Dept of Health, 1984).

Literature on the effects of spirituality on people who suffer serious mental illness is sparse (Corrigan et al., 2003; Mitchell & Romans, 2002). One possible reason for this is the difficulty associated with carrying out good research in this area, particularly when there are no generally agreed definitions (Mitchell & Romans 2002; Banks-Wallace & Parks, 2004) or a clear understanding of what distinguishes religion and spirituality.

Definitions: Spirituality and/or religion

There is a need to clarify the differences between religion and spirituality. These two concepts are often used loosely and interchangeably, but some researchers believe they can be separated reasonably and without contention (Turbott 1996; Koenig, 2000;

Mitchell & Romans; 2002, Henery 2003). Clarification is important and necessary because Māori strong in their culture do not necessarily connect wairua (spirituality) with religion, while Māori with few or no links to their culture may not be able to differentiate, or may regard spirituality and religion as the same. For Māori, the impact of colonization saw the spiritual force of tapu¹³ broken with impunity by visiting sailors from whaling and sealing ships (Sinclair, 1959). Walker (1996) noted that missionaries became politically influential as peacemakers during the early 1800s. European diseases and musket warfare debilitated Māori tribes and whole tribes began converting to Christianity¹⁴ because it was thought the Pākehā God was more powerful than Māori Gods. According to Elsmore (1985), that power was made manifest in the form of ships, weapons and the amazing array of goods possessed by Pākehā. Walker (1996) observed that conversion to Christianity seriously affected the tapu of tribal chiefs and therefore greatly reduced their ability to influence their people to hold to their own spiritual beliefs. Durie (1994) also noted that when Māori embraced Christianity they were encouraged (by the missionaries) to break the customs of their pre-conversion life. Today therefore, Māori spiritual belief systems have become markedly influenced by Christianity (Melbourne, 2000), and for many modern spirituality is a blend of religion and spirituality.

In contemporary society, religion is often defined through an objective system that includes constructs such as denominations, theological belief systems and major world traditions (Corrigan et al., 2003; Winslow & Winslow, 2003). Religion has also been defined as describing the beliefs and practices of an organised church or religious institution that can encompass the total response to all issues of 'ultimate concern' (Tillich & Green, 1990; Turbott, 1996). In addition, religion has been explained as a values system, one that is a learned organisation of principles and rules to help one choose between alternatives, resolve conflicts and make decisions (Burton & Bosek, 2000). Religion is contained within structures and is often seen to be an outward manifestation of spirituality (Pierre, 2003). On the other hand, other sources of literature state that spirituality involves more than traditional religions, beliefs and practices (McEwen, 2003) and is more of an individual experience of a relationship with

¹³ The concept of tapu and its meaning is discussed in more detail later in this chapter.

¹⁴ Western forms of religious and spiritual worship centered on Jesus Christ, e.g., the Roman Catholic Church, the Church of England and the Presbyterian faith. Māori writers such as Rose Pere (1997:16), however, maintain Māori have always had a belief in Christ.

a transcendent force or being, a quality that goes beyond specific religious affiliation (Lukoff et al., 1992; Armstrong & McBride, 1995). Other researchers, such as Narayanansamy (1999), believe the notion of spirituality is influenced by religion, because it is often viewed from the perspective of Christian theological tradition. However, there are many definitions of spirituality that do not support that concept. These include: spirituality as a person's sense of meaning and purpose in life, or one's relationship to the Cosmos (Burton & Bosek 2000); spirituality involving the whole person; spirituality being seen as a metaphysical concept representing a belief and a connection to a power outside a person's existence. This power might be called God, Nature, Spirit, or unifying force, (McBride & Armstrong, 1995; Mitchell & Romans, 2002; Corrigan et al., 2003). Spirituality may therefore have no relationship with religion, but for many, religion is a means of growth and the expression of spirituality (Fry, 1998). For the purpose of this thesis, a definition of spirituality must consider Māori understandings and beliefs, which have many parts and incorporate some of the 'spirituality' definitions above. Bardill's view (1989:25) that spirituality provides the bond "which unites the individual in harmony with the wholeness of existence in self, others, and context, under God" also has some similarities to Māori concepts of spirituality. Māori nonetheless have a very unique understanding of spirituality.

Wairua Māori – Māori spirituality: Te taha wairua – spiritual dimension in health care

When it comes to understanding what spirituality is, Māori beliefs encompass some of the definitions that have been given earlier in this chapter, but are also distinct in themselves. There are many cultural concepts and/or beliefs that contribute to Māori understandings of spirituality (Potaka-Dewes, 1986; Barlow, 1991; Mead, 2003), in particular two specific concepts that stand out in the Māori perspective of spirituality – te wairua, the spirit from ira atua, and te mauri, the life essence or principle.

Te Wairua – Ira atua me te ira tangata

In Māori tradition, the act of human creation of Māori as a people (i.e. made up of mortal substances that enable one to decay and thus die) is attributed to Tāne (Walker, 1996). Tāne was seen as a demi-God, possessing the divine principle of ira atua, which is the male element from his father, Ranginui. In his search for the female element to create ira tangata or humankind, he concluded a separate act of creation was needed. It

was from his mother, Papatūānuku, that he found the element of ira tangata to fashion the first human, Hineahuone, the earth-formed maid. He breathed his mauri, the life principle into her. As Walker (1996:18) stated, “being is a duality of ira atua and ira tangata in human beings. Humans are not immortal. When the mauri leaves the physical body, death ensues. Only the wairua, the spiritual remnant of ira atua, survives death to return to Te Po from whence it came”.

Mauri

Mauri – the life essence or principle – is a special power. Barlow (1991) and Mead (2003) explained that Mauri has the power to bind or join, to enter and leave at the veil between the physical and spiritual realm (possessed by Io), which makes it possible for everything to move and live in accordance with the conditions and limits of its existence. Everything has a mauri – people, fish, animals, birds, forest, land, seas, and rivers (Barlow, 1991, Pere, 1997, Melbourne, 2000). The mauri is that power which permits these living things to exist within their own realm and sphere. Barlow (1991:83) continued: “No one can control his or her own mauri or life-essence, though it is possible to establish a mauri for some other creation, such as a house. When a house is built, the mauri is established as the sacred heart of the building”.

Māori perspectives of duality in spirituality are further enhanced by the use of the Māori language. For example, Rose Pere’s description of ‘wai rua’, and its dual concept approach, which according to Pere (1997) is an apt description of the spirit, because “it denotes two waters. There are both the positive and negative streams for one to consider. Everything has a wai rua, for example, water can give or take life. It is a matter of keeping a “balance” (p. 16). Māori do not and never have accepted the mechanistic view of the universe, which regards it as a closed system into which nothing can encroach from without (Marsden, 1975). Māori regard the universe as at least a two-world system in which the material proceeds from the spiritual, and the spiritual “which is the higher order” inter-penetrates the material physical world of Te Ao Mārama (Marsden, 1975:215). Rose Pere (1997:16) reiterated, “a powerful belief in spirituality governs and influences the way one interacts with other people and relates to his or her environment. Maori who have retained their own ancient teachings have always believed in ĀīŌ Mātua (God/Goddess, the Divine Parents) and Rehua (Christ)”. Eru Potaka Dewes (1986:13) spoke of spirituality as being wairua Māori, meaning

spirituality is part of being Māori, because “it is within the person, the essence or *te mauri*”, or in other words, spirituality is inherent (Best, 1941). Durie (1994) described *te taha wairua* as a spiritual dimension that is the intangible, spiritual soul of a person. Goodman (1989) described *te taha wairua* as determining who one is, where one comes from, and where one is going to; it is perceived as present all the time and everywhere. It provides a dynamic link with one’s *tupuna* and between members of a *whānau* group, and also strengthens the *taonga* (treasures)/*tikanga* values of one’s cultural system. Clearly these Māori perspectives separate spirituality from religion. However, the diversity of Māori society needs to be recognised in that some Māori are part of Māori society, some Māori are part of general society, and some Māori are alienated from both (Durie, 1994a). As mentioned earlier in this chapter the influence of colonisation and the introduction of Christianity have created diverse spiritual beliefs among Māori. Therefore contemporary concepts of spirituality combine both traditional Māori spiritual beliefs and Western religious concepts. Regardless, both traditional and contemporary views on healing as held by Māori and as presented in the literature incorporate *te taha wairua*, the spiritual dimension.

Limitations of medical models of health

Mental health theories have often hinged on Western concepts that are alien to Māori thinking. Preoccupation with independence, individualism and a mechanistic approach to human behaviour are some cases in point (MOH, 1994). Western medicine has also tended to emphasize physical health at the expense of those functions that cannot be scientifically explained (Durie 1998b). In contrast, Māori models of health tend to balance biomedical with both mental attitudes and spiritual powers. For Māori, concepts of health are also very much bound by culture, time and interdependence (Turbott, 1996; Durie 2000).

Clinical

Turbott (1996), Koenig (2000) and McLeod and Wright (2001) believed the neglect of spirituality as a specific focus in practice by those in the health professions can no longer be ignored (Lukoff et al., 1992). Put quite simply it is the acknowledgement by clinicians (i.e. doctors and nurses) that they must be aware of and understand religious and spiritual issues in order to assess more holistically and to respect and respond to patients/clients in terms of a framework in which they believe (Turbott, 1996; Koenig,

2000). They must become sensitive to this spiritual need and diversity in all its aspects. Reinforcement in this area is needed as Māori mental health statistics have continued to show a large disparity between Māori and non-Māori¹⁵. Religiosity and religio-spiritual power are terms used to describe both religion and spirituality (Koenig, 2000; Mitchell & Romans, 2003). The ‘religiosity gap’ is one explanation given for what has been called mental health’s ‘cultural insensitivity’ towards individuals with religious and spiritual experiences in both Western and non-Western cultures. Studies in the United States of America (Lukoff et al., 1992) report both the general public and patients consider themselves to be more religious and to attend church more frequently than mental health professionals. Although comparative figures are not available for New Zealand, Turbott (1996) believed it was likely that a similar ‘religiosity gap’ prevails here. As long as such a ‘gap’ prevails, Turbott (1996) and Koenig (2000) believed, harm to patients is possible both by omission and commission. That is, harm can come from diffidence or ignorance, diagnosis is avoided because religious or spiritual content is present, and care for a mentally ill person is wrongly consigned to a ‘spiritual’ or ‘cultural’ advisor’ or vice-versa, i.e. care is consigned to a clinician. In New Zealand, the trend has been to diagnose often with little or no consideration of the cultural or spiritual dimensions associated with mental illness (Durie, 2001).

Diagnostic

The Diagnostic Statistical Manual of Mental Disorders IV, otherwise known as the DSM-IV in its current form, is not a culturally appropriate assessment measure for Māori presenting to mental health services. Lukoff et al. (1992) proposed a description of the diagnostic entities of psychoreligious and psychospiritual problems. This suggestion was acknowledged by the brief inclusion of ‘V62.89 Religious or Spiritual Problem in the V codes’¹⁶ of the DSM-IV (Turbott, 1996). Turbott further stated how use of these categories might aid the distinction of three different types of presentation: normal religious or spiritual experiences or problems; religious or spiritual problems that cause distress and may become the focus of clinical attention; and mental disorders with a religious or spiritual content.

¹⁵ Te Puni Kokiri (1996) reviewed the pattern of Māori first admissions and re-admissions to mental health services and found the results disturbing: “Alcohol related admissions for Māori male are twice that of non-Māori and is the leading cause of admission and second most common cause for Māori women; re-admission rate for Māori are estimated to be 40% higher than that of non-Māori; Māori access mental health services at a later stage of the illness and consequently are more likely to be seriously ill by the time they present to the service”.

¹⁶ V codes are other conditions which may be a focus of clinical attention (APA, DSM-IV 1994).

Māori psychiatrist Erihana Ryan, pointed out that marginalisation for Maori health continues when definitions of psychiatric illness used by mental health services do not reflect cultural concepts such as “mate Maori (illness contributed to cultural factors) and this non-recognition can become a barrier to early intervention” (Ryan, 1998). When Māori present to the health system, they may not express openly what they perceive to be the cause of their unwellness. This may be for many reasons, such as the inability to communicate what the cause may be if they believe it to be related to cultural factors, or because those presenting may feel whakamā (shy, embarrassed or ashamed) (Dyall, 1998). Cultural matters may therefore be ignored and behavioural symptoms interpreted in terms of a Western medical and or psychiatric framework, leading to inappropriate diagnosis and treatment. Assessment measures should be more than a simple statement about DSM-IV categories; they should also be capable of measuring the degree to which cultural, social and spiritual factors are associated with problems of health (Durie, 2001). Mental health services can also reduce the proportion of misdiagnoses and poor treatment outcomes through increasing the cultural as well as the clinical competence of its practitioners.

Ethical

Sims (1994:442), and Koenig (1992:1694) observed that there is no such thing as “valueless” clinical practice; “all of us, as we practice, carry our values, standards, aims and goals from the rest of our lives into our clinical practice, and much more to the point, so do our patients/clients.” They both argued that physicians and clinicians should not impose their religious (spiritual) or ethical views on others nor should they ‘prescribe’ religious beliefs or activities for health reasons. Therefore, for reasons of moral integrity, mental health services must consider the manifold ethical implications of its interface with religious and spiritual issues (Turbott, 1996). Māori healing methods include the recitation of karakia – prayer and incantations (Parsons, 1985; Potaka-Dewes, 1986; Durie, 2001). For the health profession, the appropriateness of a spiritual intervention such as prayer in professional service is one example that can present an ethical dilemma. Research states that prayer as an intervention with patients fits in the broader spectrum of spiritual care (Winslow & Winslow, 2003; McEwen, 2003). Ethical questions arise about how and when to include prayer in ways that are respectful of patients in clinical settings; whether health professionals should offer and

say the prayer, and what to do about patients and professionals who have different spiritual beliefs or a health professional who does not subscribe to such beliefs (Fry, 1998; Winslow & Winslow, 2003; Koenig, 2000). Other researchers such as McLeod and Wright (2001:304) do not see the integration of spirituality into clinical practice as an ethical issue. They observe that, “health professionals need new understandings of how we wittingly and unwittingly oppress by sealing off our practices to the spiritual as well as how we might open space for spirituality in our practices”. Māori health professionals on the whole would agree that spirituality in their practice presents an ethical dilemma. The issues in this researcher’s view would be about Māori health professionals’ levels of cultural understanding and cultural practice and their understanding of the cultural diversity of Māori and their access to te Ao Māori. These raise moral questions not ethical ones. What is important for both parties to this type of argument is the moral integrity of health professionals, Māori and non-Māori, their personal meaning (Henery 2003), and their ability to respect patient choice and open space to spirituality in their professional practice.

Benefits of spirituality in health care

Research on understanding benefits of religion and spirituality is mostly correlated to health outcomes (Burton & Bosek, 2000; Mitchell & Romans, 2003; Koenig, 2000). One recent study undertaken by Mitchell and Romans set out to analyze other research and what was more beneficial for a small sample of those suffering bipolar illness, i.e. a person’s religious or spiritual beliefs. The study was inconclusive because both were found to be beneficial, most patients held strong religious or spiritual beliefs, and most saw a direct link between their beliefs and the positive management of their illness. What was also interesting was that the study found many of the patients’ religio-spiritual beliefs and practices often put them in conflict with medical illness models and advice used by their medical advisors. Mitchell and Romans (2003) also noted that respondents saw mainstream forms of spiritual healing as important in illness management, while Māori found Māori spiritual interventions important. Although there is current enthusiasm for positive health benefits of spirituality, other research has found evidence that the spiritual beliefs of patients can be either helpful or harmful to health depending on the nature of those beliefs. Pargament et al. (1998) found that some forms of religious coping are associated with greater distress and poorer patient outcomes. This then raises another question of the cultural mix of health professional

and patient. The culture of the clinician and client can strongly affect the assessment process, the therapeutic relationship and treatment outcomes; including what is considered an appropriate outcome from the treatment process and what can produce better health outcomes. In alcohol and drug services, research on cultural matching between clinician and client showed higher initial functional scoring, lower treatment drop-out rates, and higher client satisfaction (Kurasaki & Sue, 1998; Huriwai, Sellman, Sullivan & Potiki, 1998). Mental health services in New Zealand can therefore contribute to better treatment outcomes by acknowledging, valuing and integrating spiritual interventions (Ramsden, 1990), and by alignment of appropriate clinician to patient need.

Spirituality and indigenous experiences: The use of indigenous models of healing internationally within mental health services

As outlined in Chapter One, the Draft Declaration on the Rights of Indigenous Peoples identified health as a priority. In 1996, the WGIP¹⁷ focused on health and the Committee on Indigenous Health (COIH) was established (Alderete, 1998). Research shows Indigenous peoples have similar views on health and well-being. These similarities include: the belief that everything has spiritual value; the spiritual and the physical are united; cosmology is spatial and timeless; teachings are from traditional elders; and the need for balance and therefore healing in health needs to incorporate a holistic approach (Alderete, 1998; Struthers & Lowe, 2003).

While Indigenous Peoples may share similar beliefs of healing they do not share similar responses to similar experiences of illness and traditional healing methods. Durie stated:

three classes of healers have been described: herbalists, medicine men and shaman. Herbalists use an array of botanical substances, often in combination, for a variety of disorders including dressing wounds. Medicine men employ supernatural methods to restore health while shamans are able to enter into trances in order to summon the spirits to give counsel. (Durie 2001:161)

Durie also observed that most healers, however, employ more than one method. Take, for example, the experience of a Native American tribe such as the Navajo – many of

¹⁷ See the section in Chapter One on Working Group on Indigenous Populations (WGIP); this group facilitated the drafting up of the Declaration of the Rights of Indigenous Peoples.

their essential beliefs stem from the Earth as their mother and her ability to give life. Navajo traditional healing practices include different ceremonies that connect to Mother Earth. These ceremonies, led by their health experts otherwise known as medicine men, place bodies, minds and spirits within the wisdom of Mother Earth. Like most Indigenous Populations, the perspective of Native Americans with regard to Mother Earth, is based on a strong spiritual connection with the environment, which in turn supports improving the health of an individual. Some examples of ceremonies include the peace pipe, the sweat lodge, the sun dance, and the Hogan for healing (O'Brien, Anslow, Begay, Pereira & Sullivan, 2002). While Māori, on the other hand, place Io Matua Kore as the centrifugal force of healing, and acknowledge the sustenance Papatuanuku provides, they believe that without ira atua and mauri¹⁸ there is no wholeness and balance. This perspective encompasses such elements of the environment as land and water and cultural relevance. Some examples of Māori healing ceremonies are mirimiri (massage), the spiritual cleansing and healing abilities of water, and conservation practices in healing when using nature's products such as trees, plants and bushes for medicinal purposes. Both ritual and spirituality feature in the healing process as all these ceremonies are accompanied by karakia (incantations). Like the Native Americans, Māori believe that when the environment is healthy and maintained so too is the individual, the extended whānau, and the tribe.

Durie (2001) noted that traditional healers come from diverse backgrounds. In some countries they are regarded as sacred and earn much respect not only as healers but also as cultural and sometimes political leaders. Native Americans also have had these types of healers (elders) who pioneered new ways of thinking. Chief Sitting Bull was a famous medicine man and leader of the Hunkpapa band of the Teton Sioux Indians during the late 1800s (O'Brien et al., 2002). As he was advising his followers to take the best of the white man's ways and the best of old Indian ways and drop the bad from both, Māoridom's Apirana Ngata was advising Māori to do the same. The following whakatauaiki (proverbial saying) written by Ngata¹⁹, has been prescribed by Durie (1994b: 11) as "a powerful prescription for Maori health":

¹⁸ See the section on Wairua – te ira atua me te ira tangata earlier in this chapter.

¹⁹ A year before Ngata's death in 1949, he wrote this in the autograph book of a young Māori girl, Rangi Bennett at Potaka (Ngata A.T. 1949, '*ki a Rangi*')

*E tipu e rea mō ngā rā o tōu ao
 Ko tōu ringaringa ki ngā rākau ā te Pākehā, hei oranga mō tōu tinana,
 Ko tōu ngākau ki ngā taonga ā ō tīpuna, hei tiketike mō tōu māhunga,
 Ko tōu wairua ki te Atua, nāna nei i ngā mea katoa*

*Grow up tender plant for the days of your world,
 Your hand to the tools of the Pākehā for your material advancement
 Your heart to the treasured possessions of your ancestors as a plume for
 your head,
 Your spirit to God, the creator of all things. (1949)*

Maori have also had their leaders in improving health outcomes, like Ngata, Maui Pomare, Te Rangihiroa (Durie, 1998b), and, in more recent times, Eru Pomare and Mason Durie. In other countries such as Australia, aboriginal healers who possess healing and divination powers have no special status and live very much as ordinary citizens, attracting little attention, except from their clientele (Durie, 2001).

Another comparison can be made with Native American health professionals who complement their Western medical education practice with traditional healing practices, either as a direct application in their own practice or by providing access to these methods (Lamberg, 2000; O'Brien et al., 2002). This type of integrated service delivery model needs to be more readily accepted in New Zealand's health services. Recent research undertaken by Māori health researchers on Māori mental health workforce emphasizes the need not only to implement, value and recognise Māori traditional healing and models of health (Milne, 2001; Te Kahui Tautoko, 2001), but also to develop a workforce that is both culturally and clinically competent (Milne, 2001; Te Rau Matatini, 2003). Struthers and Lowe (2003:269) state: "Indigenous frameworks of healing should be utilized within the healing process to facilitate culturally appropriate and multifaceted approaches for mental health care for Native Americans". Some gains²⁰ have already been made in New Zealand but the integration of Māori traditional healing into service delivery needs more commitment from all types of mental health services. Research shows mental health professionals worldwide need to liaise with indigenous healers in a collaborative manner (Alderete, 1998).

According to WHO (Alderete, 1998), Indigenous Peoples have increased vulnerability, compared with other poor or marginalized populations. This vulnerability stems from at

²⁰ See sections on The Tohunga Suppression Act and on Māori Models of Health

least two factors: the close link and spiritual relation with the land, which is at the same time the basis of material subsistence; and the profound differences that exist between Indigenous Peoples' world view and cultural norms, and those of Western societies. Some key differences include the materialistic and individualistic orientation of many Western societies, their lack of respect for the environment and its resources, their hierarchal structure based on materialism not on wisdom and age, and that everything is time bound and Western societies do not value the source of a higher power greater than man himself (Alderete 1998). In recognizing these differences, it is important that Indigenous Peoples are supported to facilitate methods of healing that address their cultural need, beliefs and values. Therefore the Committee on Indigenous Health (COIH) have an expectation that Governments will provide indigenous peoples with adequate community-based health services, drawing on their traditional preventive and healing practices and medicines. The COIH also expects that Indigenous Peoples will participate in the planning and delivery of these services, or take overall responsibility for and control of the health service. For Māori, their ability to access their traditional healing practices has met with resistance from Western society.

The Tohunga Suppression Act 1907 (repealed 1963)

Māmari Stevens (2000) commented that the passing of the Tohunga Suppression Act in 1907 was the result of an anxious and confusing period of New Zealand history. The Act was seen as an attempt to prompt Māori health reform and to neutralize powerful Māori leaders, particularly Rua Kenana. According to Durie (1998b), this Act signalled to Māori that health care would be firmly based on Western concepts and methods. Māori health professionals such as Pomare and Buck both had reservations about traditional and not so traditional Māori healing and were aware of the advantages of medical science in the control of infectious diseases such as tuberculosis (Durie, 1998b), and they supported the passage of the Act. Further study of Stevens (2000) work shows that neither of the two aims of the Act was achieved. Rua Kenana was never convicted under the Act (Stevens, 2000) and Māori, not wanting to invite supernatural retribution, were reluctant to inform on tohunga (Voyce, 1989). Durie commented:

In any event ...the Act forced Māori healers underground, although their skills were not entirely lost, the transmission of their methodologies

faltered. For succeeding generations the significance of rongoā (traditional healing treatments) and karakia (rituals such as prayer) were not only scarcely appreciated, but often with scorn, even after the Act's repeal in 1963. (Durie, 1998b:45)

Four decades later Māori traditional healing methods are becoming an accepted complementary treatment by Māori for Māori suffering from serious mental health illness. Māori have always had their own healers, known as Tohunga Puna Ora²¹. A basic definition of the term tohunga refers to an 'expert'; however, traditionally there were many meanings and various levels of expertise and specialised skill, including health and other areas such as whakapapa (tribal genealogies), tribal lore, carving, tribal defense and protection.

Some significant gains for Māori traditional healing have been made over the past decade. In 1992, the formation of a national association of healers took place in Auckland, and in 1995, the Central Regional Health Authority signed a contract with Te Whare Whakapikiora o te Rangimarie, for the delivery of traditional healing services. Since then there have been other contracts signed with Māori providers of traditional healing in both rural and provincial urban settings (Durie, 2001). While questions are still being asked on how traditional health systems can contribute to better health, mental health services have been cautious in their acceptance of the value of rongoā. Perhaps this cautiousness is a remnant of colonization or a genuine lack of understanding on how best to implement an integrated service delivery model to ensure access to Māori traditional healing. Regardless, the majority of Western mental health services still remain firmly entrenched within a medical model of illness, hence the challenge that goes out to mental health services – “the need for balance” (McLeod & Wright, 2001). The introduction of the Tohunga Suppression Act in 1907 limited and/or cut off Maori access to traditional ways of healing. Current Government policy and legislation have created opportunities to help meet the balance of clinical and cultural dimensions within mental health clinical services. Part of this balance can be met through new liaisons between mental health services and Māori health experts such as tohunga.

²¹ Definition taken from Glossary of Terms, Standards for Traditional Māori Healing, 1999 (Ministry of Health)

Tikanga Māori

In relation to health, Tikanga Māori is about the values and belief systems that focus on maintaining balance between people and their physical and spiritual world. Tikanga is also Māori culture that embraces traditional values, beliefs and practices such as: pōwhiri, karanga, karakia, whakapapa, te reo Māori, and whanaungatanga. Durie (2001) described a prescription for the use of these tikanga practices in healing as Mauri therapy. This type of cultural therapy is described as a type of healing based on Māori concepts such as Rangi²² and Papa, Io Matua Kore, Matakite, Mākutu, Tapu, Wairua, Moemoeā, Whanaungatanga, Karakia, Marae, Poutama. Mauri therapists and/or practitioners allow clients to work through their own needs, but they supply knowledge and perspective and use a variety of song, stories, traditions, and physical therapies such as dance, action song, and mau rākau²³. Mauri therapy aims to foster a strong cultural identity and to restore a sense of vitality and purpose based on the understanding of traditional values and concepts.

Cultural identity

The importance of a strong cultural identity complimented by active participation and fulfillment of one's cultural role within society is imperative to good mental health (Durie, 2001). A longitudinal study undertaken by Te Hoe Nuku Roa, Massey University, involving Māori families in four regions (Auckland, Tairāwhiti, Manawatu-Wanganui and Wellington), has identified four cultural profiles: secure, positive, notional and compromised Māori identities (Durie, 1998b). Findings thus far indicate that a secure and positive cultural identity offers some protection for Māori against ill health and is more likely to be associated with educational and employment participation. A secure sense of self-identification as Māori involved marae participation, knowledge of whakapapa, ancestral lands, tikanga, and te reo Māori. A positive identity showed lower levels of involvement in te Ao Māori; a notional identity portrayed one as having no access to things Māori, nevertheless identifying as Māori; and a compromised identity is depicted as non-identification of being Māori, in spite of

²² **Rangi** – Sky Father; **Papa** – Earth Mother; **Io Matua Kore** – the great spiritual being; **Matakite** – someone who possesses the gift of second sight; **Mākutu** – an illness caused by violation of a cultural practice; **Tapu** – see explanation further on in this chapter; **Wairua** – spiritual, **Moemoeā** – dream, vision; **Whanaungatanga** – relationships; **Karakia** – prayer, incantations; **Marae** – symbol of identity; **Poutama** – denoting pathways to higher learning, knowledge and skills

²³ An ancient form of training with a taiaha (spear) combined with cultural practices such as karakia, to promote fitness, dexterity and a sense of spirituality (personal knowledge).

having access to te Ao Māori. For Māori, cultural identity depends not only on identification as Māori and knowledge such as whakapapa and language but also on access to Māori society and participation in whānau and hapū activities, access to ancestral land, and contact with Māori people (Durie, 1997). It also depends on being able to express one's culture and have it endorsed within social institutions such as health services (Durie, 2001).

Marae

The marae is a symbol of tribal identity and solidarity (Melbourne, 2000, Walker, 1992). Formerly the marae was designated as the open area of land directly in front of the sacred carved house and was known as the marae ātea. It was on the marae ātea that the tohunga (priestly experts) conducted their sacred rituals on behalf of the people, such as whakapapa recitations and tribal history. The lack of access to marae, a natural setting for hearing the Māori language, as well as lack of access to one's genealogy and links to people and the land is noticeable by Māori elders and those who keep te ahi kā (the home fires) burning. The following quote encapsulates the sadness and also the knowing of what this lack of access to this part of te ao Māori can mean to strength of identity and the future survival of traditional practices:

My heart reaches out to the people who have not had the opportunity of being on the marae, listening to the kaumātua, to the reo (language) and observing the traditional customs. Our main concern is that our marae are being abandoned and the people are living in ignorance of the knowledge and the customs of our people. (Pā Henare Tate in Barlow, 1991:x)

Barlow (1991) reported that Māori have made advancements in establishing marae in urban areas, e.g., on schools and university campuses, and in communities; and this is a positive indication that Māori culture will survive. These types of marae settings are important for not only the transmission of Māori culture but also for the identification of cultural links and, subsequently, for the health of the individual, whānau, hapū, iwi, and community.

Te Whenua

The promotion of linking Māori back to their marae is also about their links to the land, and to who they are and where they come from. Land is the basis of Māoridom and is

central to Māori identity, linking them with ancestral mountains, rivers and seas, as well as whānau hapū and iwi (Walker, 1996). Personal identity for Māori includes the environmental features of mountains, rivers, lakes and seas, papakāinga (traditional land use), and tūrangawaewae. Tūrangawaewae is about belonging to the land and being part of the land (Melbourne, 2000, Durie, 2001). It is also about the spiritual connection to Papatuanuku, our earth mother. The guardianship and responsibility for taking care of the land and the environment were vested in the whānau group and passed on from one generation to the next. In relationship to health, land promotes a positive sense of tribal, whānau and individual well-being due to this sense of belonging. Land links Māori to the past – and is a vital link between one's tupuna and the ongoing living world (Dept of Health, 1984:17). This dual relationship of the linking of the physical and spiritual well-being of Māori being to the land, and more importantly to the ancestors of the land, is significant in terms of health, identity, and sense of whānau, hapū and iwi. The colonization process that alienated Māori from their land has therefore had a profound and lasting effect on their health.

Te Reo Māori

Just as the impact of colonisation contributed to Māori alienation from their land, colonisation has also been the cause of the decline in the continual use of te reo Māori. Many Māori working in mental services therefore are not fluent in the use of te reo Māori (Milne, 2001; Te Rau Matatini, 2003b). This is also the case for the majority of adults accessing mental health services. It has been this older age group, aged between 45 and 60 years, that has most felt the effects of colonisation education policy, which saw the banning of the use and learning of te reo Māori in schools (Te Puni Kōkiri, 1996a). The Māori decade of development (1980–1990) is responsible for the revitalisation of the Māori language. This revitalisation has been a Māori community development, led by the Kohanga Reo movement (learning nests for pre-schoolers), which contributed to the increased numbers of Māori learning and using Māori in their everyday pursuits (Te Puni Kōkiri, 2001). Again for better health outcomes, by keeping the language alive, Māori culture, customs and traditions are preserved, identity is strengthened, and access to te Ao Māori is improved and ensured not only for the individual but also for their whānau.

Whānau

Today, as a result of land and cultural alienation from cultural resources, and as a result of urbanization and socio-economic factors, many Māori do not have the whānau and hapū support structures of the past – social cohesion and social support are related to the health of individuals and whānau and their communities. Historically, te whānau defined as an extended family was the basic social unit of tribal society. It was the unit in which the person was socialized as part of the kinship system and culture – the primary agency of cultural transmission (Henare, 1988). Durie (1994) and Metge (1995) defined whānau as more than simply an extended family network, based on a common whakapapa (descent from a shared ancestor). They discussed the term whānau, and its various definitions that reflect the diverse range of relationships that can exist in different circumstances, and includes: a set of siblings; descent groups also known as hapū and iwi; the nuclear family; and a group of unrelated Māori who interact on an ongoing basis and share common goals and aspirations. These definitions recognise the diversity of whānau in today's society. In the area of mental health and illness there are implications for the individual and whānau. Whānau mental health and well-being are influenced by a range of social, economic, cultural and political variables and the diverse realities that shape whānau experiences (National Health Committee, 1998). Disintegration of social networks is likely to occur when there is a combination of cultural and socio-economic deprivation factors with high risk of detrimental effects on health that can potentially spread to involve all members of society (National Health Committee, 1998). Durie et al. (1995) suggested that a “secure identity” protects Māori individuals, whānau, their communities and the wider Māori society against poor health. Mental health services that recognise whānau are supported within a wider network of cultural structures and require services that reflect Māori cultural values will progress whānau mental well-being (Ministry of Health, 2002).

Tapu and noa

As imperative as it is for individual and whānau well-being to have access to te ao Māori, understanding the practices on which the well-being of te ao Māori depends is essential. Sir Apirana Ngata (in Durie, 1994) emphasised that the foundations of health for Māori have their roots in Te Ao Tawhito, and that the law of tapu, which governed the spiritual, social, cultural and economic circumstances of Māori, had more meaning to it than that of “sacred” or “religious”. Durie, explained further:

...as a concept tapu is a means of social and behavioural control that maintains the harmony, balance and unity of the mind, body, soul and family of man. It protects people and their existing resources and ensures continuity with the past and future through systems of tribal kawa (rituals) tikanga (customary practices) aroha (love) karakia and fearsome respect. It fosters an integrated set of values, beliefs and attitudes that promotes and maintains behaviour conducive to the ongoing health, well being and welfare of the community. (1998:8, 15)

The duality of spirituality is again apparent; the concept of tapu creates the bond between the two worlds, the world of the ancestors and spiritual powers and the world in which we live, the world of Tū²⁴, Rongo and our ancestors and our world (Marsden, 1975). Therefore, when we speak of spirituality we link back to Te Ao Tawhito to receive the root of learning as in learning about tapu, and to noa as to its relationship to the physical world and its realities. Its modern day application to Māori health may appear to contrast with traditional meanings, which have been primarily religious in nature for those who sought spiritual answers for managing social conduct and behaviours. However, traditional and contemporary views have common acceptance of tapu and noa as codes for social conduct and adaptation to the environment (Durie, 2000). Durie applied the principles of tapu and noa as a way to reduce risk within mental health services. His analogy to the marae in modern times applies to three domains – space, boundaries and time. In essence, each of these domains, when enacted within a marae setting, promotes caution in social interaction and behaviour so as not to offend the tangata kainga (the local people who belong to that marae), the manuhiri (visitors), or the atua (spiritual powers), nor to break kawa (rules and protocols set) and put oneself or others at risk. Durie (2000) encouraged the same caution when applying these three domains of space, boundaries and time to reducing risk in mental health services. This is best illustrated in the following table.

²⁴ Tūmataunga – God of War; Rongo maraeroa – God of peace.

Table 2.1 *Space, Boundaries, Time & Risk Assessment*

	Space	Boundaries	Time
Low risk	Use of space is negotiated	Recognition and respect for boundaries	Time is prioritized
Moderate risk	Space remains unexplored	Avoidance of interface	Easily distracted
High risk	Commandeered	Disregarded	Easily distracted

Source: Durie, 2000:11

The facilitation of tapu and noa processes as contained within these three domains can be applied to the clinical endpoint of risk assessment for patients and also to the safety of clinical services for patients. The latter moves from the focus on an individual to that of the service and their responsibility to make clinical services safe for the individual and their whānau. In fact, both these descriptions move mental health services towards best practice standards in risk assessment and the achievement of best outcomes for appropriateness of service environment and delivery. Understanding the principles of tapu and noa supports the concept of spirituality as contained in Māori models of health. As has been explained in this section, the roots of these concepts are spiritual since they are from te ao tawhito. The following examples will show that foundations of Māori models of health are firmly based on tikanga Māori concepts and spirituality.

The use of Māori models of health in mental health services

The decade of Māori Development (1980–1990) re-introduced Māori approaches to healing in health. The current decade has seen significant progress made in the installation of Māori models of health in mental health services as led nationally in the Government's Māori health strategy and by Māori themselves. Māori models of health describe cultural concepts and/or preferences; they are not traditional healing models but articulate mechanisms through which traditional concepts can be considered (Durie, 2001). A number of accepted models exist, most are holistic and reflect a broad notion of health similar to the World Health Organisation definition of health. The Māori models of health described in this section are those most familiar to the researcher through past and current work experience and include Te Whare Tapa Whā, Te Wheke, Ngā Pou Mana, Pōwhiri Poutama and Ko te Tuakiri o te Tangata.

Te Whare Tapa whā

Four cornerstones, considered essential by tangata whenua to promote and achieve good health, are placed in the Te Whare Tapa Whā Māori model of health. Te Whare Tapa Whā recognises traditional cultural practices. The use of this model was reinforced by kaumatua at a Mental Health Hui (meeting)²⁵ where it was emphasised that clinical and treatment practices needed to consider the whole person when working with Māori in mental health services (Mental Health Commission, 1998; Koenig, 2000).

The four cornerstones are: te taha wairua (spiritual); te taha hinengaro (mental and emotional); te taha whānau (family), and te taha tinana (physical). While the focus for this research is on Te Taha Wairua, the holistic nature of the Whare Tapa Whā model and its cultural appropriateness and applicability to Maori health demands that all four tapa (sides) stay inter-linked and connected. Therefore, while only brief definitions of the other three tapa will be given, it in no way diminishes their importance in the model.

Te Taha Hinengaro is the mental and emotional aspect of a person. Durie (1994) explained that mind and body are inseparable, and that central to the concept of Hinengaro is the principle of mauri, the vitality spark or life essence of a person. It is this principle that determines how one feels about oneself; and confidence and self-esteem are important ingredients for good health (Durie, 1994). Te Taha Whānau is the extended family system that embraces all whakapapa and contemporary/current significant (person) support ties. It is the principal social, living and learning unit in Māori society (Henare, 1994; Durie, 1994; Metge 1995). Whanaungatanga provides a sense of belonging and collective strength. Te Taha Tinana is the physical side (of one's life), and factors such as socio-economic and environmental circumstances affect the capacity for physical growth and development. Good physical health is necessary for optimal development (Durie, 1994).

In mental health services, Durie (1994) developed the description of taha wairua, noting that while the focus is spirituality, its key aspects include faith and wider communications and its main theme acknowledges the influence on health of unseen and unspoken energies (Durie, 1994). This model provides an opportunity for Māori

²⁵ *Report of the Key Messages to the Mental Health Commission* from the Hui held at key centers in New Zealand February–April 1998, Mental Health Commission (1998).

working in, and for Māori accessing Māori mental health services to experience te taha wairua without having certain structures, requirements and or requisites put on ‘spirituality’.

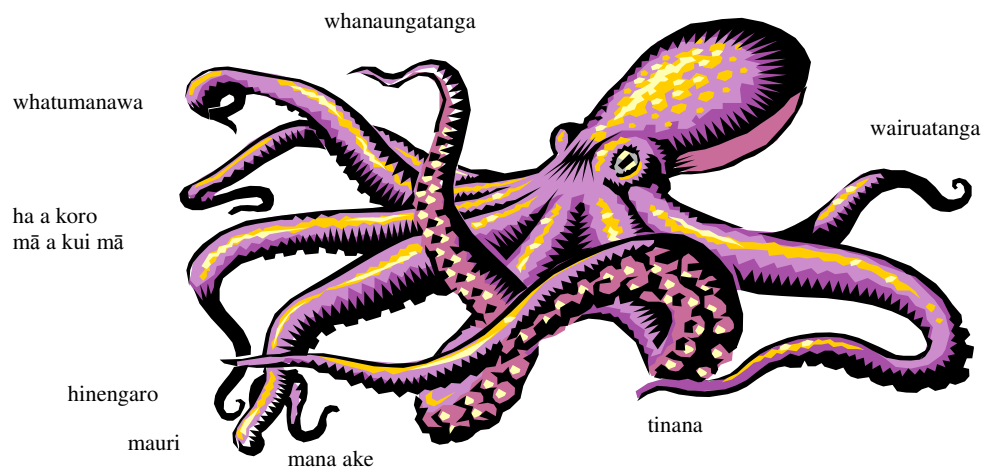
Table 2.2 The Whare Tapa Whā Model

	Wairua	Hinengaro	Tinana	Whānau
Focus	<i>Spirituality</i>	<i>Mental</i>	<i>Physical</i>	<i>Family</i>
Key Aspects	The capacity for faith and wider communication	The capacity to communicate to think, to feel	The capacity for physical growth and development	The capacity to belong, to care and to share
Themes	Health is related to unseen and unspoken energies	Health and body are inseparable	Good physical health is required for optimal development	Individuals are part of wider social systems

Source: Durie, 1998:69

Te Wheke

Rose Pere (1991) used the symbol of the octopus (te wheke) to illustrate the total development of the individual within the context of the whānau. This researcher will demonstrate Pere’s model through the use of an image (as developed by Pere herself).



An explanation follows:

- The body and head represent the individual/whānau unit
- Each tentacle represents a dimension that requires and needs certain things to help give sustenance to the whole
- The suckers on each tentacle represent the many facets that exist within each dimension
- The eyes reflect the type of sustenance each tentacle has been able to find and gain for the whole.

The intertwining of the tentacles represents a merging of each dimension. The tentacles portray certain Māori concepts and values:

- *Wairuatanga* or spirituality, acknowledges one's godlike beginning;
- *mana ake* is the absolute uniqueness of being an individual;
- *mauri*, is the life principle;
- *Ha a koro mā a kui mā* is the breath of life through the heritage handed down by forebears;
- *tinana* is the physical state of being;
- *whanaungatanga* is based on the principle of both genders from all generations supporting and working alongside each other;
- *whatumanawa* is the sustenance and understanding of emotional development;
- *hinengaro*, is the mind, which is the source of the thoughts and emotions;
- *waiora*, reflects total well-being (Pere, 1991:178–182).

Ngā Pou Mana

This Māori model of health also has a holistic approach but with more of a macro-economic focus. Ngā Pou Mana was developed in 1988 as part of the Royal Commission on Social Policy proceedings (Durie, 1994). The model acknowledges for the individual and the whānau that good health is influenced by a number of socio-economic factors often outside the control of the individual and the whānau. These broader determinants of health, such as education, housing and employment, are included and aligned with culturally significant factors. The cultural concepts are:

- *whanaungatanga*, based on the influences of the extended family;
- *taonga tuku iho*, which represents one's cultural heritage;

- *te ao tūroa*, which relates to significant factors of the physical environment which may impact on health;
- *tūrangawaewae*, which is the source of identity, where one comes from, who one is, and how strongly one affiliates to that identity.

Other Māori models of health have also been developed that enable Māori health practitioners to provide cultural awareness and cultural intervention tools for the individual and the whānau. The next two Māori models of health, Pōwhiri Poutama and Ko te Tuakiri o te Tangata, are used specifically to support individual and whānau healing in therapy.

Pōwhiri Poutama

Kōrero pūrākau, one of the traditional stories from te ao Māori, informs this model. Again it is Tane²⁶, the Māori demi-God who climbed the poutama, the twelve steps to heaven, using the pōwhiri process to obtain the three kete of knowledge (Walker, 1995).

Te Ngaru Learning Systems²⁷ developed this model in the mid-1990s, initially to support Māori working in the Alcohol and Drug field. Māori health workers in other areas of mental health services adapted the model to support their work with the individual and the whānau. The Poutama or stairway to heaven is part of Māori whakapapa, which connects one to Io Matua Kore (the highest spiritual power). The Poutama is remembered today mainly through its depiction in the Māori traditional weaving art form of tukutuku²⁸. This type of artwork is displayed on the walls in all traditional whare whakairo²⁹, more recently in some of the more modern Māori meeting-houses, and also as an individual work of art for the home.

Pōwhiri is a Māori traditional custom associated with the welcoming and hosting of visitors (manuhiri) onto the marae. When visitors are welcomed so are the spirits of those who have passed on, who are being brought to the occasion by the visitors

²⁶ In some tribal areas this feat is attributed to Tāwhaki, another Māori demi-God, see the section Wairua Māori – Māori spirituality; te taha wairua – spiritual dimension in health care for the first introduction of Tane.

²⁷ The information for this Māori model of health is taken from the training notes and discussion between the researcher and kaumatua Tūroa Hāronga, (Ngāti-Kahungunu iwi, 2004) and also from the researcher's own knowledge and experience with the model.

²⁸ Weaving specially prepared strands of natural material such as flax, collected from the bush, into patterns illustrating Māori concepts and values often attached to kōrero pūrākau.

²⁹ Māori meeting-houses.

(Barlow, 1991). Part of the pōwhiri³⁰ custom is to be ushered on to the marae or to a hui³¹ by a traditional call, the karanga, which also allows a linking between those who are present physically and those who have passed on to the spiritual worlds. An exchanging of formal speeches (whaikōrero) takes place between the manuhiri (visitors) and the tangata kainga (hosts). When the speeches are completed, the tangata kainga then invite the manuhiri to move across the open space that has divided them to harirū (shake hands) or to hōngī (press noses)³² with the tangata kainga, and then to sit at a meal together. The first meal completes formalities or the tapu part of the pōwhiri, after this meal the manuhiri are noa and are able to move freely amongst the host people (Barlow, 1991).

The poutama is the framework for the model in the form of steps, and the pōwhiri is the process that allows the therapist and the individual or whānau receiving the therapy to move from one level of the poutama (stairway) to another level in either direction, depending on the level of engagement and or wellness of the individual or whānau. According to the steps one moves to, different components of the pōwhiri process are observed. Other cultural concepts also support this framework:

- *karakia* (prayer, incantations) to begin the therapeutic process;
- *take*, the reasons that bring the individual or the whānau to receive support; *whakatangi* allows the releasing of emotions caused by the issues and problems that have caused grief and concern;
- *whakapuaki* is the opening up and sharing of their stories;
- *whakaratarata* enables healing goals to be set and exploration and experimentation with possible solutions;
- *whakaora* signifies the ability of the individual and/or whānau to maintain their own wellness independently;
- *whakaoti* is the celebration of successful healing outcomes and possible discharge from the service.

³⁰ This explanation of the pōwhiri custom is taken from the researcher's own experience and knowledge.

³¹ The pōwhiri custom also occurs in modern settings outside of the traditional marae.

³² The hōngī, the act of pressing noses has two primary meanings: it is a sign of peace and also a sign of life and well-being. (Barlow, 1991:26)

Ko te Tuakiri o te Tangata

In 1996, training with Te Kokonga Ngākau³³ took place at Oranga Hinengaro Māori Mental Health Service, Midcentral Health Palmerston North. This training focused on cultural development regarding interventions for identity issues. Aroha Terry demonstrated the framework to kaimahi Māori (workers) present, who then developed this model into a tool of practice in the field of mental health for Māori.

Ko te Tuakiri o te Tangata means the identity or personality³⁴ of a person³⁵. The methodology includes learning about oneself and telling a story through colours that describes who one is. It is important to remember that everyone is unique. The model allows for growth, and with that growth comes change. Therefore, the stories also change, to accommodate the new learning and growth. As this is an individual journey as set and led by the individual, there can be no right or wrong to the life stories portrayed.

What can be learned from ko te tuakiri o te tangata is like looking deep into a clear pool of water and seeing a reflection of oneself. The model supports identification of personal strengths, and increased awareness and knowledge of cultural background; it also provides an opportunity to build on these new learnings. In the course of the process new strengths are developed, and therapy and healing are able to occur for underlying issues that would otherwise remain hidden and unaddressed for unnecessary periods of time.

Māori cultural concepts³⁶ used in this Māori model of health include:

- *mauri*, life's principle or essence;
- *iho matua*, acknowledgment of spiritual beings with spiritual powers;
- *tapu*, that which is sacred or represents situations that can cause one to be 'at risk';
- *ihi*, self-perception;

³³ A private Māori training provider based in the Waikato

³⁴ Williams Dictionary gives one definition of tuakiri to be 'a person or personality' (1985:445)

³⁵ The information for this Māori model of health is taken from the training notes and discussion between the researcher and Māori mental health worker Gail Bosmann (Tūhoe te iwi). Gail has worked in Māori mental health services as a Social worker and Youth specialist worker; this particular model is one she used frequently with tangata whai ora and whānau.

³⁶ Definitions provided here may not be direct translations of concepts, but are used in support of the model and have been described by the researcher with the support of her Tikanga advisory Roopu

- *mana*, in this instance, relates to levels of self-esteem;
- *wehi*, how others may view the individual;
- *pūmanawa*, human characteristics;
- *ngākau*, the heart that claims to be the seat of affections, feelings and thought³⁷;
- *whatumanawa*, the emotions;
- *waihangā*, fluidity and building of cultural concepts collectively or individually.

Both Pōwhiri Poutama and Ko te Tuakiri o te Tangata have been developed to be used by Māori for Māori. Therefore, Māori health practitioners who seek to practise within Māori frameworks are encouraged to know their own level of cultural identity, to strengthen that identity, cultural learning, and practices, and to apply those learnings holistically, i.e. in all aspects of their lives, work, personal, social, community and family. Māori models of health can allow for the interweaving of elements from Western frameworks into scopes of practice, e.g., narrative and cognitive behavioural therapies.

Acknowledgement is made of those Māori who continue to develop new styles of presenting Māori cultural values and concepts to help the healing of Māori experiencing mental unwellness. It should also be noted that culture is dynamic and fluid and so too are contemporary Māori models of health. Māori are not homogenous and therefore neither are their health practices, Māori concepts and values may be applied to each iwi, hapū and Māori community organisation to suit the local situation. Māori health practitioners also are known to do this³⁸.

Conclusion

This chapter has outlined Western, Indigenous Peoples, and Maori notions of spirituality. A comparison of definitions of what constitutes spirituality and religion has been made with a clear indication that they do not share the same meaning. The literature also showed that Maori have distinctive beliefs about spirituality that are significantly influenced by Maori cultural concepts, beliefs and practices. The limitations that Western medical models of health put on the concept of spirituality

³⁷ See Williams Dictionary (1985:227)

³⁸ Kōrero by Tūroa Hāronga – Ngāti Kahungunu Kaumatua and Māori mental health social worker and cultural advisor for many years to Oranga Hinengaro Māori Mental Health Services, Palmerston North (March 2004).

restrict opportunity for spirituality to an accepted and integral part of indigenous and Maori health practices in mental health. Regardless, current research attests to the benefits of the use of spirituality in positive health outcomes for clients/consumers/and tangata whaiora. The foundations of Maori traditional health practices, which have their roots in Te Ao Tawhito where systems of social control were governed by the lore of tapu, were traced. Examples have been shared of the adaptation of the concepts of tapu and noa and other tikanga concepts and practices that form the basis for Maori models of Health currently used by Māori who work in mental health services.

CHAPTER THREE

Methodology

Introduction

In the past, “a great deal has been written about Māori, mainly by pākehā researchers and within the constraints and methodologies based on western theories” (Stokes, 1985). Research has also been seen always to have served non-Māori interests (Walker, 1995), and has tended to emphasize negative statistics, causing Māori to treat research suspiciously and to question the researcher’s motives and methodologies employed (Tomlins-Jahnke, 1996). More recently we have seen a reversal of this trend. There are now more Māori tertiary researchers and Māori Research units. Te Oru Rangahau, a Māori Research and Development Conference held at Te Pūtahi-ā-Toi, Massey University, in 1998, was significant in the area of Māori research. Its published proceedings attest to an increasing number of Māori presently involved in research. Ninety-two papers were delivered, with the representative majority of presenters being Māori from all over the motu³⁹. This conference provided an opportunity for Māori researchers to share information as well as to raise the level of importance and involvement needed to make gains for Māori development in areas such as health, the social sciences, hapū and iwi development, law, education, and Treaty issues and claims. It also emphasised the need to use appropriate methodologies in pursuit of Māori knowledge, and that knowledge, as suggested by Te Awekotuku (1991:67), “...needs to be responsive to expressed Māori needs, needs expressed from within the community and not needs perceived by those outside it.” Clearly this view and the views of others in this paragraph demonstrate that Māori have reached a turning point in research concerning Māori, and it is they who will decide the parameters and terms of research for Māori.

³⁹ Māori word for ‘island’, but denoting (in this context) both the North and South Islands of New Zealand.

In this chapter the methodology used for this study will be discussed and the importance of incorporating a Māori world-view and Māori knowledge will be outlined. Second, the methods used to guide the research are discussed, and the final sections of the chapter describe the data analysis, ethical issues and the processes of selecting and meeting the research participants.

Māori research methodology/paradigms

Bevan-Brown, (1998:231) described Māori centred research as “by Māori for Māori, about Māori”. However, one might ask just what that means and is that enough of a description. Being firmly encased over the last 160 years in a Western society, one could argue that Māori have not found ‘putting into practice’ the ideology of ‘by Māori, for Māori, about Māori’ quite that simple. It seems that it has only been during the last decade or so that a ‘need’ for Māori centred research has been finally acknowledged and has gained some acceptance by mainstream researchers in New Zealand. Durie (1998c:417) claims that, “Had a conference on Māori research been held ten or fifteen years ago it might well have attracted scorn rather than enthusiasm. Māori people and researchers have not always enjoyed each other’s company”.

Durie (1996) further maintains that three developments have hastened trends towards a Māori centred approach. These are: the push by indigenous people worldwide for self-determination and autonomy; the renewed emphasis of the Treaty of Waitangi by the New Zealand Government; and the emergence of distinct frameworks favoured by Māori that emphasize Māori perspectives.

Definitions: Māori centred versus kaupapa Māori research

Over the past decade, the development of what is broadly defined as kaupapa Māori research overtly acknowledges Tino Rangatiratanga⁴⁰. Tomlins-Jahnke (1996) defined kaupapa Māori research as ‘research over which Māori maintain conceptual, design, and methodological and interpretative control’. Irwin (1994) described kaupapa Māori as research that is ‘culturally safe’, relevant and appropriate, which stands up to the rigour of research and is undertaken by a Māori researcher, not a researcher who happens to be Māori, and involves the ‘mentorship’ of elders. Irwin also grounded her work in a

⁴⁰ Defined as self-determination and autonomy.

paradigm that stems from a Māori worldview. Graham Smith (1990) has written extensively about kaupapa Māori research initiatives and summarized kaupapa Māori research as: related to "being Māori; connected to Māori philosophy and principles; taking for granted the validity and legitimacy of Māori; the importance of Māori language and culture; and being concerned with the struggle for autonomy over our own cultural well-being".

On the other hand, Cunningham (1998:398) described a research approach that defines the degree of Māori involvement. He identified that at one end of the spectrum there is "Research not involving Māori", which is thought to have no impact on Māori. This is followed by "Research involving Māori", where Māori are involved as participants or subjects, or possibly as junior members of a research team. Both these types of research are controlled by mainstream and the analysis is mainstream. Then at the other end is "Māori centred research", still controlled by mainstream; however, Māori are significant participants and the analysis undertaken is Māori and produces Māori knowledge. The fourth stage is "kaupapa Māori research", which has some of the attributes of the "Māori centred" approaches yet differs significantly in that Māori have the control and the research meets expectations and quality standards as set by Māori.

The above definitions show, therefore, that Māori centred research is not always facilitated by Māori and does not always have a strong degree of participation by Māori. Kaupapa Māori research, however, promotes a research approach that locates Māori as the focus and beneficiary of the research activity (Durie, 1998b). It also promotes Māori control where the analysis is Māori, which produces Māori knowledge and meets Māori expectations and quality standards.

For this research, I have chosen a kaupapa Māori framework that adheres to kaupapa Māori research principles and tikanga Māori processes. It is therefore very important to define more clearly other positions on kaupapa Māori research and the knowledge source from which it draws. The researcher's attitude to knowledge strongly links to the kaupapa Māori research view in that it refers to a developing body of knowledge that draws from traditional and contemporary mātauranga Māori in dynamic ways, but also includes the utilisation of Western scientific knowledge (Durie, 1998b; George, 1999). Durie (2002) supported this view further in that he explained that science is one

body of knowledge; faith is another; and indigenous knowledge is yet another. Rather than contesting relative validities, an increasing number of indigenous researchers use the insights and methods of one to enhance the other. A traditional view of mātauranga Māori as seen by Māori (Pere, 1997; Durie, 1985), is that it is a gift given by the Creator to the ancestors to be passed on down through the generations, expressed in the phrase “ngā taonga tuku iho”⁴¹. The example of Tane Mahuta who gained the three baskets of knowledge, usefully describes this concept, as explained by Walker (1995:9): “Tane did not receive the knowledge as of right; he had to be tested to prove his worthiness, before he was able to receive that knowledge”.

So it was with the researcher, who did not take it for granted that knowledge would be gained just by being Māori, but that there needed to be “a thorough consideration of one’s own ability to fulfill the research requirements; factors to consider did include tribal background, gender, language (te reo Māori) fluency, age and qualifications” (Te Awekotuku, 1991:2). Irwin (1994) and Smith (1995) argued that being Māori, identifying as Māori and as a Māori researcher, is a critical element of kaupapa Māori research.

Māori knowledge does not belong to the individual and neither do all Māori own it equally. Knowledge does not belong to Tane – he was the recipient. It is whānau, hapū and iwi and not the individual who retain ownership of all tribal knowledge. The researcher also accepts there is tribal knowledge available only to tribal members, which does not belong in the public arena. This is unlike the pākehā attitude, where people are assumed to have a “divine right” to knowledge (Stokes, 1985; Smith, 1992).

Another important underpinning of kaupapa Māori research is the use of multiple methodologies and analyses grounded in and consistent with a Māori world-view. These methodologies take into account the concepts of manaaki⁴², koha, mahitahi, mana, māramatanga, and the spiritual notions of mauri, wairua, and tapu (Metge, 1995:90; Durie, A., 1992:7). Tapu or mauri, when practised as it should be, can

⁴¹ Treasures of culture and knowledge handed down through the generations.

⁴² **Manaaki** – caring in a reciprocal manner; **koha** – a small token of appreciation, not necessarily monetary ; **mahitahi** – co-operativeness; **mana** – control, prestige, influence; **māramatanga** - enlightenment ; **mauri** – life principle (essence) ; **tapu** – something being subject to restriction for good reason (e.g., personal or community safety).

produce “a collectively beneficial outcome to research for Māori and can avoid stepping on the mauri or prestige of other people, i.e. by indiscriminate use of knowledge” (Rangihau, 1977:12). Mauri is also the essential principle that permeates all things and allows for ‘unity to exist in diversity’ (Durie, 1985; Marsden, 1990). Mauri is therefore able to facilitate an integrative, holistic and collectivist approach that recognizes the diverse and complex nature of reality within Māori society as reflected in the Māori worldview. All these concepts inform my practice both as a researcher, and as a worker, working for Māori within mainstream mental health.

Methods

In the discussion above I believe I have shown this research is more than Māori-centred. Therefore, in applying a combination of kaupapa Māori concepts as described by Durie, (1998), George, (1999) Pere, (1991) Te Awakotuku, (1991), Smith, (1999) Irwin, (1994), and Marsden (1990) to this framework, I have attempted to ensure concepts such as mātauranga Māori, identity as Māori, manaaki, koha, mahitahi, mana, mārāmatanga, mauri, wairua, and tapu are the foundations of this research, and that the outcomes of the research will benefit the development of Māori knowledge.

Principles

A guiding principle used in conducting the research was ‘whakawhanaungatanga’⁴³. According to Bishop (1998:133), the concept of whakawhanaungatanga has three major, overlapping implications. The first implication is that the researcher is involved in establishing and maintaining relationships with “whānau of interest” throughout the research. The second is that the researcher is involved in the process, “physically, ethically, morally and spiritually and not just as a researcher concerned with methodology”. The third implication is that, “establishing relationships in a Māori context addresses the power and control issues fundamental to research, because it involves participatory practices” (Bishop, 1998). Participation, consultation and cooperation with appropriate whānau, hapū and iwi in a collaborative manner are the primary organizing principles that sanction a kaupapa Māori initiative and distinguish this approach from Western ideologies (Marsden, 1990: Durie, 1992; Smith, 1999). According to Durie (1998c) and Smith (1999), a Māori worldview must be incorporated

⁴³ For this research networking and establishing relationships in a Māori context was through whānau of interest (Bishop, 1998:133).

into every process that requires a “negotiation of relationships” and into the development of collaborative, agreed-on practices involving Maori. The whānau principle supports the negotiation of relationships approach and is identified by Smith (1990) as an important aspect of kaupapa Māori approaches. Smith (1999) argued that in pre-colonial times it was the whānau, rather than the individual, that was the core social unit, so it is today that the whānau remains as a persistent way of living and organising the social world. Smith further stated, “in terms of research, the whānau is one of several Māori concepts which have become part of a methodology, a way of organising a research group, a way of incorporating ethical procedures which report back to the community, a way of ‘giving voice’ to the different sections of the Māori communities, and a way of debating ideas and issues which impact on the research project”.

Whānau is one of several aspects of Māori philosophy, values and practices that are brought to the fore in kaupapa Māori research. As the area of research would explore the concept of wairua as expressed by Māori cultural and clinical workers in their work and personal lives, it was my hope that the appropriate whānau of interest and the relationships established between participants and me as ‘researcher’ would provide support for participants if issues arose associated with the research. Having had a long-term involvement and commitment to working within mental health services and Māori mental health services for over 15 years I became quite passionate about wanting to understand the concept of wairua and its influence in the mental health services. I therefore felt the research topic would be subjective and could evoke much emotion.

Subjective involvement is another principle I believe is necessary when undertaking Māori research, and is defined by Marsden (1975:117), who asserts that the path to the Māori world “through abstraction is a dead end, it requires a passion and subjectivity”. I wanted participants and their whānau of interest to feel their contribution (knowledge shared) would be valued and respected. Part of the power and control of the research was to enable participants to check back for themselves on any of the information shared, as well as with their whānau of interest. This process further contributed to the robustness of the study findings and again is consistent with kaupapa Māori research, in that a partnership model is evident with the researcher sharing the power and control of the research with participants.

Supervision and support

Irwin (1994), like Bishop (1998), argued for the importance of the concept of whānau as a supervisory and organisational structure for handling research. Bishop referred to this as a “research whānau of interest”; Irwin referred to a “whānau of supervisors”. As noted by Smith (1999:185), “for both Bishop and Irwin the whānau provides the intersection where research meets Māori, or Māori meets research on equalizing terms”.

Supervision and support for this research was mainly provided in two ways:

- Through an academic framework under the supervision of Māori staff at a mainstream education institution – a university
- By a tikanga advisory roopu made up of te hunga mātāpuna⁴⁴, five kaumātua and pakeke, independent of any mainstream links.

The Tikanga advisory roopu, made up of kaumātua and pakeke, included the researcher’s own iwi and Te Rau Puāwai whānau. Te hunga mātāpuna were representative of whānau, hapū and iwi, to ensure reliability, accountability and cultural safety for the researcher and participants in Te Ao Māori. The Tikanga advisory roopu provided different areas of support to the two academic supervisors. The mentoring and tikanga supervisory support provided was important in protecting the tino rangatiratanga, whanaungatanga and mana of the participants and their whānau as the guardians of the information. Without these ongoing sanctions and apt use of Māori concepts the research would not have occurred.

Both sets of supervisors supported the scholarly and the tikanga needs of this research. Throughout the research, the researcher took many opportunities to discuss relevant cultural and academic concepts as raised in the study by many of the participants with both sets of supervisors for clarity and improved understanding.

This model of supervision, as described by Irwin (1994:29), promotes a relationship characterised by aroha, collective responsibility and co-operation.

⁴⁴ The wellsprings of knowledge.

Preparing the ground

To establish whakapapa links, the first part of the process facilitated by Whanaungatanga was to consult with the 'Whānau of interest' (Bishop, 1998). This involved identifying key Māori health professionals working in the area of Māori mental health who had access to wider networks in te ao Māori. I began with the whānau of Te Rau Puāwai⁴⁵. I first sought guidance from Te Rau Puāwai kaumātua and the coordinator. The idea of studying significant effects of taha wairua in mental health services sounded exciting, but was it possible to achieve this in an academic setting without the study seeming too large?

The original aims of the research proposal were to uncover to what extent the use of taha wairua influenced mental health practices, and whether te taha wairua influenced when and how Māori models of practice were utilised. Also under examination was when and how clinicians were influenced to support access for Māori patients/consumers to alternative methods of healing, namely Rongoā (Māori medicines) and thereby Māori patient/consumer access to Tohunga Puna Ora (Māori healer). Specifically, this research would investigate aspects of client presentation that presented practitioners with an opportunity to explore the use of Rongoā or 'other' strategies in working with Māori. Those other strategies included the influence of taha wairua in supporting and providing whānau, hapū and iwi links for the patient/consumer. However, after much discussion and thought a broad research concept was developed:

An exploration of the concept of taha wairua and any significant effects it may have on the clinical practice of Māori clinicians working within Māori mental health services.

Te Rau Puāwai kaumātua believed the research was possible and the coordinator introduced me to a possible supervisor. I then sought the advice of my own iwi kaumātua about the study. Potential participants would be from different iwi, and I needed to discuss the appropriate cultural protocols to follow. I also discussed my ideas with Māori colleagues who worked in mainstream and or Māori mental health services.

⁴⁵Te Rau Puāwai is the body of Māori Mental Health workers connected through their study at Massey as part of the Te Rau Puāwai scholarship programme. There have been over 435 recipients in the 5 years the programme has been running. The whānau includes cultural workers, nurses, social workers, consumer advisors, managers, psychologists, kaumātua, family therapists and counsellors.

The support and approval gained from all these whānau gave me confidence to continue.

Profile of researcher: my journey – wanting to make a difference

I am a Māori woman of Whānau-ā-Kai, Whakatōhea, Ngāti-Kahungunu and Ngāti-Porou descent with a relatively sound understanding of Kaupapa Māori research and Treaty issues as they relate to the experience of Māori in their search for health and well-being.

One of the most visual portrayals that comes to mind as I recall my journey leading to this research is that of a frond of the punga fern unfurling. My journey has not been limited to the unfurling of the main stem of that frond but has also encompassed the individual unfurling of each rau (leaf) attached to that particular punga frond.

My interests in Māori mental health were first developed in 1988, when I worked in the local communities of Hastings, Napier and Havelock North as an education liaison worker between the secondary schools and Māori whānau. It was then that the reality of socio-economic factors of income levels, employment and unemployment, housing conditions, daily food consumption and diet, whānau support systems impacted on me. While visiting many of the homes, I saw poverty first hand – poor housing, negative influences of ‘benefit dependent’ families, low-income families struggling to provide healthy food for daily living, as well as trying to pay school fees or necessary medical fees, often for many whānau.

Durie (1997) maintained that good mental health is not compatible with unemployment, demeaning and unrewarding work, negative experiences at school, and powerlessness. He has also repeatedly stated that a secure identity for Māori requires more than a superficial knowledge of iwi or hapū. Such an identity depends on access to the cultural, social and economic resources of te ao Māori, especially te reo Māori, whānau and land. All three underlie and reinforce identity, and (good) mental health. I witnessed the cultural effects that lack of resources had on whānau not living close to extended whānau, or to their marae, hapū and iwi links barely, if at all, existed.

I wanted to make a personal difference.

That employment experience was the springboard for my moving into tertiary studies and the rau of the fern frond started unfurling. It is said that, “knowledge is the key to power and the ability to control’s one’s life and that of others” (Mutu, 1998:51). I studied for a Massey University Certificate of Social and Community Work while working part-time as a counsellor for Māori at a local girls’ high school. On completing the certificate, I began a professional career in mental health mainstream services. My passion for and interest in mental health emerged from the many experiences I had working with troubled rangatahi while part of the education sector. The majority of my casework was with young Māori, both male and female, and their whānau. The mainstream models of care I had had training in were not appropriate.

I found I wanted to do something that would make a difference for these rangatahi Māori.

I began utilizing Māori health models of care, such as Te Whare Tapa Whā and whakawhanaungatanga, and incorporating this learning into my work with Māori youth. I found that through the use of these models I could remain rangatahi-centred, whānau-centred and Māori centred in the treatment and care of rangatahi. The models focused on the importance of having an identity (Māori) and strengthening it. There was also a strong focus on connecting with whānau and/or significant others, and on finding, developing and establishing extended whānau, hapū and iwi links. I had first-hand experience working with and experiencing te taha wairua.

Examples of this work included working with rangatahi who had self-harmed or were at risk of self-harm. I included karakia, waiata and mihimihi every time I met with the rangatahi and their whānau either in one-to-one situations or as a group. I adapted a Māori experience of tūrangawaewae⁴⁶ to support rangatahi linking with each other, with me and with other rangatahi. I found when tikanga Māori (Māori cultural processes) was in place, the strong influence of te taha wairua gave a ‘voice’ to rangatahi and whānau, allowing them to share their hurt, to tell what was happening for them, and to identify ‘other’ safe ways of dealing with their hurt, anger and hopelessness rather than

⁴⁶ Tūrangawaewae, ‘the place where one stands’, traditionally refers to one’s origins of birth or early years of childhood. In this exercise, it gave participants the opportunity to identify their birthplace, their current place of residence, a physical place where they felt safe, and significant persons attached to those places.

self-harm. It also gave me (and my colleagues) the opportunity to know how best to support them and what ‘safety’ strategies needed to be put in place for them and their whānau. Rau of the fern frond continued to unfurl, not just for me but also for rangatahi and for many of my colleagues who worked alongside me in this work.

The Māori models of health that I worked with became a part of my everyday practice. The four-and-a-half years I spent with Te Puāwai O Te Whānau Oranga Hinengaro Kaupapa Māori Services were for me a time of cultural affirmation. It presented me with the challenge of working to develop and implement culturally appropriate processes in Te Puāwai and also in the adjoining mainstream mental health services. Again, other rau began to unfurl.

Working alongside levels of management and not just clinicians presented a new challenge. Institutional racism and personal racism were not new to me, but the playing field changed, and that was new. Where I expected those in management to be more open to the rights of Māori in mental health through the Treaty of Waitangi, my experience proved this was not so. This experience was not limited to non-Māori, Māori too were either ignorant of cultural practices or had assimilated into the roles assigned them by non-Māori. The Blueprint for Mental Health Services and How Things Need To Be (1998) became a standard guide to work by in the workplace.

I resolved to make a difference by working to improve and increase responsiveness by mental health services for Māori accessing and or working alongside mainstream services increased. I wanted to help Māori to access appropriate cultural treatment and intervention whilst receiving mental health assessment, treatment and care.

Although the development work in mental health services has been curtailed at times through lack of resources, other opportunities arose to ‘help make a difference’. A new frond unfurled, when I joined the Māori workforce at Waikato District Health Board (WDHB), Waikato Hospital, Hamilton Campus. The ‘Towards Māori Health Gain Organisational Framework’ (WDHB, 2002) is that organisation’s response to putting the Treaty of Waitangi principles of partnership, participation and active protection into practice. The framework’s guiding principles are: Māori Health is everyone’s

responsibility, and requires collaborative and co-operative effort; changes are about evolution, not revolution, and need to be sustainable (WDHB, 2002).

I am fortunate to have been a part of some of the development and current implementation work of this framework, which has been organization wide and not restricted to mental health. Many cultural processes and policies focusing on Māori participation have been implemented, together with consultation on and at all levels. An organizational cultural education and training programme has also been implemented. Non-Māori and Māori alike are now also afforded the opportunity to ‘help make a difference’ in health gains for Māori.

Ethical Considerations

Smith (1999:120) identified seven ethical responsibilities as a prescription for Māori researchers. Therefore because of the nature of the research it seemed appropriate that these and the other guiding principle of ‘whakawhanaungatanga’ would be used as the primary guide to this researcher’s behaviour in establishing the processes for this study:

- Aroha ki te tangata (respect for persons)
- Kanohi kitea/kitenga kanohi (the seen face –present yourself to people face-to-face)
- Titiro, Whakarongo –Kōrero (look, listen, speak)
- Manaaki ki te tangata (share and host people, be generous)
- Kia tūpato (be cautious)
- Kaua e takahia te mana o te tangata (do not trample over the mana of people)
- Kaua e mahaki (don’t flaunt your knowledge).

Other key ethical issues for the researcher were confidentiality and anonymity. Some wanted anonymity assured. However, anonymity cannot be guaranteed. There are a small number of Māori mental health services that exist under the umbrella of mainstream organisations; therefore there is a high chance of recognition if we are not careful. Māori staff were, and continue to be, outspoken in their views of the appropriateness of service delivery to Māori and the acceptance and value of Māori models of care in mental health service delivery. At times those views have not

appeared welcome. However, through the process of assigning numbers to participants' views, the researcher will do her utmost to maintain their anonymity.

Organising when and where the interviews would take place was not a straightforward process. Again, because of the nature of the topic of study, and acting under the guidance of kaumatua from the Tikanga advisory roopu, I needed to allow time for participants to arrange whānau support or consultation with their kaumatua before the interview. I needed to check that participants were also comfortable with my bringing along whānau and kaumatua support for the actual interviews. Only two of the interviews were held without any whānau support present. The focus groups also had the korowai of kaumatua support. As most of the participants were based throughout the North Island of Aotearoa, careful planning of time and travel for all those involved was required for the interviews to be successful. All the individual interviews were held in the rohe where participants worked. The area travelled included Whanganui-ā-Tara (Wellington), Papaioea (Palmerston North and Fielding) to Heretaunga (Hastings), and Kirikiriroa (Hamilton). Participants were given a choice of venue in which to be interviewed. All but two of the interviews were held in participants' homes. One was held in the workplace, the other at Te Pūtahi-ā-Toi, Māori Studies, Massey University.

Profiles of participants

All the participants approached and invited to be part of the study were very willing to participate in the research. The individuals interviewed were people who were working with mental health tangata whai ora⁴⁷ in both primary and secondary mental health services. Of the eight, three are psychiatric nurses, one with team leadership clinical responsibilities, and the other has a cultural leadership role. The remaining five participants fill roles that include kaimanaaki, kaitautoko, kaumatua, and clinical psychology. The kaumatua also has cultural leadership roles. Participants ages varied from rangatahi to pakeke and kaumatua and between them have 54 years of mental health work experience, 33 of those years specialised within Māori mental health. Iwi identifications where participants claimed links to more than one iwi included Ngāti Kahungunu, Te Āti-Haunui-ā-Pāpārangi, Ngāti Raukawa ki te Tonga, Ngāti Maniapoto, Tainui, Tūhoe, Kaitahu, Kāti Mamoe, Waitaha and Te Arawa.

⁴⁷ See Chapter One, p. 13, footnote 4, for an explanation of how this term is being applied in this thesis.

Focus groups

The research also included two focus groups. In one group, participants were mainly mental health workers, with two in management positions (11 participants). The other group of three participants was made up consumer advisors, who were or continue to be consumers of Māori mental health services as well as working in paid advisory positions for mental health services. The majority of participants in both focus groups were part of Te Rau Puāwai whānau.

Focus group participant iwi identifications included Whakatōhea, Tūhoe, Ngāti Porou, Waikato, Te Āti Awa and Kāti Mamoe.

The gender mixes of the individual interviews are five men and three women. In the focus groups there are five men and nine women. The gender mixes as well as the mix of clinical, cultural and consumer kōrero from the interviews and focus groups provided a range of opinions and experiences.

The decision to include a focus group made up of consumer advisors came near the end of the data collection period and was suggested by kaumātua in the Tikanga advisory roopu. This proved an excellent move, because they had had experiences receiving mental health services from both mainstream and Māori mental health. They were more than willing to share their knowledge of and differences in experiencing ‘te taha wairua’ in the context of receiving mental health services in a clinical setting. They also provided some support for the views shared by those interviewed individually on the ‘significant effects’ ‘te taha wairua’ might have had as a result of an intervention being facilitated by taha wairua. Their combined years of experience of receiving mental health experiences spanned 25 years.

The majority of the participants involved in the research either as individuals or as part of a focus group were very involved with their community, and included strong marae commitment. Many of them do not currently live in their own iwi area, yet they had fostered whanaungatanga relationships within their community and aligned themselves to other iwi or to urban-based marae. This experience on its own seemed to strengthen their resolve, as reflected in their kōrero, to support tikanga Māori, and more

specifically the inclusion of the concept of wairua as part of the service delivery to Māori in mental health services.

Collecting the data

Connecting with Rau Puāwai and accessing the Māori Workforce pool of resource have been highlights of the research. I learnt much about the value of whānau, whānau of interest and whakawhanaungatanga. Many doors were quickly opened because of the seeds planted, watered, grown and nurtured from within Rau Puāwai.

The primary instrument for data collection was the researcher. Consultative focus group hui and in-depth individual interviews were facilitated with the use of Māori traditions of oratory, te reo mihi and poroporoakī. Whānau and participants were greeted with appropriate tribute paid to Matua i te Rangi, te whenua, te hunga mate me te hunga ora. These affirmations of a Māori worldview established the kaupapa for the day. Māori Marsden (1990:5) has said that, “...by acknowledging the past and laying down the foundations for the future; past, present and future are brought together in one space”.

Each focus group hui and individual interview began and ended with karakia. Within the hui the researcher, participants and whānau of interest were given an opportunity to mihimihi (formally introduce themselves). They were also able to provide testimonies and stories of individual and collective histories as they related to the research aims.

Informed consent⁴⁸

At the start of each interview each participant was asked for written consent for the interview discussions to be audio-taped and transcribed verbatim. Participants were ensured of the opportunity to review the typed transcripts and amend if necessary. Verbal consent was obtained for the Rau Puāwai whānau focus group and the consumer advisor hui to be audio-taped and for the discussion and comments to be transcribed. Consumer advisor participants also signed written consent forms.

⁴⁸ See Appendices A: Participant Information Sheet and B – Consent Form.

The process of informed consent is ongoing as part of the shared-power relationship and the participant-centred approach, and strengthens the research findings because it empowers participants by supporting individual choice and decision-making in their level of participation within the interview process.

Managing and analyzing the data

Data management is defined as an operation necessary for the systematic, coherent process of data collection, storage and retrieval (Huberman & Miles, 1994). Huberman and Miles (1994) identified the three main aims of this process as: the ensuring of high-quality, accessible data; the accurate documentation of analyses processes; and the retention of data and associated analyses after the study is completed. The researcher also undertook an inductive approach (Patton, 1990), with data management and analysis conducted as an integrated process. Seven questions⁴⁹ were used to collect data, and as raw material was collected, i.e. the interview tapes and field journal notes, the material was transcribed by the interviewer. This allowed for an in-depth understanding of the data and enabled the process of transcription to become part of the analysis. Copies of the transcripts were sent to participants to substantiate their kōrero and, once confirmed, the material was prepared for thematic analysis. The data reduction process permits information to be reduced in an anticipatory way, allowing the researcher to develop a conceptual framework, research questions, cases and instruments (Kingi, 2002). The researcher used Nvivo, a qualitative data analysis package to analyze the consumer focus-group interviews. In doing so, fields were created within the database that mirrored the questionnaire. While data were inputted manually, the database allowed this information to be more efficiently managed. It permitted summary reports to be generated for each question as well as for aggregated data. Independent reports pertinent to particular interviews could also be generated. The material was then coded manually per question into sub-themes. Sub-theme materials were then sorted into clusters of key themes. This type of process is defined as data display, which is an organised, compressed assembly of information that allows for conclusion drawing and/or action taking (Kingi, 2002). The final process involved the clustering of organising themes into global themes, using a thematic network as described by Attride-Stirling (2001). Methodological triangulation also occurred as

⁴⁹ See Appendix C: Questions for Participants and Consumer Advisory Group.

conclusion drawing was compared and checked with supervisors and key informants from the tikanga advisory roopu.

Issues: the moral and the perplex

My original proposal had included participants from Te Puna Hauora, the Kaupapa Māori health unit at Tauranga. Due to time constraints I was unfortunately not able to include them. Following approval from Massey University's ethics committee a suggestion was made, in supervision, to begin the research with a Te Rau Puāwai whānau of interest focus group. This was very helpful both in the process of determining prospective participants for the more in-depth individual interviews, and in 'testing' the topic. It would be another 3 months before participants confirmed their availability and selection could be made. More participants volunteered than were needed for the study. The eight selected participants and focus-group members were from both primary and secondary interfaces of mental health care working for Māori mental health services.

The importance of having regular interactions with one's supervisors and tikanga advisory roopu while working through the moral and perplex issues of the research cannot be underestimated. The appropriate timeliness of those interactions proved invaluable as they provided clarity of thought and direction for the researcher as a result of which barriers dissolved into opportunities and a way forward was found.

Conclusion

The methodology used for this research has been outlined and discussed. Differences and similarities between a Māori-centred and a kaupapa Māori approach are defined and discussed. This discussion has strengthened the researcher's stance about her choice of a kaupapa Māori research model being the appropriate foundation for this research. The study is based on the Māori concept of 'te taha wairua'. It is about Māori, and the outcomes are expected to help develop Māori knowledge. Mātauranga Māori both in a traditional and a contemporary sense is acknowledged, and differences in te ao Māori and Western world cultures in the obtaining and sharing of mātauranga Māori have been explained.

The significance of using kaupapa Māori concepts to guide this study has been shown. Preparing the ground by establishing whakapapa links and consulting with the researcher's own 'whānau of interest' and 'whānau of supervisors' were paramount, not only in defining the research question and initially moving the research forward but also in maintaining an integral kaupapa Māori approach. Having the primary, 'seven ethical responsibilities' (Smith, 1999) to help guide this researcher's behaviour as interviews were set up and arranged gave added value to a kaupapa Māori framework.

The knowledge and experiences, as shared by the researcher, her supervisors and participants, reinforced the belief that participatory practice in a Māori context addresses the power and control issues fundamental to research that have contributed to the robustness of the study findings.

CHAPTER FOUR

Sharing their Experiences

Introduction

This chapter presents the major themes from the participant and key informant interviews. The first part of the chapter centres on how tikanga and Māori models of health support the facilitation of taha wairua within Māori mental health clinical and cultural practice. The second part outlines significant benefits and or changes that have occurred for tangata whai ora and whānau, Māori clinicians and their colleagues as a result of the influence of taha wairua. The third part examines Māori concepts and principles pertinent to cultural roles undertaken in Māori mental health services.

A profile of participants has been presented in Chapter Three. Briefly, participants were Māori workers working directly with tangata whai ora in both primary and secondary mental health services. Key informants represent comments from the researcher's tikanga advisory roopu; numbers distinguish participants and key informants; consumer focus-group participants are clearly identified as consumers. This reporting system maintains confidentiality for all participants, key informants and consumers, yet makes the distinction between their responses and comments.

Wairua Māori – Māori spirituality; Taha wairua – spiritual dimension: Māori perspectives

As already established in Chapter Two, Māori understanding of spirituality is distinctive and attributes spirituality as having immortal (god-like) and mortal (human) qualities. This researcher notes that in the literature review, wairua Māori was put forward as a description of Māori spirituality (Potaka Dewes, 1986), and taha wairua to denote the spiritual dimension (Durie, 1994). In the data, the Māori term 'taha wairua' is used more often than not to describe spirituality, and for the purposes of this section the term

‘taha wairua’ is used to support the notion of the spiritual dimension and Māori spirituality within the context of participants’ experiences in mental health:

What is wairua? Well, to me it’s about spirituality and it is inherited, he taonga nō ngā tūpuna i tuku iho, nō Io Matua Kore. (key informant 3)

Wairua... it’s part of the whānau from the Atua. (participant 5)

I see taha wairua as encompassing and for a lot of Māori, taha wairua is part of who they are. (participant 4)

Participants’ and key informants’ views reflect those Māori perspectives of spirituality defined in the literature. Although Māori acknowledge that wairua consists of more than one cultural concept, it differs from the Western world’s perspective of components. Ross (1997:38) described spirituality as dual concepts of horizontal and vertical elements where the vertical dimension is “the person’s relationship to God” and the horizontal dimension is “the individual’s lifestyle and relationships with self, others and environment”. These Western dual concepts do not take into account the holistic Māori world-view that spirituality for Māori is intrinsic, and is not separated into parts or pieces, which “suggests a field ready for measurement, insertion, replacement and manipulation” (Henery, 2003:555):

You can’t departmentalise taha wairua – that is what kotahitanga is about, everything works together. (participant 8)

The differences between the two philosophies led one participant to comment on the place of taha wairua in mental health services and how it might be facilitated within service delivery:

Does taha wairua belong in mental health services? On one hand, we are talking about the intangible, on the other we are talking about the tangible. For taha wairua there is already a ‘structure’ in place and we should leave it in its purest form. (participant 7)

Taha wairua links are both tangible and intangible; in either sphere the effects of the influence of wairua are far-reaching and real, as described by participants:

I see wairua as your link to the whenua, your identity, the environment and a real link to God, or the atua or a higher being and having access and equity to the intangible as well as the tangible. (participant 6)

Wairua is all encompassing because it is an intangible influence, it can be physically felt and the effects of wairua can be seen and yet cannot be physically touched. (participant 5)

Within our work with taha wairua, we need to allow the wairua to go where it wants to go and then move from there ... 'mai roto' – healing from within. (participant 7)

A holistic view allows for diversity and acceptance of where the tangata whai ora is. The clinician can then work comfortably in two worlds:

...everybody has wairua – we are just all on different currents – wai rua – two waters, so you need to find the current the tangata whai ora is in and then bring your current alongside. (participant 8)

Power lives in the honohonotanga of one's tinana and wairua – the joining of one's physical and spiritual self – so when it comes to healing, how you live those principles is how you will be able to heal and that applies to whether you are giving (providing) the healing or receiving the (benefits) of healing (key informant 2)

Some participants and key informants understood clearly that wairua (spirituality) is not to be confused with religion:

I've spoken to a few kaumātua through hui and asked, "What is wairua?", and they all talk about various things mainly relating to religion but don't actually give a definition. For me, my wairua is an exact duplication of my tinana and it is attached (to my tinana) by the cord from my bellybutton, and when it is broken, the mortal remains have died and the spiritual side – the wairua lives on and goes on to join our ancestors. (participant 3)

Many people, Māori included, confuse wairua with religion. What is wairua? To me, it's having a personal relationship with te Atua, or God if you prefer – a relationship that is one of respect, one of acknowledgement; it is regular, it is in harmony with one's own life values, beliefs and living patterns... (key informant 2)

I think that taha wairua...is more of something you feel and wairua can't be contrived nor controlled. I think that religion doesn't always encompass spiritual things – man's ideas and concepts are part of religion these days. (participant 4)

The literature review showed that indigenous, Western and Māori perspectives separate spirituality from religion. They are not seen as one and the same. The literature also demonstrated that wairua is not able to exist alone, te mauri, life's principle or life force is required, and in order to enhance one's wairua, according to participants, it must be endorsed by a person's actions.

Wairua does not exist alone, it has been aligned to mauri, I say mauri ora which is the life-force – but a life-force only when it is enacted upon the principles which build one's wairua, i.e. the principles of tika, pono and aroha. (key informant 1)

You have to have a knowing to acknowledge that taha wairua is there. (participant 2)

Everyone has wairua what kind of wairua depends on how they put it into action, that's another thing. (participant 3)

Continuing with the theme that wairua is not able to work in isolation and the need to enhance wairua with action, some participants drew parallels with the use of Māori models of health such as te whare tapa whā:

...you need to attach it to the other three taha...and taha wairua needs to be the korowai with whatever else is around, taha wairua can't work in isolation, I don't believe it can. (participant 2)

It is intangible and doesn't work on its own – like it's connected to the other taha, feelings and thoughts, the hinengaro, a still small voice – tinana, how you look after your wairua. (participant 5)

Key informants were very clear about the existence of good and evil influences, and that the type of wairua influence present at certain times depends on an individual's choice (of actions):

There is wairua poke⁵⁰ – an unseen life force with evil intent. People can choose which influence they choose to have in their lives, according to the choices they make. Choices made will befit one as one lives the principles of that pathway of choices one makes. (key informant 1)

⁵⁰ Williams' Dictionary (1985:289) defines pōkē as 'appear' as a spirit or 'haunt', he also defines pōkē as 'dark, gloomy, sullen – the definition in the data is taken as described by the key informant (a Ngā Puhi kaumatua).

There are good wairua and bad wairua – everyone chooses which of the two - by choices they either consciously or unconsciously make or both. (key informant 2)

Best (1941) stated that the wairua of a person could be subject to attack. On occasion, when this may seem to be the case or an evil influence is felt to be present, the application of the three domains of tapu as presented in Chapter Two may be necessary. These domains of space, time and boundaries provide an opportunity to contain a potentially at-risk situation while putting in place appropriate cultural interventions such as kaumātua or tohunga support to render the situation noa (safe). Understanding Māori perspectives of spirituality therefore helps explain Māori models of health, and that the holistic approach for Māori is important in re-establishing balance in those areas where balance is needed. Taha wairua plays a significant part in re-establishing and restoring balance because Māori perceive wairua as being present all the time and everywhere (Durie, 1994). The significance of taha wairua to tikanga Māori (Māori culture) as well as to Māori models of health will be demonstrated throughout this chapter.

Tikanga Māori and Māori models of health

Williams' Dictionary (1985) provides a range of meanings for the words 'tikanga' and 'Māori'. For 'tikanga', these include: to rule, plan, method, custom, habit, anything normal or usual, a reason, meaning, authority, control, correct and right. For this discussion all the above definitions for 'tikanga' can apply. However, for the word 'Māori', the second and third definitions seem more apt. These two definitions describe Māori as a person of the native race belonging to New Zealand. All participants identified themselves as Māori, tangata whenua, native people of the land of New Zealand. Mead (2003:11) provided a modern meaning: "for many people tikanga Māori means the 'Māori way' or done 'according to Māori custom'".

The term 'Māori model of health' is a contemporary one coined to reflect the use of Māori concepts and values for healing and treatment interventions. In my view, a Māori model of health is an alignment of Māori customary concepts and values to Western models of practice based on scientific and evidence-based knowledge and fact in the healing and treatment domains of health. I believe such Māori models of health are a response by Māori to recognise Māori needs and to incorporate their own cultural beliefs and concepts to support their healing and well-being. They also serve to educate

those in the ‘mainstream’ to understand the value of cultural concepts in healing practices, and to progress acceptance of cultural ways of healing. In today’s environment acceptance levels of responsiveness are varied and remain a challenge for Māori and mainstream alike:

...our manager of mental health (is pākehā) and has very different views...While I am employed as a cultural advisor, I still have a battle to get her understanding and support for things Māori. (participant 3)

This lack of understanding and/or prevailing attitude questions the knowledge base of those on senior decision-making levels. Since 1998 government policy has recognised that healing for Māori is not found solely in physical remedies offered but also draws on cultural and philosophical principles and embraces a holistic approach with the inclusion of the individual, the whānau, the hapū, the iwi and the spiritual realms of te ao Māori (MHC Blueprint, 1998). The exercising of Māori concepts and tikanga practices in healing are not new to Māori; however, it would be fair to say that it has only been over the past decade that the use of Māori centred approaches has been more widely used in mental health services. Durie’s (2001) discourse on Māori approaches to healing and treatment is helpful as it covers both tikanga and Māori model of health approaches. These are:

- Traditional healing approaches that focus on customary practices such as rongoā, mirimiri and karakia, and are facilitated by tohunga or those with cultural expertise and knowledge.
- Bicultural models that are a modification of conventional methods and involves cultural therapy and therapeutic partnerships inclusive of Māori community experts, and
- Māori centred approaches where Māori concepts and values form the basis for interventions, can include such models as mauri therapy and paiheretia, and are administered by mauri and relational therapists.

Closer inspection of Durie’s explanation of Māori centred approaches could well be another definition of a Māori model of health. All the above approaches definitely place Māori at the centre, with Māori delivering the therapy. Participants in this research made it clear there is a distinction between the use of tikanga and when (one is) practising in a framework of a Māori model of health. Many of the participants, when

describing their experiences and knowledge of taha wairua, used the term tikanga Māori rather than Māori models of health:

I prefer to just say I work with tikanga Māori ... You know, models are a pākehā description for how they work (Māori health practices); we as Māori just use tikanga, perhaps in different ways to suit our mātauranga, our iwi, hapū – but in the end it's tikanga Māori otherwise it's not tika. (participant 8)

The appropriateness of the use of Māori cultural practices has been questioned in literature (Dyall, 1997; Durie, 2001) and even today Māori continue to work in a questioning environment from colleagues and peers:

There is a resistance out there when you talk about kaupapa Māori, when you talk about the taha Māori, especially when you start assessing taha wairua. There's a lot of resistance, so although people do see positive changes and the work that you do, they are still skeptical about what you've done, how you've done it and where it's going to. (participant 7)

Amongst the participants there were varying opinions about tikanga processes and Māori models of health used in mental health services. However, all participants agreed on the value and positive benefits of using tikanga processes such as karakia, whakawhanaungatanga and mihimihi. It is also important to note that some participants did not see taha wairua as needing a Māori model of health to influence a situation:

Taha wairua is naturally part of the way I work and, yes, I believe that we do not need a 'model' as such to experience taha wairua in our mahi, either myself as a clinician or the tangata whai ora me te whānau that I work with. (participants 5, 7 & 8)

Participants who reflected this outlook were fluent in te reo Māori and were very comfortable in their use of the language in mental health settings. Tikanga practices were a 'natural' part of the working lives of these participants, and their links to whānau, hapū and iwi were strong. Others, however, who had not displayed such strong links to te ao Māori, spoke enthusiastically of how their way of working had been enhanced by their learning about Māori models of health:

In terms of how I operate when I assess people, the guiding beacon, if you like, were the psychology models that I had learned – I would look back and

say, “Okay, do I have all the information pertaining to this issue?” That’s how I used to assess. Now in learning about Māori models of health and cultural assessment I use a lot of whanaungatanga – I work to establish rapport, I try to integrate te whare tapa whā within my initial framework for assessment. (participant 4)

The examples above show that the diversity of participants’ cultural experiences reflected the level of exposure and access they had to te ao Māori, combined with their education and training experiences.

Cultural diversity

While some of the participants had very strong links to iwi, and their cultural experiences were embedded in te ao Māori, others did not share that same experience or the same access to te ao Māori. Māori are not homogeneous and their diversity as a people needs to be acknowledged in relation to the experiences and knowledge shared by participants. Durie (2001) pointed out that tribal identity is one dimension, but there is an equal and growing sense of a Māori identity among those groups of Māori who can relate to common values and experiences, even though their tribal paths may be quite different. Some of the participants reflected that understanding:

Not sure whether it’s lack of understanding of things Māori or where they are in their world. Given that people’s journeys are a lot different to where they sit in their Māori world, they are at different levels. Everyone’s at different levels. (participant 7)

Others did not share that view and were not so patient or accepting of Māori colleagues whose journey in te ao Māori was not as strong as their own. In fact, this was described as a barrier to working with taha wairua in a kaupapa Māori service:

...another barrier I am looking at is – working with Māori colleagues at different levels of experience and knowledge of tikanga and ‘what is taha wairua’. It’s almost as if you have to spoon-feed your own colleagues, and then fight with their own beliefs – what they believe, when they challenge my beliefs. (participant 5)

These different opinions of ‘levels of cultural understanding and diversity’ had the potential to create disharmony and disunity as more than one participant admitted they would get quite ‘hōhā’ (wearied with expectation or impatience; Williams, 1985:55)

with their Māori colleagues. Others took a more pragmatic view and identified the use of whakataukī, Māori proverbial sayings, as a means to have kaimahi ‘hold to the kaupapa’ or encourage a one-ness in purpose:

We sat under a mainstream umbrella, a kaupapa Māori mental health service, we had Māori kaimahi at different levels of their learning and understanding of being Māori. It was very hard at times to be cohesive, so how did the service manage to deal with the difficulties and conflict that arose – the service had a whakataukī, which contained the main kaupapa of service delivery, which kept everyone focused and refocused from time to time. (participant 8)

Acknowledging the frustrations of others who may see diversity in cultural learning levels as a difficulty is just as important as realising there are ways to address differences, such as in the use of whakataukī, which has the ability to support and maintain the purpose of working harmoniously in the workplace with fellow kaimahi, tangata whai ora and whānau:

*Mā te mau ki te hanga o te whare tapa whā
kia puāwai ake o te huanga o te tangata whai ora me tōna whānau*

*By adhering to the four cornerstones of health,
the well-being of the client and the family are assured.
(Ngahiwi Tangaere, Ngāti Porou kaumatua, 1998)*

The understanding, acknowledgement, and acceptance of the diversity of Māori are of equal importance not only for Māori working together in the workplace but for those working appropriately with tangata whai ora and whānau and the many diverse views they bring. The diversity of views shared amongst participants reinforces a need for ongoing and effective cultural education for Māori staff working in Māori mental health services.

Cultural components of tikanga that support taha wairua

Tikanga Māori includes a series of practices such as the way in which people are received into the services, the way hui are conducted, the way decisions are made, reciprocity, and the sharing of resources. These processes reflect group rather than individual bias and a cultural structure that is formal yet responsive to need, and is

based on outcome rather than output⁵¹. Participants shared specific examples of how tikanga and Māori models of health supported taha wairua to influence particular situations:

With tikanga processes like karakia, mihimihi, whakawhanaungatanga and the use of te reo Māori – I have had many experiences in seeing ‘taha wairua’ influence a difficult, stressful and aggressive situation into a calming one. (consumer group participant)

The ensuing discussion will focus on participants’ views on tikanga practices of pōwhiri, karanga, karakia, whakawhanaungatanga, whakapapa, the use of te reo Māori, and the capacity and capability of these practices in facilitating positive change, based on the concept of taha wairua.

Pōwhiri

Pōwhiri is a custom associated with the welcoming and hosting of visitors onto the marae (Barlow, 1991:99), and in modern times is often used to mean every aspect of welcoming visitors, beginning with karanga, formal speech making, greetings and then kai. Its implication for healing is described by Durie, (2001:175) as being due to the fact that the ‘welcome’ extends well beyond a reception for visitors. It is, “an encounter calculated to reduce space and distance between groups and to explore the basis of relationships. The process seeks to create a sense of cohesion between groups, also an opportunity to affirm the different identities of those who are represented” (Durie, 2001:175).

Culturally appropriate experiences on initial contact and assessment are essential, the Blueprint states the services Māori access must meet their needs and expectations, and strengthen their identity (MHC, 1998:60). While most kaupapa Māori services endeavoured to welcome Māori to their services appropriately, one participant came from a service that wholeheartedly accepted and practised the tikanga practice of pōwhiri:

On accepted entry to our service – for our tangata whai ora – there is a pōwhiri or whakatau process that takes place every time...and our pōwhiri

⁵¹ Outputs are the number of services delivered to people. Outcomes are about the services being delivered focusing on health gains (for service users) (Durie & Kingi, 1997:8–9).

processes include all services who are present and on site when the pōwhiri takes place. (participant 7)

All groups of participants believed that where tikanga has been a lead process for tangata whai ora entering mental health services, meaningful interaction has occurred, leading to very positive outcomes:

I've seen where when tikanga is present at the start, particularly on first admissions, tangata whai ora and whānau recover more quickly from short term psychotic episodes⁵². (consumer group participant)

Interestingly, participants singled out the karanga as being particularly important in producing a meaningful first-contact interaction. The karanga is one of the very first components of the pōwhiri, and involves two parties, the manuhiri and the tangata whenua, and prepares each party to meet the other's needs and desires.

Karanga

Karanga as part of the pōwhiri has a very distinctive purpose. It arouses the spirits of those who live in another realm of the earth, and similarly, when a woman gives birth, her cry in labour indicates that a sacred new life is about to come forth (Barlow, 1991:39, 100). How fitting it then seems that a mental health service, which subscribes to indigenous practices, provides opportunity for Māori suffering from mental unwellness to start a new beginning, a new life. The karanga therefore can reinforce the desire to affirm interaction and sets the foundation in forming new relationships. According to participants, the roles of manuhiri and tangata whenua within the pōwhiri process are interchangeable according to need:

...dealing with tangata whai ora on entry to the service, you're dealing with manuhiri. What do you do with manuhiri? You karanga – the karanga is the call for them to come in, that you are here to listen, to learn, to hear, to help, to heal. When they begin their journey you (the kaimahi) become the manuhiri, because it's their journey.(participants 7 & 8)

Although karanga and karakia have specific roles in the context of tikanga processes and te ao Māori, both are quite similar in that when practised in an appropriate cultural context they have the ability to establish a link between the physical and spiritual

⁵² A mental illness lasting less than 4 weeks (personal knowledge).

domains, thus supporting taha wairua. The frequent use and the value of karakia were shared many times and were clearly linked by participants to te taha wairua.

Karakia

Barlow (1991) described karakia as consisting of pleas, prayers and incantations addressed to the gods who reside in the spirit world. Its use has the ability to establish a bond between the person praying and the spiritual dimension, or source of power. Salmond (1976) added that the wider purpose of karakia is to create a sense of unity – at one with the ancestors, at one with the environment, at one with the spiritual powers. Participants' experiences confirm the spiritual connections, the healing capacity and strengthened understanding through the medium of karakia that occurred not just for themselves but also with colleagues and with tangata whai ora:

...there have been periods when I've found I've gotten stressed and sometimes anxious about my work and when that happens it's really hard to think things through clearly. I've found karakia helps and that's something I can do personally. (participant 1)

...Karakia opens up an opportunity for tangata whai ora to kōrero, to tangi and also whakapuaki, to open up, to gain insight into what has or is happening for them – the pōwhiri poutama happens all the time if the karakia is pono. (consumer group participant)

Others felt karakia was absolutely necessary to work with te taha wairua, to ensure one could move appropriately from the state of noa into tapu and vice-versa:

...when we are talking about working with wairua...my belief is that we need to be in a state of tapu and to do that there has to be a process – the process is that we have karakia every morning, and I expect staff to say karakia every time they meet with the tangata whai ora...otherwise they [the staff] are in a state of noa, so how then can they work with wairua? (participant 3)

All the participants felt that the strength of karakia is according to a person's individual knowledge, beliefs and personal experience. Participants also mentioned that not enough recognition is given to karakia and its ability to open up the way for wairua influences:

Also not enough acknowledgement is given to karakia and its ability to open up the way for wairua to flow, to be felt and to influence.
(participants 1,3,7,8)

With whare tapa whā, for me, I look first at the wairua, someone is, say, mad, not bad, and is psychotic, there is not time for us to do our Māori mahi except to go in there and have an inoi to whakawātea. In that case, I prefer to clear the pathway so that the most urgent mahi can be done right there and then. (participant 5)

All participants connected karakia with wairua influences and processes, yet accepted there are many other things associated with karakia that contribute to the presence of wairua:

It's more than the karakia said, it might be the words, it might be because it's spoken in te reo Māori, it might be the mihimihi – but I think all of it can be because of the presence of wairua. (participants 5 & 8)

The relationship of karakia to whakawhanaungatanga makes it possible for both processes to create a sense of unity in establishing useful and helpful relationships between tangata whai ora, clinician and whānau. These types of relationships are important in the mental health setting to support te taha wairua and in facilitating Māori models of health to benefit Māori desires in recovering from mental unwellness.

Whakawhanaungatanga

Chapter Three illustrates whakawhanaungatanga as a guiding principle used in this research; moreover, for this part of the research it will be shown as a principle and a value that guides work practices. Mead (2003:28) defined whakawhanaungatanga as “a principle or standard of behaviour in te ao Māori that applies to greeting and meeting with people; and a value in regard to which ‘whakawhanaungatanga’ is held to deserve; importance or worth”:

When I've needed to support their assessment, care and treatment directly, I always use whakawhanaungatanga. Part of that, where possible (tangata whai ora and whānau choice) is mihimihi, karakia, katakata (humour) and growling (no choice there, that's just me and I only growl if I really have to and it has worked, got us all back on track to the kaupapa) (consumer group participant)

The *Blueprint* (MHC, 1998:60) stated that, “to work effectively with Māori it is necessary to know and understand the components that contribute to their well-being”. The process of whanaungatanga – establishing relationships – is one such component that when initiated and ‘practised’ well, is a key to inviting te taha wairua, in having tangata whai ora and whānau open up and share their stories:

One of the greatest tools we’ve got as Māori...is whakawhanaunga or mihimihi. What happens in today’s society is that we are bombarded with questions, and whilst you may be sick – not mentally either, you could have a toothache – who wants to listen to and answer forty questions? All you want is to have something for the pain or just pull that tooth out! Mihimihi cuts that process, it’s about acknowledging, linking, bonding – and not with using lots of questions, you get most of the answers you want. (participant 3)

Whakawhanaungatanga also embraces whakapapa because both focus on relationships that go wider than actual bloodline links and extend to relationships that are created through having a sense of purpose, goals and experiences in common.

Whakapapa

Whakapapa or kinship, as explained by Mead (2003), is the social component of the ira, or the genes, whereby an individual is born into an already established kinship system of many generations. That individual is a beneficiary of two whakapapa lines, the mother’s and the father’s. In te ao Māori, a single whakapapa line is sufficient to define a place within the hapū and provide one’s identity within a tribal structure. With the whanaungatanga principle, relationships reach beyond actual whakapapa relationships and include relationships to non-kin persons who become kin through shared experiences:

Like, how whanaungatanga establishes iwi and whānau links and also builds trusting relationships with those one hasn’t met before. (consumer group participant)

The Māori worldview acknowledges that their whakapapa begins from the atua. Meads explained: “Ira tangata (genes) is a new life created and the new life is human. Ira tangata are more than biological elements, however. There is a godlike and spiritual quality to all of them, and ira tangata as human beings descend from ira atua, the Gods”

(2003:42). Many of the participants acknowledged that their whakapapa had spiritual beginnings and therefore ensured them of their own right to have a wairua:

...the guts of all things Māori for me is whakapapa, my whakapapa has given me a wairua. Without a whakapapa, I wouldn't exist. My whakapapa started from Io Matua Kore. (participant 3)

Te Reo Māori is an integral part of te ao Māori and its tikanga and culture. Traditionally, its importance to the whole of Māori society was vital, not only in everyday use in communication but also because the spoken language was the main medium by which whakapapa, tribal and whānau history were preserved and passed on. To be able to recite one's whakapapa today in te reo Māori is encouraged and when accomplished brings forth admiration from one's whānau, hapū and iwi.

Te Reo Māori

Over the past 2 decades the revitalisation in the use of te reo Māori has been a priority for Māori community development, and many initiatives are currently in place to support this happening (Te Puni Kōkiri, 2001). One participant noted that currently both staff and tangata whai ora are much more conversant in te reo Māori and commonly accept its use in Māori mental health services:

We find that the tangata whai ora are more tūturu Māori ...and that's even when you get down to the younger ones, who over the last 4 to 5 years have gone into seeking to learn the reo, taking advantage of Te Whare Wananga o Aotearoa, which offers free training of te reo Māori. Added to that, most of our staff are attending (these te reo courses) at least 3 and a half hours per week, and that's done in working time. (participant 3)

Te reo Māori has had legislative recognition as an official national language of New Zealand since 1987. Its use within mental health services was reiterated in the *Blueprint* in 1998. This has been a short time for Māori to have had the authorised support and ability in using the medium of te reo Māori to work with those who use mental health services. All participants extolled the benefit of using te reo Māori in the clinical setting and its capacity to support Māori to maintain cultural safety and dignity of tangata whai ora, whether it's within the assessment interface or in the multi-disciplinary team meeting:

...the doctor started questioning her and initially quite upset her, it started to elevate her...so we snapped into our process...acknowledged the doctor and the kuia, had a karakia and spoke to the kuia in te reo Māori. Through the use of te reo Māori, the kuia was enabled to come on top of the situation, she even started opening up and saying to the doctor that the questions were inappropriate and she didn't want to answer certain questions, and gave reasons. (participant 7)

Opportunity is provided within these types of hui for advice to be sought and for an exchange of views and opinions to support positive ways to address any issues that arise for a case worker or the tangata whai ora. Participants emphasised how appropriate te reo Māori was when sharing very sensitive and personal information and knowledge:

Like dealing with some of the hard issues – sexual abuse, incest, whānau dynamics, there are ways of being able to discuss that sensitively in te reo Māori – when that was able to happen in the multidisciplinary team hui, I found it helpful.... (participant 8)

Compromising situations often arise in mental health settings and are not restricted to crisis situations in the community or an inpatient unit. Where services do not have a culturally appropriate approach or environment, Māori can easily feel intimidated when their 'way of being' is under question and in defence can react in either a timid and withdrawn manner or aggressively:

I've seen where through the use of te reo Māori, an aggressive situation has been de-escalated. (consumer group participant)

Tikanga processes like karakia, mihimihi, whakawhanaungatanga and the use of Te reo Māori. Within those processes I have seen and experienced 'taha wairua' influence a difficult, stressful, aggressive situation into a calming one. (consumer group participant)

Te reo Māori can be used in all mental health interventions and the experiences shared by participants were all positive. Risk management in mental health services aims to minimise the likelihood of adverse events in the context of the overall management of an individual, to achieve the best possible outcome, and deliver safe, appropriate, effective care (MOH, 1998:2).

Table 4.1 *Oranga: Significant benefits for tangata whai ora and whānau through the influence of taha wairua as facilitated through tikanga processes*

Tikanga Processes	Healing aspect	Mental health interface	Benefits
Pōwhiri	Reduces space & distance for meaningful interaction to occur	On admission to service	Quicker recovery from short term psychotic episode
Karanga	Creates a sense of cohesion between physical & spiritual domains	On initial contact	Opportunity for a new beginning to a life of wellness
Karakia	Establishes a bond and creates a sense of unity between tangata whai ora whānau & the spiritual dimension	In all cultural and clinical interactions facilitated by workers, tangata whai ora or whānau	Allows for passage to sharing of issues; shedding of guilt and shame; to gain insight into illness
Whakawhanau-ngatanga	Establishes helpful Relationships between individuals, whānau and mental health workers	Particularly useful in assessment and treatment and rehabilitation phases of care	Permits use of traditional stories, laughter, scolding and allows for deeper bonding between parties
Whakapapa	Acknowledges significant relationships of kin and non-kin persons	In all cultural and clinical interactions	Sanctions whānau involvement in all aspects of care
Te Reo Māori	Encourages use of the Māori language to express feelings and concerns and share sensitive issues	Especially useful in de-escalation of challenging situations	Supports Māori to comfortably participate in treatment
Karakia, te reo Māori, cultural worker, kaumātua, tohunga	The combination of tikanga practises appropriately facilitated offers protection and safety	In all cultural and clinical interactions but gives added value in ‘high risk’ situations	Minimises the use of legislation i.e. Mental Health (CAT) Act and seclusion

The use of Māori models of health based on tikanga values and te reo Māori has many benefits. Kaimahi Māori not so confident or experienced in their cultural practice and use of te reo can be guided by the tikanga components within the model of care. They in turn can support tangata whai ora and whānau to link back to their positive cultural experiences to sustain them when experiencing mental unwellness.

This section has outlined cultural principles and values contained in tikanga processes and that, when influenced by te taha wairua, opportunities for enhanced healing can occur. The following section discusses how tikanga processes are integrated into cultural assessments so that cultural workers, clinicians, tangata whai ora and whānau may be guided by cultural as well as clinical principles and values.

Māori assessment tools guided by tikanga and Māori models of health

Cultural assessment

Cultural Assessment “refers to the process through which the relevance of culture to mental health is ascertained” (Durie et al., 1995:21). Proactive efforts by Māori working in the mental health field over the last decade have led to the Ministry of Health’s support in formalising the ‘Cultural Assessment Processes For Māori’ Guidelines (Mental Health Commission, 2001a). The guidelines aim to recognise the Treaty of Waitangi, which includes the principles of partnership, participation and protection. Cultural assessment tools that adhere to the guidelines enable those principles to occur for tangata whai ora and whānau, and enhance the cultural perspective of the client and whānau through appropriate assessment, care and treatment, and involve Māori in all aspects of care. While there is not one standard cultural assessment tool, because provision is made for tribal kawa and tikanga differences, the guidelines encourage *kotahitanga* or ‘oneness’ in purpose. The guidelines also reinforce the Code of Health and Disability Consumer Right One, “Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social and ethnic groups, including the needs, values, and beliefs of Māori” (Commissioner of Health and Disability, 1999). Participants’ views show that when the cultural assessment is enacted in a timely and effective way it can be very helpful in supporting the presence of taha wairua:

When we got involved, the first assessment was usually a cultural assessment, and that meant the assessment was completely under tikanga Māori. The clinician decided from the time they walked in ...the presence of wairua...even if other clinical expertise was needed, the process was still allowed to run under kaupapa Māori. (participant 8)

Cultural assessment processes are seen as a means to help service providers support and provide cultural safety for Māori and can be used to determine the significance of cultural factors for a person. The information gathered could formulate planning of treatment and rehabilitation processes that address any cultural issues, and could also

make possible the offering of Māori healing practices as an addition to treatment for tangata whai ora:

We use a te ao Māori cultural assessment format – it is based on measures of identity as Māori i.e. positive, secure, notional or compromised identity. We use these as a measure as to whether or not we are able to capture some motivating factors for tangata whai ora to heal with their cultural identity. Usually we try and get this assessment done as soon as possible.
(participant 6)

All participants in this study who worked in kaupapa Māori services were either actively involved or very knowledgeable of cultural assessment processes and the cultural tools used to achieve assessments. All linked their cultural tools to te taha wairua as the foundation on which assessments are guided:

We use te whare tapa whā and the values it incorporates as the cultural assessment tool. For me it is always encompassed by wairua, the other taha are supported and given meaning by te taha wairua, the assessment can take up to two to three hui to complete, as guided by the tangata whai ora and the whānau. (participant 7)

Māori assessment tools used by participants are based on Māori models of health such as te whare tapa whā or ko te tuākiri o te tangata. Participants were clear that the tool served as a guide and tangata whai ora set the pace. The tools' objectives include measuring strength of identity and assessing against the domains of cultural concepts contained in the tools for cultural factors that may impact on the present condition of the wellness or unwellness levels for tangata whai ora. Recent research by Simon Bennett (2001) reinforced the concept that positive psychological outcomes share significant relationships with cultural identity, indicating mental health is influenced by the relative strength of an individual's cultural identity. The assessment can also provide clinical knowledge that informs clinicians, as well as treatment and recovery plans. It is becoming more readily accepted that a tool that encompasses clinical as well as cultural dimensions and can measure both the intensity and quality of experience to assess the level of balance provides for more efficient, effective and timely interventions on behalf of the tangata whai ora. The following table developed by Durie (2001) demonstrates how such a tool would work. It is important to note that

although the rating of such tools depends on the judgement of the assessor, whānau and tangata whai ora can validate the ratings.

Table 4.2 *Whare Tapa Whā assessment schedule*

	Intensity Continuum			Quality Continuum		
	<i>High</i>	<i>Medium</i>	<i>Low</i>	<i>Non-adaptive</i>	<i>Reality oriented</i>	<i>Distressed</i>
Wairua	Enhanced	active	abated	diffuse	reality focused	self-oriented
Hinengaro	Accelerated	consistent	diminished circular	circular	problem solving	burdened
Tinana	hyperactive	able	retarded	compensated mobility	painless mobility	painful mobility
Whānau	whanau centred	adaptable (self-whānau balance)	isolated	enmeshed	mutual benefits	abusive; neglectful

Source: Durie, 2001:238

Māori have only very recently seen culturally appropriate assessment processes extended to include measuring mental health outcomes. Te Hua Oranga (Kingi & Durie, 2000) is one such tool developed to measure mental health outcomes for Māori based on te whare tapa whā.

Health outcomes assessment and tikanga

Several participants stated that the use of tikanga values and concepts could more fittingly describe a health outcome for Māori. While Durie (1997) and Dyall (1997) believed that Māori would benefit from measures that consider clinical aspects of outcomes, Dyall (1997:85) argued that, “culturally founded outcome preferences need to be explored so that a more complete assessment of outcome, aligned to Māori concepts of health can be determined”. The cultural assessment tool “Te Hua Oranga” involves three principal stakeholders – the tangata whai ora, whānau, and the clinician. It can be used at clinical endpoints of assessment, treatment, community care and discharge, and in an inpatient or community mental health setting. Although the tool is yet to be validated, it has been through a series of trials. Its scoring system is based on Māori cultural values such as whanaungatanga and strength of identity. The Mental Health Commission (1999) considered the benefits of constructing valid outcome measures for Māori might be significant, not only in terms of quality assurance but also as a means of validating Māori approaches to treatment and care. Although the following view was stated by one participant this view was supported by a number of participants:

...the mental health act would seem to value the outcome as opposed to the process and that is to come off the (mental health) act or to discharge from a ward...this is why I believe we should use tikanga practices to assist healing and to measure the outcomes because it allows culturally appropriate processes to occur to empower the tangata whai ora and the whānau. (participant 2)

It is clear that Māori want and need culturally relevant assessment tools that not only enhance their assessment and treatment, but also support sound recovery pathways that encourage a balance and regular progress in achieving wellness. Recovery is a journey as much as a destination and it is different for everyone (MHC, 1998:1–2). The participants in this research all strongly advocate the use of tikanga Māori and Māori models of health as a necessary part of the recovery journey for Māori tangata whai ora and whānau.

Tikanga, Māori models of health, recovery and significant benefits for tangata whai ora

Recovery is defined in the *Blueprint* as the ability to live well in the presence or absence of one's mental illness. For Māori, recovery is seen as the recovery of *tino rangatiratanga* or empowerment inclusive of self, whānau, hapū and iwi (Milne, 2001:12). For this level of empowerment to occur, mental health services supported by government must provide culturally safe services for Māori and ensure all Māori with mental illness have the opportunity to use kaupapa Māori services (MHC, 2001b: 88). The following key themes of recovery support Māori aspirations and tino rangatiratanga: Hope; personal responsibility and self-advocacy; education, support, and personal meaning. From the experiences described, it would seem many participants incorporated recovery themes and principles in their practice, as a result of their tikanga practices and cultural knowledge rather than as a learned skill. The experiences shared also outlined some significant benefits for tangata whai ora.

Māori models of health such as pōwhiri poutama featured as a regular means of supporting tangata whai ora and whānau to take *personal responsibility* and to gauge progress of their recovery pathway:

...[pōwhiri] poutama is a good counselling model in that it can help the tangata whai ora measure where they were, to how far they have progressed or regressed.(participant 6)

It is a momentous milestone in people's lives when they can take *personal responsibility* for their own care, whether it is responsibility for taking medication or for being free of medication. Participants provided examples of tangata whai ora who were adverse to taking medication but once the benefits (and side-effects) were recognized and the medication prescribed proved helpful to their condition, these tangata whai ora took responsibility and became self compliant and self managing. One such example was provided of how tikanga could be substituted for Western medication once a mental health condition became manageable:

...yeah, I've been medication free for a while and the rongoā I use now is karakia, kōrero, katakata. I think it's a big achievement – I was on medication for 5 years.... (consumer group participant)

This view demonstrates there is a place in recovery for the use of both Western and traditional remedies (though not necessarily in concurrence), and this view is supported in the literature review (Mitchell & Romans, 2003). *Self-advocacy* provides an opportunity for tangata whai ora to 'find their voice' again, to re-engage with their environment, to try, succeed and fail, and try and succeed once again:

Pōwhiri poutama is an organised process, with the ability to go up and down the poutama according to the tangata whai ora and where they are at – sometimes one may have to go up and down several times before being able to complete the process and that is the beauty of it, steps are interchangeable. (participant 3)

This next example of *self-advocacy* is from one who has been a tangata whai ora for 9 years and has undertaken employment in a mental health service in the role of a tangata whai ora advisor. This illustration is significant in that this participant's continued wellness is maintained through the use of tikanga practices and has provided a strong sense of identity. Through instilling regular karakia and waiata into daily routine, this participant has been able to *self-advocate* in a sometimes 'unfriendly' environment:

Being strong in myself has helped me to grow personally in ways that I know how to deal with the service I work for and with other kaimahi in the community. (consumer group participant)

Another key theme within the recovery process is *hope*, *kōrero pūrākau*. Traditional stories of te ao Māori are frequently used to explain difficult situations and to provide comfort and give confidence and hope. *Hope* contains the seeds of recovery:

In whānau hui I have found it comforting for tamariki (suffering from parental issues and whānau separation) to actually take them through the kōrero of our ancestors. Talk about the wehenga (separation) of Rangi and Papa...about Tāwhirimātea – he had an important role to play in us being here today, he gave us the breath of life; however, while he gave us that he blew us over too in his anger. He became the God of elements, he made it rain, storm, and there are days when he brings out beautiful sunshine. There are so many kōrero, I go on to talk about Te Ua Te ngangara, the eldest son who created the wānanga ...I see this as giving them hope and options through the stories of our tīpuna. (participant 3)

Another example of *hope* displays noteworthy benefits for tangata whai ora and also the zeal of this participant in the application of tikanga to support the well-being of tangata whai ora and whānau. That enthusiasm provided the impetus for the positive effects of taha wairua to take precedence, and minimised the use of legislation:

...one of my roles is I'm a duly authorised officer, and over one year I can say I have placed someone (Māori) under the mental health act 3 times, whereas, compared to my other colleagues, they would have placed between fifteen to thirty under the Act. At least half of those if not more – were Māori. I have utilised tikanga processes – it could be karakia, te reo Māori, whānau, kaumatua, tohunga rānei in every situation and, apart from those three, I have been able to avoid use of the mental health act. (participant 5)

This participant's role as a duly authorised officer is performed across the wider mental health service, and involves providing acute services to Māori in mainstream as well as kaupapa Māori services. The participant was confident that the records kept by the relevant mental health service would affirm these results as reported. Given that the majority of Māori enter mental health services through the police and the justice system, the above experience shows major advantages in the support, care and treatment for tangata whai ora through the use of tikanga and the influence of taha wairua.

One other key theme in the recovery process is the development of individuality and a sense of identity gained through a discovery of *Personal meaning*. One participant explained how this is achieved through the use of a Māori model of health:

With the pōwhiri poutama model, it's a model that allows the person to have their journey, how they see it and how they want to see it. What happens today...is that tangata whai ora can have their journey changed for them, because along the way through talking to (many) different people there's these other perspectives ..."No, that's not how it is, this is how it is", so it becomes quite confusing, so that's why I use pōwhiri poutama. (participant 7)

The next example involves the tangata whai ora applying *personal meaning* to what it is to be a Māori and in so doing earned the respect of their mental health worker:

*When I work with people they are not just Māori, they may be part pākehā or Pacific Island, too. Their sense of identity is important, although they may not realise it...and there are many of them with a mixed heritage, that don't want to go there ... I have been told by one tangata whai ora, "My Māori identity is as much as what I make of it and I'm as Māori as you". She then made it really clear that she connected to me through **my** looking Māori...I needed to respect that ...and I do. (participant 1)*

This tangata whai ora was able to give 'voice' to her identity, and her response to the worker showed she believed she had a strong identity, she knew who she was and how she was able to connect to the worker. Again, it is important that the worker respected the self-belief and personal meaning the tangata whai ora expressed. The next experience also encompasses *personal meaning* and how in this participant's view tangata whai ora, when guided by taha wairua, can give their own meaning to how their lives have been influenced:

A lot of it has to do with self-identity, how you see yourself...as we grow up we create, we have experiences, we create thoughts, those thoughts influence our behaviours...so through the years, sometimes we've created a story and we don't know who we are, we don't know our whakapapa, we feel lost – these are feelings and thoughts that have been shared with me by many tangata whai ora ... so what I've found in my mahi is that they [tangata whai ora] give their own meaning to taha wairua and how it might influence them...what I've seen are what I term as flow on-effects such as ...setting goals day-by-day, some sense of fulfilment in themselves, having a

sense of not being so lost in the world, limiting negative behaviours, releasing some of the 'mamae' and 'pouri stuff'. (participant 2)

Participants provided further insight to personal benefits for the tangata whai ora when their dignity is maintained and their wairua is looked after, and they are strengthened within themselves and for who they are:

I've seen blame and shame come off them and seen their mana restored.
(consumer group participant)

Education about one's illness, medication, early warning signs, illness/wellness cycles, triggers – things that get them well – are also a key in the recovery journey and their inclusion in the clinical care of tangata whai ora and whānau is long overdue:

...ko te tuakiri o te tangata, it's an interactive model and requires personal commitment and a good understanding of how it works plus time and planning, it's not just restricted to cultural learning but education about what's happening to them and why, is it a good way to work? ...because tangata whai ora set the pace of learning, discovery and progress.
(participant 1)

Use of group processes provides *Support* for the development of or strengthening of identity:

we run a group for 10 weeks, we take ten (tangata whai ora) at one time, and we do Māori multiple therapies. We use mau rākau, waiata, and tikanga practices (kōrero, mihimihi, karakia) to strengthen the identities of Māori rangatahi and to provide peer support. (participant 2)

From what I've seen, and through other Māori clinicians facilitating group work, working through issues using tikanga and Māori models of health – it gives tangata whai ora a sense of achievement, it builds self-esteem, feeling proud of who they are. Another thing obvious is the whanaungatanga and the positivism The main thing I most definitely see for tangata whai ora is their identity, finding out who they are and feeling good because of that.
(participant 4)

Table 4.3 *Tikanga Hauora: Significant benefits for tangata whai ora and whānau through the influence of taha wairua as facilitated through Māori models of health and supporting recovery themes*

Māori Models of Health	Healing aspect	Recovery themes	Mental health interface	Benefits
Cultural assessment	Provides measures to facilitate safe passage into and through mental health services and to address cultural issues	Support Personal meaning	Most beneficial when able to be used as the first assessment Is able to be practised in all clinical endpoints of mental health interventions	Facilitated by Māori workers in partnership with tangata whai ora provides opportunities to gauge: <ul style="list-style-type: none"> - strength of identity - level of access to te Ao Māori - cultural factors that may impact on well-being and, - whānau, hapū validation
Te Whare Tapa Whā	Has a holistic approach and encompasses the spiritual, physical, emotional and mental and family aspects to well-being – Wairua is pivotal, whānau involvement is essential	Support	Assessment and rehabilitation	Allows tangata whai ora to receive a complete picture of health situation and to identify any imbalance and any contributing cultural factors. They are able then to help formulate necessary components of care that will support their recovery goals.
Pōwhiri Poutama	Is an organised process with interchangeable steps and flexible in setting pace of treatments	Personal meaning Self-advocacy Personal responsibility	Counselling and rehabilitation	Return journey to tangata whai ora allows them to find their voice' and, measure their own progress
Kōrero Pūrākau	Modern day application of traditional stories of te ao Māori	Hope	Individual counselling and family therapy	Supports tangata whai ora and whānau to understand their situation and to set recovery goals
Ko te Tuakiri o te tangata	Is an interactive model based on the use of colours and sets of Māori concepts within a triangular format	Personal meaning Education	Individual and group therapy	Supports the development and strengthening of identity. Assists learning and understanding of mental illness and affects of medication

While acknowledging the exceptionally positive benefits that have occurred for tangata whai ora as a result of the influence of taha wairua as facilitated through Māori models of health, it is accepted in Māori society that people with serious mental illness are not ill in isolation – families, extended whānau and significant others cannot escape being affected by it:

I don't think you can ever work on an individual basis with Māori whānau...just through one whānau member you open options up for the whānau...when that happens it's important to empower whānau....
(participant 2)

Beyond the immediate family are others, i.e. friends, neighbours and workmates, who may have an important role in the life of the person and need to be part of the healing or recovery programme (MHC, 1998:9). In the next section participants share 'whānau' experiences.

Positive benefits for whānau due to the influence of taha wairua

Whānau is a Māori social and cultural structure and has the ability to assume responsibilities on behalf of its members, and to assign responsibilities to them. Similarly, whānau has the potential to be nurturing, supportive, and safe or it can be a risk to the good health of individuals who belong to this unit. Including whānau as part of the care and treatment of tangata whai ora was natural for participants who were also mindful to check with tangata whai ora about whānau involvement. As mentioned earlier, one's whānau is not limited to biological factors. The National Mental Health Standards (MOH, 2001:46) defines family as extended family, partners, friends or others nominated by the person who receives mental health services. It is a recent shift, but one worth noting, that mental health services are now actively working to include whānau in their whānau member's care and treatment. Some mental health services have recently appointed a family/whānau advocate. Some of those appointed are non-Māori; one in particular in Waikato has developed protocols in partnership with this researcher (in a previous role) to work alongside the cultural workers to ensure any Māori whānau referred will be provided with choice:

...the services are more focused now on including whānau and that's really good, as well as the acknowledgement of extended whānau, as well as kaupapa whānau. (consumer group participant)

Durie (2001:192) depicted kaupapa whānau as “a group who share not a common heritage but a common mission – a whānau support group, team or flatmates perhaps”. While this description is not unlike the National Standards definition, it is important to include it here because it confirms that Māori are diverse not only in their tribal and traditional beliefs but also in their practice of the ‘core’ Māori unit, the whānau:

...most definitely I saw positive changes...not really with immediate family but with flat mates, they commented on the positive changes they saw with their friend (the tangata whai ora), they commented how it helped develop their relationship more by just finding out more about their friend. It took their relationship to another level...up until then their friend had been struggling to fit in – he had been suffering from depression... when he was able to express his feelings and to share more with his flatmates, they were able to understand and support him better. (participant 4)

Being able to communicate effectively is essential in one’s healing. Processes, systems and illness often dis-empower tangata whai ora and whānau. So it is quite significant that this tangata whai ora was able to find a strong voice, share feelings and engage the support of his friends. It made a difference in his personal relationships and ability to find his place in this kaupapa whānau. It is essential that mental health staff recognise the principle of whanaungatanga – the interconnectedness and interdependence of all members of the whānau, including the tangata whai ora, and the healing that can occur within a whānau. Another important gain for whānau is found in this next example. Participants described how recognition of the whanaungatanga principle helped their colleagues in the workplace and supported whānau to locate their ‘voice’ and value the skills and capabilities they could contribute to their whānau member’s journey to wellness:

*When the whānau came on board it’s helped them recognise what they have and helping them utilise what they have, even though **they** might have forgotten. Whānau realised they have skills, knowledge and experience and they have aroha – that goes along way...we need to build on these strengths. Whānau can assist with healing and where they can we need to put in place the resources to assist them to do this, my pākehā colleagues are learning about this – whānau ora. (participant 5)*

The above example was also important for non-Māori workers for they experienced an increase in personal learning and expansion of their practice to include whānau models

of care. Inclusion of whānau in care means there is a need to work in partnership and a need to establish an effective working relationship. The principles⁵³ that guide this relationship are consultation, cooperation, mutual respect, equality, and clarity of expectations:

Relationships became closer because we included the whānau, we set up a plan together – education was involved and the whānau realised that their reactions were elevating the stress of the environment. Through education that stress was lowered and the whānau made changes in the environment when they realised they were the anchor for their whānau member. (participant 7)

Other examples of positive benefits for whānau included having dedicated cultural and whānau roles in the workplace, the inclusion and empowerment of whānau through effective relationships, relevant education, and clear communication. Although these examples do not specifically mention tikanga practices or taha wairua, it is important to remember that these positive benefits came about through the facilitation of whānau hui by Māori cultural and clinical workers. The last illustration, describes a whānau member's happiness, a significant benefit directly linked to taha wairua:

...for me, through the influence of taha wairua, I saw this young boy's mum smile (first time in several weeks), because this boy's wairua was getting back on track. I saw, through mum having hope and being positive, the family was able to come together and support this young tama. (participant 8)

⁵³ See RANZCP Involving Families: Guidance Notes MOH 2000b:4

Table 4.4 *Whānau Ora: Family well-being involvement as influenced by the use of taha wairua on Māori clinical and cultural workers practice*

Key factors for mental health workers	Whānau rangatiratanga principles	Positive indicators
Recognition of whānau diversities e.g. whānau-a-whakapapa whānau-a-kaupapa	Whakawhiti kōrero, whakaaro, whatumanawa	Improved communication and personal relationships for tangata whai ora and significant others
Accept and utilise whānau skills, knowledge and ability to support healing and recovery	Manaakitia	Whānau able to locate their 'voice' and apply their knowledge, experience and skill
Seek whānau validation in information gathering processes	Tiakitia	Whānau involvement in their whānau member's assessment, treatment and rehabilitation; education able to take place
Acknowledge whānau gains	Āhua pai	Whānau able to express and feel happiness

What has become apparent throughout this research is that to support a recovery-focused service to deliver cultural processes, and to do that well, there must be dedicated roles and an appropriate environment. The following section focuses on cultural roles known to the participants and describes their views on both the roles and the type of environment that are conducive to te taha wairua.

Cultural roles that support te taha wairua in service delivery and the mental health setting

Cultural roles as defined by participants can be separated into three main areas – the cultural worker, the Māori clinician, and the kaumātua. The importance of the cultural mix of health professional and patient can lead to better health outcomes. Kurasaki and Sue (1998), Huriwai et al (1998), also support this position as outlined in the literature. The role of the cultural worker, specifically engaged as part of their employment to discharge cultural duties, will be discussed first. The next part of the discussion involves Māori workers in clinical roles, such as nurses or social workers who provide cultural as well as clinical interventions, the latter being the main duties prescribed and expected in their day-to-day duties. Of these duties, the most important is their being Māori and working in a Māori mental health service. The role of the kaumātua on whom participants call to guide the cultural issues will be discussed in more detail later.

Cultural roles were described by most of the participants according to their own world view and in various cultural terms such as cultural clinician, cultural therapist, kaimanaaki, kaiāwhina, kaitautoko, kaitiaki tikanga and cultural advisor. Two had received hapū and iwi input in the naming of their roles:

... the pākehā translation to my position was social work, but sometimes it was counsellor, sometimes it was support worker, sometimes it was cultural assessor – my position was kaimanaaki. I like the tūranga kaimanaaki, because for me that's the first kawa...manaakitanga comes before everything else. I saw my position as one needing to manaaki the tangata whai ora who may have some pieces missing from their being completely well. Everything you can do, you do to utilise the principle of manaaki. (participant 8)

All the cultural workers brought cultural skills such as marae-based tikanga practices and te reo Māori, whakapapa, and community and whānau knowledge. Cultural tasks attached to the roles gained through the experience of working in mental health:

When I first started working in mental health services, there was no job description as such; we made it up as I went along. Now I feel very clear about what my role is and this has happened due to the support of kaumātua, and learning what cultural skills were necessary to work in this field. (consumer group participant, participants 7 & 8 see above for multiple quote)

Other participants, however, were not so clear on what the cultural role involved and called for clarity to benefit both the workplace and tangata whai ora:

...that's another issue in itself – is that it's one thing to have a cultural worker, and it's one thing facilitating taha wairua, unfortunately if the cultural worker's role is not clear, how will this be able to happen? I think part of it is a training issue not just for the cultural workers, but also for all in the workplace. Clinicians need to be know what the cultural role is ... I have experienced hui where tikanga processes took place but the tangata whai ora's needs were not met, all of the time was spent on mihimihi but the actual purpose of the hui was not addressed. (participant 1)

An integrated service delivery model needs to consider both cultural and clinical functions in roles, which is made sound through adequate and appropriate education and training for all in the workplace. Having comprehensive job descriptions will also

go a long way in contributing to cohesiveness and clarity between kaimahi Māori, and ensuring that tangata whai ora needs are met.

Paiheretia, or relational therapy as described by Durie (2001, 171–179), provides a guide to establishing the tasks of the cultural role as shared by participants. Paiheretia places Māori at the centre and is facilitated by Māori. It requires therapists to work in a way that helps tangata whai ora strengthen their relationships, their cultural identity and their understanding. Paiheretia does not expect therapists to be experts in all aspects of Māori culture, but they do need to know how to enter the Māori world and support access for tangata whai ora to cultural occasions such as tangihanga, to cultural learning such as te reo Māori, waiata, karakia, and the holistic approach that acknowledges the links between, mind, body, spirit and family. As outlined below, these views were built on Māori principles and values.

Māori concepts appropriate to the cultural role

Tuakana/teina

All participants agreed that the cultural role was one of facilitating tikanga processes. This role was also supportive of kaumatua. Participants often regarded themselves in the cultural role as tuakana, i.e. the more experienced in a particular situation or the one who led the way; and at other times, as teina – the one who took a supportive or respectful stance as and when required with tikanga processes. Mead (2003, 40) explained the tuakana/teina principle as one that grants more status to the elder sibling (tuakana) than to the younger (teina). This principle can also be extended to other relationships outside whānau, as demonstrated below:

Well tuakana teina, because in some ways I am a tuakana, and then in other ways to some, such as to my kaumatua, I class myself as a teina...it's not always an easy thing to know when you are the tuakana...at times I wait till the kaumātua says or if I'm with another worker doing tikanga we sort that out ourselves. (participant 7)

Ngā mahi matarua: dual roles

As well as being able to operate in the realm of dual cultural principles such as tuakana/teina, many participants had dual work-place roles: performing cultural tasks

and clinical tasks within the clinical setting. Concurrent clinical and cultural roles brought some challenges and expectations:

Sometimes I feel too much is expected ...I work as a nurse and a cultural advisor ...my role involves providing cultural supervision, to provide cultural advice to colleagues in our kaupapa Māori service and to mainstream colleagues ...as well as one-to-one nursing responsibilities for tangata whai ora and working with the whānau...yes, sometimes I wonder which hat do I have on today. (participant 5)

Having dual roles can also cause boundary conflicts, particularly if the participant is working in a clinical position, has strong cultural skills, and is working alongside cultural workers who may be unclear of their role:

Yeah, and that's another issue in itself – it's one thing to have a cultural worker, and it's one thing to facilitate wairua; unfortunately if the cultural worker's role is not clear, how is this to happen? We then have conflicts in our roles... and the tangata whai ora needs are not met. (participant 1)

Being required to provide cultural and clinical interventions can put added stress on an already under-resourced workforce:

There are too few resources, not enough pūtea for kaumātua, not enough Māori clinicians and cultural workers, too few of us to do the mahi, too easy then to get hōhā. (participants 3, 5, 6, 8)

A cultural advisory role described earlier by one participant (see previous page) involved advising staff in their work with tangata whai ora either on a one-to-one basis or in a clinical setting such as a multidisciplinary hui, case discussion or whānau hui. Participants found this advisory role also extended itself to providing training.

Akoranga Tikanga Māori: Training

The word 'akoranga' describes 'things taught or learnt' (Williams, 1985:7), and also 'circumstance, time, place of learning'. In many ways these definitions are appropriate for cultural training that is prepared and delivered in the mental health setting. Training that can protect Māori cultural rights, support tangata whai ora and whānau beliefs and world-view, and deal with ignorant concepts can provide a safeguard for those working with and for Māori at the coalface. Some of the participants also led and provided

cultural training, and positive feedback included benefits for tangata whai ora and the team service-delivery model:

I support staff by putting together training day activities that reflected things Māori and enhanced their cultural learning, and it is compulsory training for all in the team, non-Māori and Māori.... (participant 3)

...one of our doctors who has been exposed in a learning capacity to tikanga, actually fed back to the team about the changes he has noticed as we work towards a cultural/clinical integration service delivery model ... he sees incorporating cultural values and practices within our clinical practice helps tangata whai ora in their healing and they are recovering more quickly. (participant 6)

Cultural training in the workplace, as described by the participants above, includes the multidisciplinary team, and was seen as very beneficial. Well-prepared, regularly scheduled and competently facilitated cultural training and education also contribute to positive outcomes for tangata whai ora, whānau and the mental health workforce, and are key indicators in supporting a culturally safe environment (Te Kahui Tautoko, 2001). All of this preparation, however, takes time, and in one participant's experience it was expected that the provision of training would be managed as well as a full caseload of clients:

Yes, I do cultural training and I enjoy it, but there is no extra time or resource allocated, and I am expected to carry a full caseload. (participant 5)

Aligned to the training role is one of mediating and liaising, not only in the organising of training but also predominantly in supporting tangata whai ora and whānau.

Takawaenga: Liaison

The liaison role is important in the setting up of hui, mediation between tangata whai ora, whānau and clinician, and in mental health services and whānau. The role also provides a vehicle through which hapū and iwi are able to participate in service matters and contribute to supporting tangata whai ora recovery:

Probably my most memorable experience was working with a cultural support worker, a pakeke from a Māori provider who knew the community

well, opened doors for the service, and provided really good advice. He provided excellent support for me as a clinician and for the tangata whai ora, whānau and community...I just haven't met enough people like him...I don't think there are enough out there, and then we are limited in the numbers of cultural workers we can have access to. (participant 1)

All of the consumer participants also saw it was part of the cultural worker role to liaise and support access to kaumatua:

Cultural workers... also facilitate access to kaumatua and tohunga for tangata whai ora and whānau, particularly those who may not have kaumātua. (consumer group participants)

As already demonstrated, the cultural role requires cultural and people skills, access to te ao Māori, a good knowledge and understanding of tikanga and the ability to articulate that knowledge and understanding to tangata whai ora, whānau and colleagues in the workplace. In many ways, it requires versatility and flexibility.

Ringa raka: Versatile

“Adept and agile” is how Williams defined raka (1985:321). Ringa is hand, and ringa is used as a prefix to describe certain work tasks dominated by the use of the hand. Te Matatiki (1996:228) described ringa raka as “versatile”. Again, participants described the importance of cultural workers skilled in tikanga and marae based practices, with the ability to move from the back of the kitchen to the front of the whare. These skills and abilities need to be valued and accepted in the workplace since this work resource also presents in small numbers:

As workers in kaupapa Māori services, we need to be flexible in our roles, and that can vary and mean that on the same day you can move from being a cook in the kitchen to doing a whaikōrero on the marae ātea ... we have to be flexible, there are so few of us and not all of us can do this, it depends on our level of cultural experience and practice (on the marae) but then again that's us as Māori people...we will just do it. (participant 7)

Table 4.5 *Ngā Umanga Māori: the cultural worker and Māori in clinical roles*

Roles	Concepts	Tasks	Potential challenges
Māori Cultural and clinical workers	Tuakana/Teina	Ability to lead/to support	Misunderstandings can occur when to initiate either principle
Māori workers in clinical roles	Ngā mahi matarua	Dual clinical and cultural roles	Expectations on clinical workers to fulfil cultural tasks Clarity of roles to avoid boundary conflicts Stress and burn-out (not enough staff)
Cultural and clinical workers	Akoranga Tikanga Māori	To provide training	Time restraints to prepare and deliver regular and effective training
Cultural workers	Takawaenga	Liaison and support services Access to whānau Access to kaumātua, tōhunga	Not enough resource (staff and pūtea)
Cultural workers and Māori in clinical roles	Ringa raka	Flexibility to perform tikanga tasks	Versatility limited due to level of skill, knowledge and experience

All the above concepts are applicable to all three cultural roles portrayed in this section and have been presented according to participants' views and experiences. The kaumātua role, however, carries further responsibility, and specialised skill and ability are essential.

Kaumātua

In te ao Māori, the roles of kaumātua are many and include: resolving disputes and conflicts between families and between iwi; carrying the culture; recognising and encouraging the potential of younger members; providing cultural guidance and advice; maintaining protocol; performing ceremonial duties; spiritual leadership; and attendance at tangihanga (Durie, 1991:2-3). Although some roles are gender defined, such as karanga or whaikōrero, the roles of older Māori men and women may vary in different areas or situations for a number of reasons. Durie et al. (1996:50) warned of, “overburdening a few; and there are responsibilities and obligations which younger members might be better qualified to perform”; there should not be a blanket expectation for kaumātua guidance in all aspects of cultural processes:

...we don't always have to have kaumātua with us in our mahi, an example is of a Māori tane in seclusion in the inpatient unit ... all he wanted was for us Māori clinicians to go in and kōrero, and just help him settle and understand what was happening. Of course, not long after that kōrero, the same day in fact, he was out of seclusion, so there are many things we ourselves can do as Māori clinicians. (participant 5)

Tohungatanga

Today, the term kaumātua can include both male and female designated to fulfil the role of kaumatua on appointment by their whānau, hapū or iwi to perform specific tasks. In mental health services this may be as a spokesperson, as an advisor, to lead in tikanga or to provide healing. Kaumātua with specialised skills such as being a seer (matakite), possessing expertise in certain areas such as mātauranga Māori, whakapapa, mahi whakairo, hauora Māori and rongoā, are often referred to as tohunga:

We do have some kaumātua who we class as tohunga Māori, who are very special ... we will call him in when we need to. I've probably been working with him for nearly 15 years ...we have one who can detect and make right something before it even happens. So he's preventative. (participant 7)

Some Māori may feel they are unwell because they have breached certain cultural protocols, and they may describe their illness as mate Māori, or mākutu, and their whānau may describe their behaviour as disturbing or pōrangi. Williams (1985) defined pōrangi as “headstrong, the mind fully occupied, out of one's mind, wandering and seeking”. Māori have other terms to define mental health status. Dyall (1997:90) provided succinct and adequate descriptions, “wairangi, is used to describe someone overly excited, infatuated or foolish. Haurangi is generally used to describe someone who is intoxicated, but can also be used to convey madness. Ārangi conveys being unsettled or anxious, and ārangirangi describes someone who is listless or idle”. Clearly, where a tangata whai ora might be experiencing cultural manifestations of behaviour such as mate Māori, mākutu or mata kite, cultural and Māori clinical workers did not hesitate to call on the wisdom and skill of kaumātua and or tohunga:

Kaumātua, koroua and kuia are there for support, consultation, representation. There were times where the kaumatua were called in to respond to... a person experiencing a 'mākutu', or 'mate Māori' and even one person who said he was 'mata kite'. In each situation the kaumātua

were able to guide the person(s) and their whānau back to their own iwi and hook them up with their own people to address that. (participant 6)

Another example displayed the participant's cultural skill and knowledge in identifying that Māori cultural factors were also contributing to a young woman's health condition, not only clinical features of a mental illness. This participant sought further confirmation of these cultural manifestations by having the family member contact their kaumatua. It is important to note that wise use of cultural skill and knowledge in this case minimised the use of legislation and perhaps the negative impact of an overnight stay in an inpatient unit, and avoided a possibly depressive situation for this 'potential' tangata whai ora:

We had a time when I was asked by the psychiatrist to assist with an assessment for a young girl from Ngāti Porou – what she started sharing with the doctor, some would say she had features of schizophrenia, but her mother was there and was able to identify what her daughter was talking about – the mother then realised that her daughter was a seer or 'matakite' and because of what she was seeing she hadn't been able to sleep for a few days and the whanau were tired, 'cos they didn't understand this. The mother went off to check some things out and to speak to their kaumatua - I felt that what this young kōtiro had been through was because she was matakite and all she needed was a good sleep. The doctor wasn't quite convinced and so one of the things he was looking at was using the mental health act to get her to the unit for overnight observation and give the whānau a rest. I asked if we could give her the choice – so we did...and that's what happened – she went voluntarily into the unit and the next day she was discharged, her mother and kaumatua had assisted her, she had a good rest and was able to leave mental health services care. (participant 5)

Carriers of te taha wairua

All participants regarded the kaumātua they worked with as possessing te taha wairua and held in esteem the life experience kaumātua brought to the workplace:

...I've found that the wairua from the Kaumātua was essential – because they've lived so long, they have seen the bad side too, they know about Māori hauora, which doesn't have to do with the [Western] clinical stuff. Their age and experience seem to bring them and those with them closer to the wairua. There are those things they see that we can't see.... (participant 8)

Along with this life experience, participants acknowledged the mauri, the life principle, the aura, that some kaumātua possess and the effect it can have on a situation that

potentially may be tapu. A Māori centred approach to risk founded on the tikanga principles of tapu and noa has been outlined and recently introduced into mental health services by Mason Durie (1998b). There is recognition in this approach of the value of enlisting kaumātua to contribute to making an environment or situation safe.

Tapu and Noa: Risk management

There are many interpretations of tapu. Most have equated tapu with sacredness and have missed the more fundamental application to health, safety and the avoidance of risk (Durie, 2000). A common view now is to accept tapu and noa used in new ways, such as through codes for social conduct and adaptation to the environment. Participants were very familiar with the view as illustrated by Durie: tapu is a type of public health regulation, concerned with the avoidance of risk and the promotion of good health. In contrast, noa denotes safety (Durie, 1998b). When dealing with mental health issues, situations sometimes arise that place workers, tangata whai ora and whānau in physically and mentally unsafe positions. While not linking the practical application of tapu and noa directly in these types of situations, participants were able to verify the effectiveness of the use of tikanga in sustaining appropriate cultural management of difficult situations.

The Ministry of Health guidelines for assessing and managing risk, suggest, “as with any other clinical situation, care should be taken to consider cultural issues such as: involvement of whānau, hapū and iwi; tohunga and wherever possible utilise the skills of a tangata whenua cultural worker/kaumatua in the communication and assessment process” (MOH, 1998:21). Skilled cultural support persons guided by taha wairua also make a difference in challenging situations by knowing how much and when to apply tikanga processes:

For some reason kaumātua just bring about this – a type of peace or settling ...we’ve received calls from the (mainstream) community crisis assessment team, when we’ve found that the atmosphere when we’ve arrived there has been tense, but just the presence of having a kaumatua there has taken the tension out of there, made it easier for the whānau and we’ve been able to follow the [mental health act] processes in a more cooperative manner with all concerned. (participant 7)

With the many challenging situations that confront tangata whai ora, access to kaumātua is important and can vary for many tangata whai ora and their whānau in Māori society: some have no or little access to kaumātua depending on their own access to te ao Māori, while others have access to kaumātua in the traditional sense, i.e. as part of their whānau, hapū and iwi links.

Access and informed choice

Participants were very aware of people's diverse realities and life experiences and were clear that kaumātua involvement was not automatic and that kaumātua participation did not occur because the worker thought it should happen or because it was part of the kaupapa. Permission was carefully sought first:

When I work with tangata whai ora and want kaumatua involvement, the tangata whai ora needs to feel comfortable with that. (participant 4)

You cannot force anyone to accept wairua – many times I have been called in to see those who are quite mentally unwell, they still have a choice, whether to see me, to hear me, to accept what I may bring or may have to share – because I value what I bring, it is a taonga and I want what I bring or am ready to give to be received as a taonga. (key informant 3)

Once again participants' own practice verified their understanding of tangata whai ora rights. Where kaumātua are part of a Māori mental health service team, access for tangata whai ora and whānau to kaumātua can be assured. However, participants saw it as very important that tangata whai ora and whānau were offered an informed choice with informed consent (Code of Right seven) about who that kaumatua might be:

I think it's important that options and choice are given to tangata whai ora, that they have access to their own kaumatua and tohunga – don't expect them to just accept a kaumatua on trust. It's like connecting the dots, when they are able to access their own. A lot of knowledge and history are with those kaumatua. (consumer group participant)

If the raru [problem] sits within the whānau, it's usual for me and or the kaumatua who is with me to advise them to contact their own kaumatua or we can help if they want us. (participant 5)

Supervisors and mentors

In a changing world, it is important not to expect kaumātua to be leaders in all aspects of Māori community life. Leadership roles for kaumātua in the workplace included group and one-to-one support in the form of cultural supervision and cultural mentorship in tikanga Māori. Many of the participants agreed with the following statement:

“I had kaumatua for my cultural supervision... Initially from my own iwi and then from the rohe I worked in ...they were my korowai mō ngā tikanga Māori, mō ngā mea Māori katoa. (participant 3)

As previously confirmed by participants’ experiences with cultural workers, kaumātua input into clinical settings were on the whole well respected by all those present:

...within multidisciplinary hui, decision making is shared...what kaumātua or cultural therapists suggests when any cultural concern comes up (some of the symptoms of psychosis are quite closely related to cultural factors, such as ‘hearing’ the voice of a whānau member passed on’).. I check back with the kaumātua, and what they give is valued and is acted on. They are part of the discussions; all disciplines are there to contribute. (participant 4)

Varied examples have been presented, reminding the reader of the specialised skills and abilities of kaumātua. It is also important to remember kaumātua are not a homogeneous group, between individuals there is diversity in socio-economic levels and cultural characteristics, and kaumātua bring much needed life experience and wisdom to support, supervise and mentor the younger generation in preparation for their future role as kaumātua in their own right.

Table 4.6 *Kaumātua and their role in mental health services*

Roles	Skills and competencies	Tasks
Tohungatanga	Strong cultural leadership Māori language Māori health knowledge Specialised healing knowledge	Offer appropriate cultural advice Identify cultural factors and cultural manifestations of behaviour Provide/facilitate tikanga and traditional healing remedies
Carrier of te taha wairua	Lived reality with taha wairua influence and experience	Facilitator of tikanga processes to 'effect' taha wairua
Cultural Risk Manager	Understands Tapu and Noa Assesses cultural factors in 'high risk' situation	Supporting and making environments and people safe
Facilitate access and choice to other kaumātua / tohunga	Māori genealogies Māori networks	Link tangata whai ora/whānau to hapū, iwi and rohe
Supervisor / Mentor	Mātauranga Māori Strong cultural leadership	Provide sound and effective cultural supervision Role model cultural leadership

Conclusion

This chapter has provided examples of how tikanga practices and Māori models of health support the facilitation of taha wairua within Māori mental health clinical and cultural practice. The influence of taha wairua on the Māori clinical and cultural workers and in the recovery process for tangata whai ora has been examined throughout the chapter. This research demonstrates how taha wairua influenced practice, and how it benefits tangata whaiora and whānau. Recovery principles of hope, personal meaning and responsibility, self-advocacy, education and support, along with empowerment, strengthened identity, and raised self-esteem all underpin these benefits. The analysis thus far has identified a number of principles and concepts that support best practice standards for the cultural worker role. These will be discussed in Chapter 6, along with an analysis of research findings.

CHAPTER FIVE

Telling Their Stories

Introduction

This chapter continues to explore the themes drawn from the interviews with participants, and the key characteristics, principles and skills that guide the practices that support tangata whai ora in mental health settings. In concluding this section the researcher will also discuss the positive and negative attributes that contribute to effective and appropriate Māori mental health services and will outline a framework for development of tikanga standards of practice.

Tikanga and best practice standards

Pūmanawa

Everyone is assumed to inherit pūmanawa or personal traits and characteristics and other pūmanawa are learned (Mead, 2003:239). In most people there are positive and negative pūmanawa. Participants were very conscious of those cultural characteristics (pūmanawa) needed to be culturally effective and clear when facilitating tikanga. The pūmanawa referred to here are strongly linked to te ao Māori and tikanga Māori and reflect participants' views of what makes a cultural worker effective in their role. One of the key characteristics as defined by participants is cultural integrity.

He tangata tika me te pono

Cultural integrity is a combination of tika, to be correct, straight, direct and pono, to be true or genuine (Williams, 1985:291,416). In terms of its use with tikanga, tika me te pono is about the application of a particular tikanga practice based on whether the principles or standards of behaviour have been observed adequately (Mead, 2003:26). For participants, the principles of tika me te pono were about knowing one's identity and being honest about that distinctiveness:

...to do this mahi, you have to be Māori, you need to be pono, you have to know your identity, know your whakapapa. (participant 2)

An ideal situation for the influence of taha wairua to be felt cannot be defined because for me, it is more about personal preparation for the person who provides the access or opportunity to others to feel the influence of taha wairua – in other words, walk your talk. (key informant 1)

Appropriate processes and environments can ensure meaningful participation will be more likely if there is security of identity (Durie, 1997). For Māori, that means having access to te ao Māori and the confidence to participate as Māori (Durie, 1997). Not only is strength of cultural identity important for empowering recovery journeys for tangata whaiora, it is also important for empowering those Māori working with them, particularly in relation to facilitation of taha wairua in healing:

I believe Maori clinicians, cultural therapists alike, need to have a strong identity as Maori to understand taha wairua and recognise when wairua is present. (participant 1)

Strength of identity is also about having a strong foundation in knowing when to apply tikanga and/or Western ethical practices:

For me it's about being able to use the givens on the one hand, that is pākehā laws, ethical codes and codes of practice like the Social Workers code and-or using ngā whakapono me ngā uara – values and beliefs of the Māori ...my ancestors weren't stupid, they gave us a lot of knowledge and that's where I place my tikanga, for example, safety for children, and the issue of confidentiality. I have been able to successfully explain to whānau and even to colleagues how at times our cultural values may need to apply or how the givens [pākehā laws] can or may take precedence. (participant 3)

Tika me te pono is also about how one accepts tikanga practices such as karakia and applies them in one's own life, to one's own spiritual well-being:

The process is that we meet every morning in our whānau room and we have karakia and...well, I also teach ours (the workers) that you have to put yourself in a safe place to practice, and if you haven't looked after your wairua, then you're not well as a clinician, you're not in the best of health

to be able to work. Therefore how are you able to give your best to tangata whaiora? (participant 3)

Wairua is part of te atua, when we facilitate tikanga processes such as karakia, waiata, whakawātea, we need to acknowledge te atua and invite te atua to help those we work with, not only those who are unwell, or needing guidance and support but those who are our work colleagues. (key informant 1)

For one of the participants, these principles of tika me te pono are all embracing in the application of tikanga Māori practices:

...in the end it's tikanga Māori otherwise it's not tika. (participant 8)

He tangata tika me te pono is a person who is able to 'walk their talk' according to their level of learning and understanding not to others' expectations and understanding. Allowing one to develop in that journey exemplifies the principle of manaakitanga.

He tangata manaaki

Manaakitanga is another principle identified as important to the cultural worker role. Important attributes of manaaki, as explained by Barlow (1991:63), are to provide an abundance of food, a place to rest and to speak nicely to visitors so that peace prevails during the gathering. He tangata manaaki is a person who is able to typify these attributes, i.e. –he or she is caring and helpful to others and considers the welfare of others rather than oneself, and having a healthy respect for others as well as oneself. Manaakitanga is all inclusive, and applies in mental health settings regardless of who the people are, where they are from, and what experience they may bring with them:

... a woman had been in mental health services for fifteen years and still hadn't found peace – she had been to counselling and had tried different ways to assist her healing. When she came to us, we returned her journey to her, and her own words of how she saw that first incident and giving her ownership of it and feeling okay about it, acknowledging it, then putting it aside and allowing her to move on, in just two sessions using pōwhiri poutama – that girl has gone back into the workforce and has changed her outlook – not only mentally but also physically and she has recently come back from overseas. (participant 7)

Participants acknowledged the influence of taha wairua on their practice of manaakitanga in the workplace:

The influence of taha wairua on my practice, for me, it's just about treating tangata whaiora with respect, creating an environment in which they feel safe, involving their whānau... so it's about being with a person, listening to their stories, letting them tell it in the way they want to tell it, valuing what they share and not trying to compartmentalise that information. (participant 4)

Closely aligned to manaakitanga is mana. Personal and group relationships are always mediated and guided by the high value placed upon mana.

He tangata mana

Mana as defined by Williams (1985:172) has many meanings: “authority, control”, “influence, prestige, power, “psychic force”, “be effectual”, and “take effect”. A worker with mana will have the ability to show how to respect the mana of others even when seeming to be undeserved:

I had one experience ... where a guy was escorted by the police and ... they were pushing him into the car on the head. I remember our kui was there and she growled the police and said, “Don't do that, it doesn't matter how unwell he is.” I was really proud of her for doing that ...it has helped me remember that even though you [may] need legislation to get things done to help someone's well-being, that person still needs to be respected as a person and as a Māori when those things are happening. (participant 2)

Participants' experiences included witnessing their colleagues having to address situations where injury to mana occurred, and they saw this very much as a barrier to taha wairua:

A barrier for my Māori colleagues is where they feel that their mana has been trodden on and they lose confidence to keep practising the tikanga when we know it works for our people and their wairua suffers. (participant 5)

Having suitable cultural safety measures in place is vital in maintaining an individual's mana. All participants had access to appropriate cultural support and supervision that enabled them to keep their mana intact and or reduce the effects of harmful influences:

We are fortunate because in our service we have good support as workers from local kaumātua and some who are employed in the team. Though like everything else we need more kaumātua – currently, all up, the kaumātua fill one full-time equivalent. (participant 6)

Directly linked to tika, pono, manaakitanga and mana is aroha. A person who practises aroha is concerned about people and wants to help wherever possible.

He tangata aroha ki te tangata

Aroha has many meanings – love, pity, compassion, being affectionate, having regard, and showing approval (Williams 1985:16). How does the principle of aroha take effect in mental health services? Participants' experiences show that it's not just the meanings described above, but that it's also about empathy, demonstrating an active understanding of the diversity of Māori society, and providing cultural interventions according to their level of acceptance and understanding:

...having aroha has taught me ... that there needs to be humility ... so it's not about getting into this, "I know what this person needs". Again that's taking the journey of not only the tangata whaiora away but also the kaimahi around you. It's also about safety for tangata whaiora and others that are in the environment. It may not always be cultural, there may also be other areas. (participant 7)

Aroha is non-judgemental, it acknowledges people's ongoing ability to develop, learn and pick themselves up when they make mistakes:

On a journey of recovery, on a journey of healing, there will always be backslides but those are times of learning for that person...some experiences are also a good teacher, especially when a person is self developing. (participant 7)

Enacting aroha is also about opening tangata whaiora to new or renewed experiences, e.g., participating in hui, restoring links to kaumātua, tohunga, whānau and hapū:

I've seen where a whānau with their kaumatua wanted to support their whānau member when he became very unwell, but no-one knew what the cause was. So we held a hui, it included other hapū members ... when the mihimihi part came out and the kōrero, the mamae the tangata whaiora was carrying came out ... no-one in the whānau and the hapū knew of this

kōrero, when it all came out, they all wanted to support, even those who had attended at first with reluctance...they saw that they could all help...I saw this as very healing for the tangata whaiora and the whānau also. (participant 8)

Aroha necessitates commitment to working with culturally appropriate methods:

Most clinicians here, doctors included, are quite committed to working alongside cultural models of practice. (participant 4)

People, clinicians, need to be open to taha wairua, they need to be willing to look at a different approach – for example, there are 2 ways to look at a problem – take taha tinana – someone has a sore leg, the doctor might diagnose a Western illness or disease and Māori might say, ‘someone has tahae’d that leg. (participant 7)

All the principles drawn on thus far oblige the cultural worker to up skill, for, as explained earlier, pūmanawa are characteristics that are either inherited or learned. It is not unreasonable to presume that some characteristics need to be acquired, while others have been inherited. The next principle is pukenga or skills.

He tangata pūkenga

While the attainment of cultural characteristics has been the focus in this section, the reality for the cultural worker is that the workplace is a clinical one and the obtaining of clinical skills and knowledge is also important. Best practice standards in kaupapa Māori services include realization of dual cultural and clinical competencies (Te Rau Matatini, 2003:18). Work in dual competencies currently in progress aims to make Māori mental health nurses more responsive to tangata whaiora/whānau needs within their scopes of practice. Participants’ views show this also needs to happen for cultural workers:

We need skilled and knowledgeable cultural workers. If they aren’t, they get done. The mainstream or even our own nurses shatter their confidence by the fact that they don’t know the mental health information about the issues. Then their mana is affected if they don’t know the cultural. How then can the wairua be here, to me it’s not, it’s scattered. (participant 5)

Kaupapa Māori services also need to be clinically and culturally up skilled. It’s not enough to just be Māori, otherwise who educates the tangata whaiora and the whānau? (participant 8)

Within the Te Rau Matatini framework (2003:6) cultural competencies are of equal importance with and contain equal legitimacy to clinical competencies. This view acknowledges the value of skilled cultural workers and gives recognition of that skill and learning. However, although dual competencies are needed, participants expected cultural workers to be more skilled in tikanga practices. Perhaps this is not unreasonable, if one specialised in the tikanga Māori fields of learning:

“There continues to be lack of understanding of tikanga, and not only that but Māori social systems. Why should we go out there and educate mainstream or even our own in Māori mental health services? We should have attained this knowledge and understanding, particularly if we are in a cultural position. (participants 5 & 8)

Upskill staff in te reo Māori and tikanga, Māori first – other cultures next...make that a ‘must’ in working for kaupapa Māori services. (participant 3)

Some of the participants readily recognized and valued the specialised cultural skills of cultural workers:

I learnt the value of having the right cultural person(s) in support, even in the most difficult situations, involving the police and the mental health act. I certainly felt safer. (participant 1)

Three participants worked in teams they considered had dual competencies:

We’ve got a really diverse skill base here – we’ve got well-trained Māori who have got Western qualifications as well as cultural skills. We have nurses, social workers, cultural workers, dual-diagnosis worker, psychologists, who are all Māori, psychiatrists – one pākehā New Zealand psychiatrist, and the others are from overseas. (participant 4)

He tangata pūkenga is someone who is suitably skilled and knowledgeable for the task at hand. Some essential cultural competencies, already established via this research and in line with the competencies as suggested in the Te Rau Matatini framework (2003:12-13), include knowledge, understanding and a reasonable level of fluency in te reo Māori and tikanga and Māori models of health; application of tikanga principles such as

tuakana/teina; tapu and noa; whakawhanaungatanga; manaakitanga; kotahitanga, rangatiratanga and wairuatanga:

Understanding that everyone has te wairua and for the individual to help others access taha wairua is firstly through understanding and practising tikanga Māori and speaking and understanding te reo Māori. Before I started learning tikanga and te reo Māori, I didn't even see it [te taha wairua]. (participant 8)

Table 5.1 *Ngā Mahi Tōtika: Best practice standards that support the influence of Wairua within the cultural worker, Māori clinician and kaumātua roles*

Uara <i>Principles</i>	Pūmanawa <i>characteristics</i>	Pūkenga <i>skills and competencies</i>
Tika me te pono	Cultural integrity	Strong identity as Māori Live one's beliefs well Competent facilitation of tikanga practices Be clear, open and consistent in one's tikanga practices
Manaaki	Healthy respect for self and others	Reciprocate awhi and tautoko Empower others to do the same
Mana	Uniqueness Self-image	Support growth through recovery process Facilitate access to Māori networks and to whakapapa Maintain dignity of self and others
Aroha ki te tangata	Non judgemental Empathy Commitment to kaupapa	Treat others as equals and protect their rights Uplift others to achieve better outcomes of health and living standards Consistent in good work practices Place the tangata whaiora and whānau at the centre of one's mahi
Pūkenga	Proficient	Te Reo Māori Facilitate access to Te ao Māori Tikanga processes Commit to ongoing education and learning to attain specialised/suitable dual cultural and clinical competencies with whānau, hapū, iwi and national recognition

The above competencies complement knowledge of one's own whakapapa, and provide strong cultural identity and integrity, as described earlier in this chapter. The Treaty of Waitangi underpins all these competencies, and in saying this, tikanga Māori best practice standards call for an environment in which cultural competencies are made

valid, Māori protocols and processes are acknowledged, and where the environment allows for physical and spiritual healing to take place.

A tikanga Māori environment

The marae was and is a symbol of tribal identity and solidarity. Differences today are evident with the influence of the urban drift of Māori who left ancestral lands and moved into towns and cities. Descriptions of modern marae take in all buildings associated with a community facility and are collectively known as a marae (Barlow, 1991:71) The marae, as a centre for tribal and Māori community activities and hui, has become increasingly important to the integrity of Māori culture, if not to cultural survival (Walker, 1975). Marae have in common a set of protocols that reinforce Māori identity and restore a sense of purpose not easily maintained in the mainstream of urban living (Durie, 2001). The following key informant view does not exclude those with little or no access to the traditional marae but rather expands on Walker and Durie's views, i.e. the more access to the marae, the stronger one becomes culturally; therefore the encounters normally associated with the marae are intrinsic in that person to the extent that marae living becomes part of life whether it is lived on or off the marae:

Each marae has its own kawa, so those who come from that marae and who bring others to their marae, know the rules, the boundaries are already set. Each person who comes from the marae propagates the relationship between the marae and taha wairua. When they stand they represent that marae, how strongly they represent their marae will depend on their access to the marae, how often they link back. The more often a person links back to their marae, the stronger the bond, the stronger their identity, the stronger te taha wairua. Metaphorically speaking, that person in fact is the marae. (key informant 4)

Again, the diverse realities for Māori need to be considered, for many Māori do not have regular access to a marae or even know their ancestral marae and therefore may not necessarily experience marae type encounters in their daily lives. It is also important to note that modern situations require modern solutions, and many modern marae structures today are set up in towns and cities and may be housed in suitable buildings, e.g. unused church halls or large community buildings that allow for space to enable marae-type encounters to occur. "What is important about a marae is not necessarily the physical structure but the encounters that take place ...and where there is depletion of spirit or loss of spirit, facets of marae experience have the potential to

restore balance and impart a sense of order in lives where balance and order are lacking” (Durie, 2001:74).

Some participants understood and supported this view:

The whole base of tikanga Māori or kaupapa Māori – no matter what service you deliver – goes back to what happens on the marae. That’s where the real source is for the people and us. (participant 8)

The *Blueprint* (MHC, 1998:61) made it apparent that tikanga Māori require an environment in which Māori protocols and processes are acknowledged, and which allows physical and spiritual healing to take place. What has therefore already been established is that a tikanga Māori environment is not just a physical building or setting, though from most participants’ points of view, this is clearly needed:

The issue for us that it’s a wharenuī...it has been condemned, yet they [general management] want to put us in a building that is not appropriate. We say, “You either need to build us a new whare, or we can’t move”. They just can’t make that connection. (participant 2)

Key indicators of an environment in which Māori protocols and processes are acknowledged and in which physical and spiritual healing can take place as defined/described by participants and key informants include:

A physical building and space that will support marae encounters and provide opportunity to practice effectively tikanga principles such as manaakitanga and tapu and noa. What does this mean in practical terms? For Māori it means having adequate space where tapu and noa processes can be respected and played out. This space will therefore accommodate the welcoming of manuhiri and the exchange of greetings through the pōwhiri process of karanga, tangi, whaikōrero, waiata, koha and kai. This will include a marae ātea, a space in front of the building, with surroundings that allow for the children of Tane Mahuta and an open space that portrays the domain of tūmataunga (god of war) to allow for open and frank discussions. The building inside and out should be welcoming and warm, a suitable receptacle for Rongo maraeroa, god of peace. The building also needs to be large enough to house a party the size of a large family group and mental health workers, and have provision for noa processes to take

place, that is, running water and kai facilities. When these requirements are met there is a greater likelihood that the facilitation of taha wairua can occur throughout the cultural encounters. Participants found an appropriate physical space essential in handling situations that can violate one's rangatiratanga:

...when legislation comes in it can be really disempowering ...with the mental health act, the times I've been involved with doing admissions...has been hard for me but how we've tried to maintain wairua has been to utilise the 'wharenui', making it a process so that whānau can be involved and in a place where they can feel a bit safe... (participant 2)

A physical facility is just one element of a tikanga Māori environment, another element is the need for all staff, non-Māori and Māori, to participate in cultural education and training, which is extremely important in contributing to the type of environment needed to support taha wairua and tikanga practices. For over a decade, literature and research in the field of psychology and nursing have highlighted the need for more culturally appropriate training (Abbott & Durie, 1987; Brady, 1992; Lawson-Te Aho, 1994; Ramsden, 1996). The promotion of cultural safety in nursing education emerged from several hui; Irihapeti Ramsden, a Māori nurse educator, operationalised cultural safety guidelines for nurses (Ramsden, 1996).

Cultural safety

Perhaps the lead provided by Irihapeti Ramsden (1996) could serve as a model for mental health services. Part of Ramsden's (1996) definition of cultural safety was about understanding self, the rights of others, the legitimacy of difference; that people have different realities, and their cultural values and beliefs cannot be stereotyped or ritualised to become insignificant:

Well, it's made a difference for me...from the whānau I work with everyday I have got to learn much more from their telling their stories and what those kupu (in tuakiri o te tangata) mean and also about wairua. I am fortunate to be in an environment where people are on different levels but share similar values and principles around wairua. (participant 2)

Ramsden also suggested that cultural safety should be part of the ongoing training and professional development programme of all, including students and teachers [of nursing], and all health professional groups, including the licensing of doctors in New

Zealand. Two participants spoke of the psychiatric registrar cultural training programmes. They were short courses, and attendance was mandatory; however, there did not seem to be any ongoing commitment for regular training and follow-up courses for registrars or the general mental health workforce:

The psych registrar training has a cultural training component, which is held one day per week for ten weeks. It aims at preparing registrars to work with Māori – the training includes the dynamics of Māori whānau relationships and systems, Māori identity and Māori models of therapy. It was hard, I must say it was hard training for those delivering the training, but I'll tell you this – some of the best and more open-minded psych registrars that we had were those from overseas, more open and eager to want to learn about the culture in New Zealand. The downside is the training is only held once a year and then we don't know whether it will happen annually [curriculum is set near the end of each year], and the training doesn't include consultants. (participant 2)

Conversely, some participants commented on experiencing negative attitudes and processes and the inherent tension that becomes apparent in the workplace:

Some of the worse experiences I had was working alongside clinicians who were kūware...tino kūware, indifferent and absolute racism ...sometimes clinicians just didn't care and here am I trying to deliver a cultural intervention with mainstream colleagues like these. (participant 8)

In practice, this requires addressing the institutional racism that exists and in many cases entails a major shift in attitude on the part of other professionals in the workplace to recognise that cultural workers' skills are specialised and they do not have to conform to a Western model of care to provide valuable support and care to tangata whaiora and whānau. Māori are unable to achieve this alone, particularly if they are the targets of such negativity. There are very few kaupapa Māori mental health services that provide clinical and cultural services that sit outside of a large mainstream organisation. Consequently, all organisations involved in providing mental health services would do well to have continuing cultural education programmes in place to be receptive and responsive to Māori needs:

Competencies to work with Māori were viewed as a core component of ‘best practice’ in specific and generic mental health training paradigms:

You find the ones [clinicians] from overseas are much more willing to learn about tikanga and what is needed for our people than our own New Zealand staff. (consumer group participant)

Understanding tikanga processes such as whanaungatanga necessitates effective cultural education, and training promotes cultural safety for all mental health staff, Māori and non-Māori, inclusive of those from overseas and all types of mental health services:

Some of the barriers are systems within mainstream – lack of understanding from other parts of the wider mental health service and what is needed for kaupapa Māori practices to function effectively, that is systems that allow you to interact as a whānau and as part of one’s culture, to tell one’s own experiences, etc. (participant 4)

Similarly, those who have significant cultural roles need to have an in-depth understanding of tikanga practices in relation to taha wairua and its application to their work in Māori mental health services. Many participants, those in cultural roles included, acknowledged the need for themselves to have an in-depth knowledge of taha Māori and tikanga practices before they were able to provide that same prospect to tangata whaiora and whānau:

Well, clinicians, our own kaimahi...I can see that actually need educating. And why should we do that? Their lack of skill has caused the tikanga and the wairua to be scattered. So it’s about our own personal safety first, rather than the safety of the individual who comes to seek our help. (participant 5)

Some participants were also critical of Māori colleagues who adopted Western ideas rather than Māori cultural values as the only way to treat those Māori seeking treatment for mental unwellness:

We need to stop compromising our ideas with pākehā whakaaro, and overriding theirs with ours – which happens more times than not (participants 5 & 8)

Cultural education also provides opportunities to understand the importance of a strengthened cultural identity and to advance knowledge and skills concerning te reo Māori me ōna tikanga and Māori models of practice:

For me personally...I have much to do before I can help support the flow of taha wairua however a really good thing for me this year has been my own personal journey with tikanga and Māoritanga ...I have been learning my own iwi mōteatea, ...about where I came from, understanding the context in which our tupuna lived, it just makes me connect more and it seems to have opened me up to saying karakia more, things like that. (participant 1)

Proficient and appropriate cultural leadership was cited as another key indicator of a tikanga Māori environment. Participants were clear that Māori needed to be able to lead, guide, develop, implement and facilitate tikanga processes and policy with the support of senior management and clinical leaders:

A main barrier is sitting under mainstream, where we are impeded by a pākehā manager who sits in mainstream and determines what resources we can or can't have. There is no cultural advisor at a senior level to increase the manager's awareness of understanding Māori mental health needs...Having Māori health services managed at higher levels by Māori ...inclusive of mental health and public health... will allow for some self-determination for Māori services even under the umbrella of mainstream organisations. Having Māori management at the higher levels allows for better understanding of Māori health needs and also allows a focus on those needs. We would have more resources available. Māori need to be able to manage their own funding, to determine their own resources and not have someone else determine things for them. (participant 6)

While participants felt there is a need for more Māori to be employed in influential decision-making positions, they also saw that those Māori need to be suitably skilled with appropriate knowledge and experience when filling management roles. Training is again an issue here on all levels and is not limited to cultural and clinical paradigms but also to management levels:

... having unskilled and inexperienced Māori managers ... people who do not know the business of mental health let alone kaupapa Māori, otherwise it holds up the mahi, we don't go anywhere while they are trying to learn. (participants 5 & 7)

Participants commented on how lack of relevant skill and knowledge can not only compromise and undermine their work as Māori but also te taha wairua and the work environment amongst Māori themselves:

What can be compromised is the facilitation of the wairua when the right processes, leadership and environment are not there for the wairua to be felt or heard so that there is a positive influence and difference. So we need kotahitanga and whakawhanaungatanga in the workplace. (participant 5)

Kotahitanga is about unity and whakawhanaungatanga concerns relationship-building. Responsibility for the provision and maintenance of a culturally safe environment requires proactive, co-ordinated, committed and co-operative effort across all levels of an organisation that provides mental health services.

Collective responsibility means the onus rests with the relevant organisations (Levy, 2002:61), not with Māori who do not have the critical mass and could not be expected to progress much needed and overdue cultural service developments. The Royal Commission on Social Policy identified three principles – partnership, participation and protection – as of special importance for social policy areas (RCSP, 1988). The recommendation from the Commission was that these principles should guide the development of policy and frame the development of services for Māori. For example, one such initiative is to develop and implement culturally appropriate triage processes. As one participant explained, where collective responsibility is not evident, services to Māori suffer and access for Māori is obstructive:

Inappropriate processes are in place for Māori to access Māori ...no options are given them through a mainstream triage service...or the other one is the mainstream clinician's approach or dialogue ... the mainstream service has caused our kaupapa Māori service to backwards – a true kaupapa Māori service is 'for Māori by Māori' – that is not happening under mainstream. (participant 5)

A vision needs to be developed with mainstream to allow kaupapa Māori services to develop their systems appropriately or to provide them with the necessary funding to meet population need and to allow them to develop and deliver a Māori service delivery model inclusive of the community but based firmly on Māori concepts and values, e.g., developing and delivering a Māori consult liaison service to the community and the whānau. (participant 1)

To achieve an environment that will support taha wairua as facilitated through tikanga values and principles, Māori models of health, cultural roles and appropriate workplace conditions require a coordinated and integrated effort of human resource and workforce development, policy development, best practice development and decision-making processes, and also time, as one key informant notes:

An environment where there is respect for those who provide wairua services or support – whether they be kaumātua, koroua, kuia, pakeke. Not time bound nor controlled by any other situation other than tangata whai ora or whānau need and choice. (key informant 2)

An interesting finding was that some mental health services appeared to foster and value a greater acceptance of tikanga and Māori models of health than others, as demonstrated by participants' views and experiences; and yet the majority of participants worked as part of a Māori mental health service under a mainstream umbrella. Therefore it would not be unreasonable to expect all services would display similar values and acceptance of tikanga.

Throughout this chapter, the many experiences and views have demonstrated that participants' cultural practices are strongly influenced by taha wairua, tikanga, and Māori models of health. The following section provides some examples of positive experiences of taha wairua influence in the workplace.

Positive benefits from the influence of taha wairua in the workplace

Being valued and acknowledged in the workplace also raises the issue of retention, and this needs addressing. This is not simply a matter of personal cultural skills brought by a worker to the workplace but concerns tikanga and the Māori models of health practised. Where participants could provide care and treatment under a kaupapa Māori framework, without having to conform to a Western model of care, they felt high degrees of satisfaction and tended to remain with the services. The following examples show significant benefits for mental health services, particularly when it means staff will stay in the workplace:

Being able to practise in a Māori way, that's made a difference for me staying here in this mahi. (participant 5)

Having non-Māori 'buy in' to cultural practices produced improved peer relationships with positive spill-over effects for the workplace and tangata whaiora and whānau:

We are fortunate to have in our service, doctors coming on board and attending tikanga training ...we are developing some good working relationships between ourselves, which are benefiting the tangata whai ora and their whānau. (participant 3)

Gains were also evident where there was cooperation between Māori and mainstream mental health services. This cooperation not only enhanced the working environment but more importantly also empowered tangata whai ora and whānau through a choice of services or through access to both:

...benefits I've seen is where mainstream saw that they needed to make contact straight away with te taha Māori in order to support the tangata whaiora and to take care of their mainstream assessment in a relatively co-operative way. (participant 8)

...mainly with mainstream colleagues, some in the crisis assessment team and some of the doctors who has asked me to assist with some of their Māori tangata whaiora – they recognise what they are seeing is or may not be a mental health 'mate', so they ask for my advice...it's good when mainstream clinicians and doctors are willing to listen and learn, and is helpful to empowering the whānau. (participant 5)

Last, this experience is not unlike others already described, but displays the participant's readiness to access appropriate cultural resources to improve practice and increased responsiveness to tangata whai ora needs. This example epitomises 'whakaiti' or the quality of humility in being open to having one's own practice scrutinised and to accepting direction. This observes best-practice standards and once again benefits tangata whaiora:

I think that it's been more my constantly accessing cultural knowledge and skill on a consulting type level that I've really found tangata whaiora have benefited. (participant 4)

The examples provided above highlight the need for mental health workers to develop dual clinical and cultural competencies, and this should not be restricted to Māori workers alone.

Table 5.2 *Positive Benefits of the influence of taha wairua in the workplace*

Principles	Target	Cultural Need	Benefit
Active Protection	Managers and clinical staff	Acceptance of kaupapa Māori practice Increased workforce	Retention of Māori staff Increased responsiveness to tangata whai ora and whānau need
Participation	Non-Māori and Māori staff	Cultural training valued	Improved peer relationships
Partnership, cooperation and options	Non-Māori and Māori clinical and cultural staff	Clinical interventions align with cultural support and assessment (integrated service delivery)	Positive working environment enhancing access and choice of services by tangata whai ora and whānau
Cultural safety	Māori staff and non-Māori staff	Best practice standards in supervision	Cultural practices are supportive of best possible outcomes for the tangata whai ora, whānau, kaimahi and mental health services

The experiences described in this section show that when the facilitation of taha Māori practices is accepted and respected there are definite benefits for the workplace. There are opportunities for meaningful participation, and for active protection and partnership between Māori and mainstream mental health services. Unfortunately, this is not the ‘norm’ for most of the participants in this research. It has already been demonstrated that Māori mental health services continue to lack resources and adequate support, and that there are unrealistic expectations that this small critical mass can provide quality services to a high Māori population of mental health service users. The *Blueprint* has set the target for service access to Māori at 6%, which is double the figure set for the general population. Since 15% of the total population is Māori, 26% of all mental health service provision in New Zealand should be for Māori (MHC, 1998:57). The following section of this chapter will outline some of the barriers for Māori in facilitating taha wairua in their scopes of practice. Some of these barriers have already

been identified in this chapter and also in previous cultural studies of other professional studies such as psychology (Abbott & Durie, 1987; Levy, 2002) and nursing (Ramsden, 1996).

Barriers to the facilitation of taha wairua in kaimahi Māori practice

Key barriers already identified and outlined in Chapters Four and Five by participants included: lack of appropriate physical facilities to facilitate taha wairua; the need for cultural safety and effective and regular cultural education; the need for cultural and clinical competency; the lack of clarity of roles and of skilled and effective cultural leadership. Some important retention issues were raised: having the ability to work ‘as Māori, in a Māori way’; requiring more funding and more staff; being acknowledged and valued for cultural skills in all interventions; no tolerance towards institutional racism and the taking of active measures to address discrimination and stigma. Lack of collective responsibility was also evident, with participants citing inappropriate mental health processes (e.g., triage/access and entry), and the ongoing domination of Western practices.

Another barrier identified was the reluctance of whānau to provide support to rangatahi receiving mental health services. This was seen as a serious barrier because it often meant rangatahi would not receive necessary services in a timely and effective way. Māori are a youthful population, fifteen years and under account for approximately 37% of the total Māori population, and the median age is 21.6 years (Davey, 1998:73). Durie (2000:18) indicated that large numbers of Māori, who according to present trends will acquire a range of mental health problems, often never receive assistance and become trapped in incompatible and unhelpful lifestyles. It would seem therefore that whānau may have cultural reasons for putting up barriers and this needs to be addressed to ensure rangatahi access to timely and appropriate services:

Getting barriers put up by pakeke ...mōrehu of the whānau, and that's really hard when you're working with rangatahi, 'cos they need good role models...some of this is about whakamā, about the unknown...this creates a huge barrier and happens too many times. (participant 2)

Participants also commented on barriers caused by ignorance or indifference, delays in accessing appropriate support, and/or not offering options to tangata whai ora:

...legislation, protocols, rules, etc., they can create barriers sometimes because not all of the time are our kaumātua able to be involved in processes, or even Māori clinicians. (participant 2)

Consumer participants identified major barriers in accessing further education and professional development in both clinical and cultural practice. These barriers were mainly due to what they perceived as a lack of equality in their workplaces. When specifically talking about cultural development, the participants identified key areas, such as, lack of support for access to appropriate cultural support, mentoring and training:

We can access cultural support as peers if need be, but we do need cultural training too. We need to be able to support tangata whai ora in taha wairua practices, so we need training. (consumer group participants)

When discussing access to clinical development, participants spoke of being deliberately looked over or left out of attend training, education and mental health conferences:

Although we enjoy the mahi we do, we would appreciate support from the workplace to up-skill. We've missed opportunities for training and conferences, and we are either being deliberately looked over or left out. We need to up-skill [it seems] to be more accepted and credible in the workplace and in the work we do with tangata whai ora. (consumer group participants)

All participants spoke of not being treated by colleagues as professionals in the workplace, as still being seen as a tangata whai ora, and thereby feeling the stigma and discrimination attached to being a mental health service user:

...but in particular to be seen and treated as a colleague and an equal. We are still seen as tangata whai ora and not being seen as professionals. We want to be appreciated for the honesty we bring. (consumer group participants)

Mental health services have made ground through the employment of Māori consumer advisors but are yet to prove that ground by enacting equal employment conditions on

behalf of consumers. One participant saw the employing of consumer advisors as a reason for autonomy in budget control:

We need to have our own managers to have access to equitable resources to provide necessary services such as Māori consumer advisors. (participant 6)

While services continue to discriminate and perhaps unwittingly foster stigma, they negate the reasons for employing consumer advisors. It would seem the services need reminding that they, the consumers, are the reason mental health services are established. Although some of the barriers consumer advisors have experienced are similar to Māori cultural and clinical workers, each party has specific needs necessary to meet their roles, and will need specific strategies to address those needs.

Table 5.3 *Āhuru Mōwai: Solutions to barriers to enable an appropriate environment to support the facilitation of taha wairua*

Solutions	Barriers
Appropriate physical building & space to support marae encounters Validation of cultural skills, competencies and use of tikanga and Māori models of health Increased Māori workforce Dedicated Māori cultural positions	Cultural alienation
Effective, ongoing cultural education No tolerance policy Self governance in service development and delivery, of service management and of budget and human resource at senior levels	Institutionalised racism
More kaupapa Māori services developed and supported Improved responsiveness from mainstream services Foster and develop strong adept cultural leadership Māori led by Māori, to deliver to Māori	Non-acceptability of Western health practices
Collective responsibility to: <ul style="list-style-type: none"> - Provide equal opportunities to cultural and clinical training - Develop and implement appropriate cultural safety; recruitment and retention policies - Māori to be represented and to actively participate across all levels of decision making - Involve whānau participation in all areas of tangata whaiora care Consumer advisors treated as professionals with equal opportunities to up skill and acknowledgement of the skills they bring	Discrimination Stigma

Conclusion

This chapter has outlined the characteristics, principles, skills and competencies that help define best-practice standards for cultural worker roles. Furthermore, for consistency and sustainability of cultural practices that facilitate taha wairua in mental health services, a fitting environment needs to be fostered and maintained. This environment needs to contain physical and spiritual components such as suitable buildings; effective cultural training to promote competency; proficient leadership; more funding for more staff resource; a valuing of Māori human resource, better access to services for Māori; and a positive but much needed change in attitude from Western ideas to appreciate Māori cultural ways. What is apparent throughout the experiences described is the commitment of kaimahi Māori to tikanga practices that promote and enable taha wairua to influence their scopes of practice with tangata whai ora and whānau. Kaimahi Māori were also able to articulate the issues that created barriers for the facilitation of taha wairua. The findings and analysis in this chapter provide a foundation for the components of a taha wairua practice framework and suggest recommendations for the next chapter.

CHAPTER SIX

Findings and Recommendations

Introduction

This research intended to answer three questions: whether taha wairua, supported by mātauranga Māori, can be verified as a valid concept for use in mental health services; how Māori cultural and clinical workers facilitate taha wairua in a kaupapa Māori approach; how the use and influence of taha wairua facilitate the inclusion of mātauranga Māori. The background set out in Chapter One and the literature review in Chapter Two provided the rationale for the study. Chapter Three outlined the kaupapa Māori approach taken in this study and the basis for the analysis. The data chapters (Four and Five) provided evidence for the development of the framework. The approach taken by this researcher – to present the evidence where possible within a mātauranga Māori framework – not only answers question three but also validates questions one and two. This was partly achieved by:

- aligning the data to tikanga practices and processes such as pōwhiri, karanga, karakia, and whakawhanaungatanga (see Table 4.1)
- emphasising the importance of the use of te reo Māori to transmit Māori values and beliefs
- illustrating the inclusion of mātauranga Māori through the use of Māori models of practice and successful alignment to contemporary Western models of health such as the use of key recovery themes (see Table 4.3)
- defining responsibilities (as described/provided by participants) attached to Māori cultural and clinical roles through the use of concepts such as tuakana/teina, takawaenga and ringa raka (see Table 4.5)
- proposing principles such as tika me te pono, manaaki, mana, aroha ki te tangata and pukenga as a guide to achieving tikanga best practice in dedicated Māori roles (see Table 5.1).

Added to this is the acknowledgement that whānau, with all their diversity, remain an important base unit in Māori society and therefore whānau ora is a key goal when seeking to support tangata whai ora in their journey to recovery (see Table 4.4). Kaumatua also have significant roles to fill through the support they provide to tangata whai ora, whānau, Māori mental health workers, and in the wider work place (see Table 4.6).

The researcher will now discuss the findings of this research and present a possible framework for a taha wairua-led practice for use in mental health services, as defined by the data from participants and key informants. Strengths and weaknesses of the framework, along with the limitations and challenges to integrating this type of framework into everyday practice by Māori workers in mental health services, will also be discussed.

- *He Ara ki te Ao Mārama* (a pathway to understanding), the facilitation of taha wairua in mental health services, is a framework with six key components: *Oranga*, which focuses on the beneficial healing aspects through the use of tikanga processes such as pōwhiri, karanga, karakia, whakawhanaungatanga, whakapapa, te reo Māori and appropriate cultural roles;
- *Tikanga Hauora* is about the integration of Māori models of health and key recovery themes of support, personal meaning, self-advocacy, personal responsibility, hope and education;
- *Whānau Ora*, acknowledges the diversity of whānau and how the involvement of significant whānau members, and skills, can contribute to their whānau member's healing. Opportunity is also provided for mental health services to validate the information they receive and to facilitate appropriate assessment, treatment and rehabilitation interventions;
- *Ngā Umanga Māori* articulates the importance of having roles that are focused on supporting the facilitation of tikanga interventions to assist with tangata whai ora and whānau healing and in the work environment;

- *Ngā Mahi Tōtika* reinforces the development and implementation of best practice for those facilitating and/or supporting tikanga in mental health services;
- *Āhuru mōwai* recognises there are many things of a temporal nature that need to be put in place to provide a physical environment that permits physical and spiritual healing to take place.

This part of the discussion will be aligned to each of the key whakaaro (components). At the end of each of the discussion phases, recommendations, and the resources required to achieve them, are presented.

The research findings

Oranga

It is important to note that ‘cultural diversity’ (Durie, 2001) was a key theme in this research. Participants and key informants came to this research with diverse experience, levels of knowledge, and strength of cultural identity. These views were reflected in their understandings of ‘spirituality’, and in the way they worked with tikanga Māori and/or Māori models of health. Some participants, and all the key informants, saw religion and spirituality as being very different. Some of the literature (Potaka-Dewes, 1986; Pere, 1997) supported their view. Other participants saw spirituality and religion as one and the same. The literature supported the view that both religion and spirituality have a place in recovery (Mitchell & Romans, 2002; Corrigan et al., 2003). According to participants, so does tikanga Māori, either practised solely in its natural form or in the framework of Māori models of health. The literature showed that indigenous views of health and healing are valid (Manson et al., 1985; Cohen, 1999) and are deserving of recognition and acceptance in mental health services. Current mental health policy and legislation provide strategies to progress the facilitation of Māori healing (MHC, 1998; MOH 2002); what was noticeable is that these strategies are not built around the Treaty of Waitangi (Durie, 1994), which would ensure Māori rights to practise culturally to help improve health gains (Dyall, 1997), but rather are built on disparities. Nonetheless, participants’ integration of cultural models of health into their own practices was very clear. Although there was diversity in participant views on spirituality and religion or on practising tikanga Māori or a

Māori model of health, all unanimously agreed that the binding factor to successful outcomes in their cultural practices was te taha wairua, the spiritual dimension in health care. Having diverse views and levels of cultural experience was a source of frustration for a few participants; however, overall there was a feeling of ‘kotahitanga’, of oneness in that they had a collective intention to support tangata whai ora, whānau healing and well-being. It is interesting to note that most participants came from different Māori mental health services, with the majority of their service taking place in a mainstream context. Although in the majority of services Tikanga and or Māori models of practice were not supported in policy, all participants had this sense of collectiveness. This collective vision was undoubtedly assisted through the facilitation of taha wairua, as evidenced in the participants’ data, which demonstrated commitment to provide and or to participate in tikanga practices such as karakia, pōwhiri, karanga, whakapapa and whakawhanaungatanga. Also evident was the recognition of the increase and importance of the use of te reo Māori in every-day practice. Te Reo Māori is a way of transmitting the culture (Pere, 1997) as well as supporting healing (Durie, 2001). The researcher also observed that many beneficial effects witnessed by participants for tangata whai ora and whānau healing (see Table 4.1) would also contribute greatly to kotahitanga and commitment to the kaupapa of a tikanga-based practice.

Recommendations

As already established, current national policy and legislation is in place to support the integration of Māori healing frameworks into mental health services. Therefore recommendations are as follows:

- Policy is developed and implemented in mental health services supporting access for Māori to Māori healing frameworks, inclusive of traditional healing remedies and tikanga Māori. In recognition of the Treaty of Waitangi and the principle of active protection, the development of policy is inclusive of Māori realities and the consultation process should include local iwi, hapū, Māori community and Māori mental health worker representation.
- Opportunities to access and attend appropriate cultural up skilling in tikanga Māori, and in particular te reo Māori, are made available on a regular basis to Māori mental workers.

Resource requirements: Funding will need to be allocated to support cultural training. To be effective, funding should be targeted at identified cultural learning needs, such as learning te reo Māori (Te Rau Matatini 2003), should be sustainable, and should lead to the development of cultural competencies.

Tikanga Hauora

The key themes in this section included Māori assessment tools based on Māori models of health, the use of Māori models of health and their ability to support the ‘recovery’ (MHC, 1998) themes of hope, personal responsibility, self-advocacy, education, support, and personal meaning.

Cultural assessment processes for Māori are outlined in the National Guidelines (MHC, 2001). Where cultural assessment tools were used in mental health services, participants were very familiar with the processes. All the participants’ data showed cultural assessment formats were based on a Māori model of health such as Te Whare Tapa Whā (Durie, 1994), and required tangata whai ora levels of wellness or unwellness to guide the pace of the assessment. All the participants confirmed the cultural assessment were very useful in identifying the level of access tangata whai ora and whānau had to te ao Māori, and their strength of identity; and the information gathered was able to inform treatment and recovery plans. What was not clear in the data was how regularly and when the first cultural assessment was conducted. One participant stated that “usually the first assessment was the cultural assessment” (participant 7), others were not so committed in their responses. It appears that the cultural assessment process is still determined by what else may be happening for the tangata whai ora at the time of presenting to the service, as well as by their level of wellness. Another part of the assessment was the use of an appropriate cultural tool to assess outcomes (Dyall, 1999). The participants were not familiar with any such tool; although they were aware one had been developed and trialled (Hua Oranga; Kingi, 2001).

The researcher found it significant that all the participants worked in a way that enhanced the recovery model and its main themes. Consumer group participants confirmed this; by sharing some of their personal journeys in mental health services it was demonstrated that there is a place within the recovery process for both Western and

cultural interventions (Mitchell & Romans, 2003). All participants reinforced the need to keep providing tangata whaiora and their whānau with options. It is also worth noting the participants seemed to accept the way interventions were guided through the use of taha wairua.

Recommendations:

- Cultural assessment policy is developed and implemented and meets the 2001 Mental Health Commission Guidelines
- Mental Health services include in their annual quality assurance plans to engage culturally appropriate assessment tools for measuring outcomes for Māori
- The value of cultural interventions is recognised in the “Recovery” training package through being formalised as part of the training.

Resource requirements: target appropriately skilled and competent personnel to lead and support these recommendations. Other types of resources may be required; for example, if there is a shortage of ‘skilled personnel’, an appropriate intersectoral collaborative approach could include an exchange of human resource and/or linking to a regional body to pool resources.

Whānau Ora

Again, the diversity of whānau and their realities was an important theme. All participants were comfortable working with whānau ā kaupapa or whānau ā whakapapa (Durie, 2001). In fact, the majority of participants were strongly committed to whānau involvement in their whānau member’s care. Although formalising whānau involvement by appointing whānau advisors is a recent development in mental health services, some participants raised the issue of resources to support whānau and advisors more effectively.

Recommendation:

- Mental health services, in partnership with whānau, implement professional development and whānau involvement initiatives to support whānau rangatiratanga. This may mean providing opportunity for regular whānau focus groups to

participate in planning and evaluating services as well as more designated whānau advisory positions.

Dedicated resource: a combination of human resource and funding to ensure widening avenues for more whānau participation are sustainable and maintained.

Ngā Umanga Māori

The literature (Kurasaki & Sue, 1998; Huriwai et al., 1998) acknowledged that the cultural mix of health professionals and patients could lead to better outcomes. All of the participants either valued their role as a cultural worker or appreciated having good cultural worker support. What was common to both the cultural worker and the Māori clinical worker was that neither had a clear idea of just what the cultural role involved at times, and when this uncertainty occurred there was potential for tangata whai ora needs to be unmet. Unrealistic expectations were often expected from the Māori workforce to meet cultural advisory and supervisory roles from both Māori and mainstream colleagues. The literature confirmed there is great potential for staff burn-out if this continuation of impracticable expectations continues (Te Kahui Tautoko, 2001). Many participants saw the problem as one of not having enough human resources to do the mahi (Te Kāhui Tautoko, 2001). Both cultural and clinical workers enjoyed parts of their roles, for example, participating in the provision of training, and some took pride in being versatile in the workplace in their cultural role; again, however, it was acknowledged by the data and literature that Māori do not have the critical mass (Levy, 2001) to achieve all that needs to be done. The recommendations therefore concentrate on clarity of role and access to more human resource to provide more and better services to Māori (MOH, 1997). The 1998 *Blueprint* supported an increase in a well-skilled Māori workforce.

Recommendations:

- Mental health services, in partnership with Māori, develop a career pathway to provide vision and clarity and give added value to the cultural role, whether in a clinical or cultural context
- More resources are made available to employ extra human resources to provide better services to meet the need of Māori accessing mental health services.

Further to these recommendations is the expectation from participants that these types of initiatives are to be inclusive of kaumātua and consumer-advisor development. *Resource requirements:* extra positions required to meet the need of Māori experiencing mental illness. It is acknowledged that a number of Māori workforce initiatives are already in progress and therefore the first recommendation may be met through connecting with related national Māori workforce development initiatives.

Ngā Mahi Tōtika

Participants were forthright in determining some of the characteristics needed to be effective as Māori working in mental health services. The data show all participants support gaining of cultural and clinical skills to a proficient level, and recognised a need to up-skill. Some of the characteristics identified included cultural integrity, respect, a positive self-image, being non-judgemental and empathetic, commitment, and raising one's standard of professional practice to a high level of proficiency. From all the participants' data, come propositions for some best practice standards to support taha wairua in the cultural component of all Māori working in mental health (see Table 5.1). If any caution was to be noted, it would be that participants recognised that mainstream workers, non-Māori included, desire cultural knowledge and skill, and therefore some participants strongly advocated that Māori are the priority.

Recommendation (based on the principles of tika me te pono and rangatiratanga):

- That a Best Practice framework to facilitate taha wairua within mental health services be developed and implemented. It is strongly suggested the framework be developed in consultation and participation with local and regional Māori roopu with whānau, hapū and iwi representation. It is imperative that Māori lead this work and are provided with the *resources (human and funding)* to achieve this goal.

Āhuru Mōwai

Participants' experiences illustrated that provision of appropriate facilities to allow for safe practice of tikanga and Māori models of practice has generally not been available. Chapter One demonstrated the inappropriateness of the way in which colonial society addressed the needs of Māori members suffering from mental illness (Abbott & Haines,

1985). For one participant in particular there was a sense of being ignored and forgotten through the lack of understanding shown by mainstream management about an appropriate facility to assist taha wairua. While this may be a particular case, all the participants agreed that a marae type facility is the ideal space to support the facilitation of taha wairua through tikanga practices, because, according to participants that's what happens on the marae – tikanga. Some of the literature (Walker, 1992; Durie, 2001) supported this view. Having a workplace environment conducive to tikanga-led taha wairua facilitated practice is about permitting physical and spiritual healing to occur and where possible, concurrently. Attitude is also important. Some participants described their experiences when effective cultural education programmes allowed for a shift from negative and ignorant attitudes to positive encouragement, which permitted learning and understanding of Māori cultural values and beliefs. Such a shift created an improved work environment (Ramsden, 1996) for both the Māori and non-Māori workforce, with benefits for both tangata whai ora and whānau. However, according to the data, education programmes did not happen on a regular basis and did not target all staff; rather pockets of staff, e.g., psychiatric registrars. The data also showed that Māori cultural knowledge was better received by overseas staff, and that Māori also needed cultural education – some participants expressed concern that Māori needed to be culturally safe. A way of addressing what some of the participants saw as 'barriers' was to have their own leadership – tino rangatiratanga or autonomy. While Indigenous Peoples continue to be dominated by Western rule and ideas, this continues to be one of those hard basket issues. For Māori, it is not hard. Chapter One outlined the international indigenous health strategies (Cohen, 1999) and the New Zealand government's strategic directions (MOH, 2002) to improve Māori health; according to an indigenous view, autonomy or self-governance is a right (Te Puni Kōkiri, 1994), and the Treaty of Waitangi also supports this view (Durie, 1998a). The data showed that many participants believed that having Māori in senior levels of management would create more opportunity for equality of resources and autonomy in deciding how to use those resources. Participants did not see this equality being achieved because one was Māori but rather people in leadership need to be appropriately skilled, competent and proficient to be effective. Consumer group participants believed they were especially disadvantaged, and the inequality they experienced increased their vulnerability and exposure to stigma and discrimination. The data made clear that Māori still do not have much control over resources to support Māori in achieving tikanga-led, taha wairua-

facilitated practice in the workplace. Māori alone will not achieve this goal of tino rangatiratanga. The principle of collective responsibility (Levy, 2001) must be applied to provide the support with implementation of policy and sharing of non-Māori resource to enable Māori suitably skilled in management to facilitate all facets of running a mental health service and to focus on Māori mental health needs. All this discussion the need to value the Māori workforce and the beliefs, values and skills they bring and to incentive-based strategies to ensure retention and recruitment of workers. A coordinated and integrated effort across all sectors is needed to achieve this.

Recommendations:

- Funding for Māori mental health services are ‘ring fenced’ and include specifications of a suitable physical facility, resource for management, consumer advisors and workforce training
- Organisations to develop and implement effective recruitment and retention policy
- Implementation of a Taha Wairua Facilitated Practice.

Strengths of the framework are:

- By Māori for Māori
- Implementation can be achieved because Māori kaimahi are already aware of and familiar with the key components of the framework
- Openness of the framework allows for the diversity of Māori to be recognised – every iwi, hapū and Māori provider/community are able to apply their own tikanga/kawa
- The framework encourages key relationships across the social service sector, e.g., education, justice and health.

Limitations of the framework are:

- There is a current lack of skilled personnel in all areas of the Māori workforce, especially in mental health (MHC, 1998); therefore this type of framework in the current environment may be a challenge to implement
- Due to lack of support and resource for training and education, implementation of all or part of the framework can lead to the compromising

of tikanga best practice. Workforce development issues as identified by participants and supported in the literature by Milne (2001), and Te Kahui Tautoko (2001) confirm the need for Māori working in mental health services to up-skill both clinically and culturally and to become proficient

- Prevailing attitudes may create ineffectual relationships with key stakeholders.

Table 6.1 *He Ara Ki Te Ao Mārama: A pathway to understanding the facilitation of taha wairua in mental health services – a practice framework*

Whakaaro <i>Concepts</i>	Uara <i>Principles</i>	Pūmanawa <i>Characteristics</i>	Whakawhanaungatanga <i>Key relationships</i>
Oranga	Active protection	Inclusion of tikanga practices	Iwi, hapū, whānau, Māori providers Mental health services
Tikanga Hauora	Options	Choice of Māori models of health	Tangata whai ora, Whānau, Kaimahi Māori Mental health services
Whānau Ora	Partnership & participation	Whānau involvement and empowerment	Tangata whai ora, Whānau, Mental health workers, Mental health services
Ngā Umanga Māori	Active protection & partnership	Dedicated Māori roles – cultural clinical, consumer & kaumātua career pathways	Iwi, hapū, whānau, Māori providers Organisations Kaimahi Māori Mental health services
Ngā Mahi Tōtika	Rangatiratanga Tika me te pono	Dual cultural & clinical competency & proficiency	Iwi, hapū, whānau, Māori providers, Kaumātua, Kaimahi Māori, Mental health Services
Āhuru Mōwai	Tino rangatiratanga Collective Responsibility Ōritetanga	Strong & adept leadership Dedicated & appropriate space & buildings Effective Cultural Education Workforce development Equality in workplace	Iwi, hapū, whānau, Māori providers, Organisations, Kaumātua, Kaimahi Māori, Mental health services

By Māori For Māori will produce significant benefits for tangata whai ora, whānau and Māori and non-Māori workers in mental health. The benefits are outlined as follows:

Tangata whai ora can experience:

- support with a clinically and culturally safe passage through mental health services; access to te Ao Māori; strengthening of identity; access barriers reduced to mental health services; more timely and effective intervention;

holistic healing; minimised use of legislation when accessing mental health acute services; and quicker recovery and shorter lengths of stay in mental health services.

Whānau too will gain from the positive benefits for their whānau member, as well as experience:

- involvement in all aspects of care; feeling valued; applying their ability and skill to support in the healing process; gaining appropriate knowledge such as education about illness; early warning signs and medication (Western and rongoā); improved relationships with tangata whai ora and mental health services.

Māori workers can experience:

- clarity of roles, career pathways, up skilling in dual competencies; confident facilitation of tikanga practices and/or Māori models of health; validation of Māori cultural practices in a clinical setting; access to appropriate training, cultural support and supervision and strong and wise management; improved and appropriate workplace environment and relationships.

Non-Māori workers can experience:

- a greater understanding of a Māori practice paradigm; improved and responsive workplace environment to all ethnic needs, not just Māori; appropriate systems and processes to address cultural awareness and education responses in supporting all those who access mental health services thereby adding to their competency base; a more positive response from Māori for their part in helping reduce health disparity for Māori; improved understanding of the Treaty of Waitangi and its application to health.

Other Issues

Due to the specific topic and nature of this research, other issues were raised that were not covered in the data-collection phase; nonetheless, they require serious consideration for future research opportunities. Some of these issues have been raised in earlier hui (Milne, 2001; Te Kahui Tautoko, 2001), and include:

- The role of kaumātua in mental health services needs further research. The data clearly showed the valuable cultural leadership provided by kaumātua and particularly in the facilitation of taha wairua. What the data did not show was how and if kaumātua are valued by those in management positions and the general workforce.
- A needs assessment of the value of the consumer advisor role would help mental health services support consumer professional development, achieve equity in the workplace, and as a result, attain job satisfaction.
- Cultural awareness of the needs of the non-Māori workforce. To this researcher's knowledge, no national needs assessment for this purpose has been conducted. Māori may then in the current environment respond in a reactive way when planning, developing and delivering cultural education. Again this type of workforce initiative requires a partnership approach between non-Māori and Māori.
- Future research also needs to determine the role of spirituality-based programmes on psychiatric disabilities.

Limitations of the study

This study was a small sample of kaimahi Māori and tried to deal specifically with its topic on taha wairua. Due to the nature of the study, many other issues outside the scope of the research were raised. Gaps in the research included the need to pay more attention to the added value kaumātua and consumer advisors brought to support healing outcomes, and the cultural education of the non-Māori workforce. Much more research is required to receive a greater depth of understanding about tohunga puna ora and their Māori healing practices and their place in mental health services. This research has barely touched on these issues.

Strengths of the study

For the researcher, it seemed at first that the chosen topic would be too broad to achieve any meaningful research outcomes; however, being guided by kaupapa Māori frameworks, Māori supervisors, and te hunga mātāpuna (tikanga advisory roopu), and being supported by taha wairua were great strengths for staying on the research topic and completing it in a satisfactory way. The researcher especially enjoyed the

opportunity to display the data using tikanga concepts. For the researcher this was about being Māori and allowing the depth of feeling and passion to be expressed in this way. While the researcher had certain ideas of what a 'taha wairua' facilitated practice would look like; the data determined the framework not the researcher's preconceived ideas, and this was great, because the findings and development of the different matrix at the end of each particular date section, plus the final framework, were far greater than the researcher had envisaged. Last, the opportunity to do this research filled this researcher's kete with many new Western research skills, and with new meaning and understanding of mātauranga Māori.

Where to from here?

This piece of research deserves to be known because of what the data have produced. It is this researcher's intention to display some of the findings through a specifically focused paper presented to the Māori mental health workforce. The research participants' experiences can inform future developments of best practice standards in a cultural role and, of course, He Ara Ki Te Ao Mārama, a pathway to understanding the facilitation of taha wairua in mental health services.

Conclusion

This chapter contains the findings and the conclusions drawn from the analysis of the data. The chapter also provides the foundation for the components to make a framework for the facilitation of the concept of taha wairua in the scopes of practice of kaimahi Māori in mental health services. Recommendations and resource requirements for the framework are suggested, and strengths and limitations of the framework are discussed. The limitations of the study have highlighted many gaps in regards to the position of Māori healers and spiritual healing practices in mental health services. The findings from this research cannot be applied to the Māori mental health workforce in general – they represent, rather, the views of a small sample of workers, and therefore opportunities for future research are suggested. He Ara Ki Te Ao Mārama, the framework suggested, would require commitment and resources to develop further and implement. Its simplicity is in the whakaaro (concepts), which is Māori whakaaro and recognises and acknowledges whānau, hapū, iwi and in particular tangata whai ora. The framework's influence, however, is not so simple because those who would

participate in this type of ‘taha wairua’ facilitated practice need to be open to the influence of taha wairua.

Mā pango, mā whero, ka oti ai te mahi. By everyone working together we can achieve our goal.

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Appendices

Information Sheet

An exploration of the concept of Taha Wairua and any Significant Effects it may have on the clinical practice of Māori clinicians working within Māori Mental Health Services

1. The Researcher and Supervisor

The researcher for this project is Louise Ihimaera and I would like to interview clinical workers working in Māori Mental Health Services about their understanding of Taha Wairua and any significant effects Te Taha Wairua may have or have had on their clinical practice. I am a second year student in the Masters of Māori Studies programme, Massey University. The completion of this research project is one of my course requirements. I am currently employed as a Project manager Māori Health in Hamilton District Health Board's Provider Health services. My supervisor for this research project is Maureen Holdaway, who is employed as a lecturer in the School of Health Studies at Massey University.

2. Contact Details

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You can contact Maureen Holdaway – my supervisor – by writing to:

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By emailing: M.A.Holdaway@massey.ac.nz

3. What is the study about?

The aim of the study is to explore ways in which Te Taha Wairua may have or has had significant influence on clinical practice from the perspective of clinical workers working in Māori mental health services; and to get a broader understanding of what this means.

4. What will be expected of me if I take part in the study?

You will meet and be interviewed by Louise (the researcher) initially as part of a focus group held either at Tauranga or Te Pūtahi-a-Toi, School of Māori Studies, Massey University, and then once mutual agreement is obtained by both yourself and the researcher – you will have an individual interview at a time and place of your convenience. For example, at home, work or an Interview Room at Te Pūtahi-ā-Toi, Massey University (University Campus Maps enclosed). To confirm a convenient venue, Louise will contact you.

The focus group interview will take no longer than two hours. This time period will allow for karakia (opening and closing prayer) and mihiimihi (introductory speeches). The hui has two main purposes, i.e.

- (a) to provide information about the study and
- (b) to gather data from a set of preplanned focus questions as a basis for the development of the indepth interview instrument.

The group hui can include interested participants ‘whānau of interest’ and will include information sharing, as well as providing explanations as to the intentions, conditions of eligibility and negotiating the process of the proposed research. The hui will also serve as a means of introducing the researcher to the whānau of interest and encourage participation in the study.

You will be asked to discuss your understandings or thoughts about the concept of Taha Wairua and in particular any significant effects Te Taha Wairua may have or has had on your clinical practice.

The individual interview is not expected to take longer than one to one and a half hours.

5. What will happen with the interview information?

The interviews will be recorded and then transcribed by myself. A transcription of the information will be returned to you for editing. Excerpts will be used in writing up my research. A summary of the findings will be sent to you. You will also be told where copies of the full research can be found. The findings of this research will also be reported to the Whānau of interest and my supervisors at Massey University in partial fulfillment of the Masters Degree Māori Studies. Copies of the research findings will be stored by Massey University Library, Te Pūtahi-a-Toi, School of Māori Studies, Massey University, Waikato District Health Board’s Medical Library and with the researcher.

6. Confidentiality & Anonymity

In collecting the data I will be guided by the Privacy Act 1992 and adhere to the Massey University Code of Ethical Conduct for Teaching and Research involving Human Subjects. This means if you agree to participate the information you provide will be confidential and every endeavour will be made to protect your confidentiality. Efforts will be made to remove any identifying factors out of the final report but anonymity cannot be entirely guaranteed.

The researcher, until the conclusion of the research, will store tapes and transcripts. The researcher undertakes to maintain security of data during this time by storing it in a

locked cabinet. When the research has been completed and examined, participants may choose to retain this data or have the information destroyed.

7. Am I eligible to take part in the study?

Yes, if you currently work within a Kaupapa Māori Mental Health Service. You are employed in that service in a clinical position. Your individual practise embraces Māori Health models of practise such as Te Whare Tapa Whā and Te Wheke. If you have an understanding of the concept of Taha Wairua and if you may have experienced that Te Taha Wairua has had some significant effect(s) on your clinical practice. You belong to Te Whānau O Rau Puāwai. If you do not meet the above criteria, then you are unable to take part in this research.

8. Summary of your rights

Participation in this research is entirely voluntary. You are invited to take part and are under no obligation to do so. Should you choose to participate in the study you have the right to:

- refuse to answer any particular questions
- withdraw from the project at any time
- ask any questions about the research at any time during its course
- provide information on the understanding that your name will not be used unless you give permission to the researcher
- read and check a copy of your interview
- withdraw any piece of information that you have volunteered
- turn off the tape at any time during the interview
- be given access to the final research report when it is completed
- determine at the conclusion of the study whether you would like the interview tape to be returned to you or destroyed

“This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/121”

Consent Form

An exploration of the concept of Taha Wairua and any Significant Effects it may have on the clinical practice of Māori clinicians working within Māori Mental Health Services.

I have read the information sheet and had the details of the study explained to me. My questions have been answered to my satisfaction and I understand that I may ask further questions at any time.

I understand that I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be connected with any information from interviews or discussions. The information will be used only for this research and publications arising from this research project.

I agree/do not agree to the interview/discussion being audio taped. I understand that I have the right to ask for the audio tape to be turned off at any time during the interview/discussion. I understand that I can choose to receive my audio-taped interview or have the tape erased on completion of the study.

I agree to participate in this study under the conditions set out in the information sheet.

Signed: _____

Name: _____

Date: _____

Questions for participants and consumer advisory group

Karakia
Mihimihi

Question 1

Can you tell me about the mental health services you currently work in and your role within that service?

Question 2

How within that role and service have you experienced Māori health models of care practiced?

Question 3

How has the facilitation of such models supported or not supported the concept (influence) of Te Taha Wairua? (Which models allow for fluency/fluidity of Taha Wairua?)

Question 4

How in your experience have kaumatua/kuia support 'te taha wairua' within service delivery?

Question 5

Therefore are you able to share if there has been any significant benefits/changes for yourself as a consumer within the context of your work with:

Self

Tangata whaiora

Their Whānau

Colleagues- (Kaimahi Māori, management, tauiri staff, psychologists, medical staff i.e. psychiatrists, medical officers)

Question 6

If there are barriers, do you see a way forward?

Question 7

In a working context what (if any) do you are the components, which could contribute to a working definition of Taha wairua within mental health services?