Te Ao Māori Screening Tool for whai ora Māori engaged with secondary Community Mental Health and Addictions services in Whanganui, Aotearoa/New Zealand.

A literature review and clinical project presented in fulfilment of the requirements for the degree of

Master of Health Science

in

Nursing

At Massey University, Wellington,

New Zealand.

Cheyenne Potaka-Osborne

2020 / 2022

Preface / acknowledgements

Completing this paper over the last two and a half years has been one of the most challenging aspects of my academic journey. I have watched family and colleagues work tirelessly throughout one of the most complex, difficult times of our careers, amidst a global pandemic yet continue to support me in completing this work.

To my colleagues who supported this process, Te Hau Ranga Ora Māori Health Services, Ned Tapa and Karney Herewini and my manager Michel Manning, thank you for your contributions and mahi in this space. You saw the benefits of this kaupapa from the outset and made it your priority to work on this from the beginning. To those tangata whai ora and whānau who took the time to share their knowledge, insights, and experiences, I hope you see the worthwhile contribution your voices have made in this space. I am deeply grateful for your time and passion.

I would like to take the time thank the two supervisors who I worked with over the course of this mahi. Professor Clare Harvey who has provided me with a significant amount of support during the completion of the second part of this paper. Your time and understanding in the space of this work and also my personal and clinical work have been greatly appreciated. Thank you for your ongoing support with navigating such a complex journey.

To Katheryn Butters, the person has supported me in this journey since day one, thank you for never doubting me and for never letting me quit. Your unwavering belief that I could do this never went unnoticed. To my family, thank you for always believing in me, I will forever be grateful for your words of wisdom and encouragement.

'E rere kau mai te āwanui, mai i te kāhui maunga ki Tangaroa.
Kō au te āwa, kō te āwa ko au'.

The river flows from the mountain to the sea.

I am the river, and the river is me.

Table of Contents

Abstract

Background: Māori will predominantly not be offered or have Māori Services or Māori models of care as a first option when seeking input from health services, despite continuing to experience inequity, ongoing health disparities and poor health outcomes across Aotearoa. Current health strategies continue to explicitly highlight the importance of holistic and cultural approaches in terms of models of care, assessment and treatment interventions within the mental health and addiction sector, however, services do not reflect Kaupapa Māori approaches that are by Māori for Māori with Māori, unless they are being provided by an iwi-led organisation.

Aim: Part one - completed 2020:
The aim of the integrated literature review is to examine national and international literature, to understand the limitations of current mental health and addiction assessments and screening tools, and identify the best available evidence and contemporary strategy and policy in Aotearoa to underpin the development of a cultural screening tool.

Part two – Completed 2021/2022:
The overall aim of the project is to Co-design and produce an integrated cultural screening tool for tangata whai ora and whānau whānau that is appropriate for the Aotearoa context. The screening tool will identify current cultural needs of tangata whai ora, and uphold Te Tiriti obligations, and is based on the best available evidence.

Methodology: An integrative literature review was completed to identify the current constraints of mental health and addiction assessments and screening tools in terms of cultural inclusiveness. A co-design methodology with a Te Ao Māori lens was then utilised to co-design a cultural screening tool for use with Māori, which supports with identifying where tangata whai ora are currently sitting in terms of their cultural needs including beliefs,

values and practices. This was completed in partnership with Whanganui District Health Board (WDHB) Māori Health Services, ensuring that local Māori tikanga was utilised and developing a draft cultural screening tool for Māori, by Māori, with Māori.

Results: The main themes identified through the integrative literature review were, the importance of lived experience and co-design, biomedical and paternalistic approach to MHAS Services, and perceptions and disproportionate insights and micro and macro needs within MHAS. In Aotearoa the implications of this is that the biomedical model does not primarily allow a person's cultural needs or social determinants to be a determining factor when considering treatment options. Evidence indicates that current assessment and screening tools in Aotearoa do not consistently reflect a cultural, recovery or partnership approach in terms of cultural inclusivity and Te Tiriti.

There is a clear need for our MHAS to consider utilising the concept of integrated models of care in terms of service provision and the development of assessment frameworks and screening tools, especially in terms of the integration of Māori models, cultural frameworks and social determinants of care. As part of the aim of this work, a draft Te Ao Māori screening tool and an education plan has been successfully developed for trial, evaluation and implementation within Community Mental Health and Addictions (CMHAS) by the leadership team and Māori Health Services at WDHB.

Conclusion: It is well evidenced that Māori experience significantly worse health outcomes in almost all areas of health care, compared to non-Māori, and Māori are predominantly not offered kaupapa Māori health services or Māori models of care when engaging with health services. Inequities to Māori accessing health care continue to present as complex in nature and are made up of multiple factors. This research has highlighted that in Aotearoa health care services, there is a clear gap due to the lack of Te Ao Māori assessment

and screening tools to identify the current cultural needs of tangata whai ora. There needs to be a greater focus on the cultural needs of tangata whai ora and whanau if we are to improve equity, health outcomes for Māori, and see a reduction of inequities for groups at increased risk of preventable and chronic mental health and addiction issues. This research has been successful in developing a co-designed cultural screening tool and clinician's education sessions for implementation and evaluation with the CMHAS environment to reduce current health inequities experienced by Māori. If we are to improve health outcomes for Māori, then health services need to acknowledge that cultural identity, beliefs, values, and connection are the foundation of tangata whai ora and whānau wellbeing.

1. Introduction

As a tangata Māori wahine working as a registered nurse across Mental Health and Addiction Services (MHAS) for fifteen years, I believe there is significant opportunity for change in terms of developing a culturally inclusive assessment tool that speaks to identifying the cultural needs of tangata whai ora engaged with services and who identify as Māori. Health outcomes for Māori are worse in almost every area of health when compared to non-Māori, the reasons for these inequities are both multi factorial and complex in nature and range from poor responses by health services to inequity through to access and engagement with health care providers (Durie, 2001; Elkington et al., 2020; Kingi et al., 2017; Manatū Hauora Ministry of Health (MOH), 2002, 2020b, 2020d; Waitangi Tribunal, 2019a). Māori will predominantly not be offered or have Māori Services or Māori models of care as a first option when seeking input from health services (Health and Disability System Review, 2019; Kingi et al., 2017; MOH, 2020d; Te Rau Matatini, 2014). In terms of MHAS, Māori models of assessment and treatment interventions also

predominantly do not reflect Kaupapa Māori practices unless they are being provided by an iwi-led organisation (Waitangi Tribunal, 2019a).

As with many problem-based funded health services, the Aotearoa health system is structured in a way that often creates gaps in care that continue to misrepresent the cultural and social needs of populations (Durie, 1994; King & Turia, 2002; Kingi et al., 2017; MOH, 2001, 2020b, 2020d, 2021; Mold, 2017). This perpetuates the occurrence of inequity for Māori who continue to experience ongoing health disparities and poor health outcomes across Aotearoa (Durie, 2001; Kingi et al., 2017; MOH, 2001, 2020d; Williams, Haarhoff, & Vertongen, 2017).

This project is unashamedly translational and clinical in its approach. It aims to co-design and develop a local integrated cultural assessment screening tool for tangata whai ora and whānau that is appropriate for the Aotearoa context and upholds Te Tiriti o Waitangi obligations. It aims to acknowledge and address issues of identity, equity, and connection for whānau, hapū and iwi who are engaged with secondary MHAS within the Whanganui rohe. It is hoped that the cultural assessment screening tool will help to identify the holistic needs of tangata whai ora and enhance and prioritise the importance of whānau, iwi and hapū connections and accentuate the use of shared values and belief systems including tikanga and Kaupapa Māori health practices within a predominantly westernised health care system (Durie, 1994; Elkington et al., 2020; Kingi et al., 2017; MOH, 2020d).

The integrative literature review will look to review a wide range of literature from research databases in order to understand whether or not there is evidence that indicates that current assessments and screening tools in Aotearoa reflect recovery, partnership, and Te Tiriti approaches when working with tangata whai ora. If not, what gaps currently exist within the mental health and addiction sector? It will explain both the method and research strategy, limitations, inclusion and exclusions criteria for research, in order to

understand and articulate the common themes and findings found from the research. It will then identify recommendations and possible implications for clinical practice which will lead support part two of this paper, a clinical project to develop a cultural screening tool that allows clinicians to incorporate a Te Ao Māori view alongside there clinical practice. The screening tool needs to be appropriate for the Aotearoa context, upholds Te Tiriti obligations and is based on the best available evidence.

2. Integrative literature review

An integrative literature review was completed as completion of Part One, of a 120-point thesis in Master of Health Science. There were several pieces of literature that were significant regarding exploring this matter. The literature review aimed to identify the current constraints of mental health and addiction assessments in terms of cultural inclusiveness whilst identifying the best available evidence and contemporary strategy and policy to underpin development of a tangata whai ora plans. Although the literature did not directly refer to actual assessment tools, the evidence did reflect on the processes required to develop assessment tools that were meaningful and embodied the concepts of recovery orientated care, cultural inclusion, and co-design.

2.1 Introduction

The Aotearoa Government and Manatū Hauora, Ministry of Health (MOH) has worked intensively to improve service provision which is consistent and targeted towards improving health outcomes for those in the community utilising primary and secondary specialist MHAS (Mental Health Commission, 1998, 2004, 2012; MOH, 2010). This has included formulating several different health care strategies, all of which have claimed to be focused on ensuring priority actions are centred on quality improvements aimed to

enhance current services (Evans, Nizette, & O'Brien, 2017; Gawith & Abrams, 2006; Mental Health Commission, 1998, 2007b, 2012; Morrison-Valfre, 2017). A key component of this ideology is supporting individuals and the community to consider changes which may improve their overall health and wellbeing (Evans et al., 2017; Mental Health Commission, 1998, 2012; Morrison-Valfre, 2017). Health presentations rarely occur in isolation; therefore, improving health and wellbeing outcomes requires a whole of system / whole person approach that considers core health issues in conjunction with social determinants and social context (Barker, 1999; Chow & Priebe, 2013; Mental Health Commission, 2004; Morrison-Valfre, 2017; Rapp & Goscha, 2012). This requires the healthcare system to focus on and promote self-management and collaborative health planning which are primarily based around the Te Tiriti o Waitangi principles and relationships based on partnership, participation, and protection (Durie & Kingi, 1997; Maori Health Commission, 1998; Mental Health Commission, 2004; Morrison-Valfre, 2017; Rapp & Goscha, 2012).

Institutional racism and intergenerational poverty are perpetuated by current health, economic, educational, legal, and social systems of Aotearoa resulting in Māori experiencing poor equity, access, and health outcomes (Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Harris et al., 2006; MOH, 2018). Health services that undertake a paradigm shift to a system which is founded on tikanga and Māori values, including whānau centeredness, holistic care, balance and wairau (spirit) are able to better encompass one's life course to wellness (Berghan et al., 2017; Durie & Kingi, 1997; S. Palmer, 2004; Pitama, Huria, & Lacey, 2014). This shift would enable the health system to be better placed in terms of access, equity and sustainability for all living in Aotearoa, in particular Māori (Baxter, 2008; Baxter et al., 2006; MOH, 2018; S. G. Pitama et al., 2017). The health system would also need to consider shifting philosophical paradigms to mental health approaches such as the consumer movement, the recovery approach, social inclusion and co-design as these are best placed to incorporate the self-identified needs of tangata whai ora,

family and whānau (Gawith & Abrams, 2006; Mental Health Commission, 2007b, 2012).

Co-design is a method whereby health services work in partnership with tangata whai ora, family and whānau regarding service planning and quality improvement (Aitken & Shackleton, 2014; Britton, 2017; DiGioia & Shapiro, 2017). Co-design was developed in the United Kingdom approximately 15 years ago but was not introduced to Aotearoa until early 2008 (Bate & Robert, 2007; DiGioia & Shapiro, 2017; Williams & Smith, 2019). The core values of co-design views tangata whai ora experience and expertise as the basis of all improvement projects (DiGioia & Shapiro, 2017; Williams & Smith, 2019). The challenge is to align service delivery with what works best for tangata whai ora and their whānau whānau within MHAS, whilst upholding our obligations under Te Tiriti o Waitangi and incorporating the recovery model (Aitken & Shackleton, 2014; Baxter, 2008; DiGioia & Shapiro, 2017; Nursing Council of New Zealand, 2011; Palmer, 2004; Slattery, Saeri, & Bragge, 2020).

The 20th century saw the concept of the recovery model being established as a mechanism for assisting those experiencing mental health issues to see beyond their illness and consider they could have more in life than just surviving and existing (Amering & Schmolke, 2009; Jacob, 2015; Oshodi & Rush, 2011; Rapp & Goscha, 2012; Stromwall & Hurdle, 2003). The guiding principles aim to encourage health professionals and tangata whai ora to focus on building resilience, emphasising hope, self-determination and providing a process that lends a holistic view of what is happening collectively for a person at any time (Jacob, 2015; Jones, Fitzpatrick, & Rogers, 2016; Jørgensen & Rendtorff, 2018; Oshodi & Rush, 2011). Evidence suggests that when people are supported in terms of developing self-management strategies and determining their recovery own goals, relationships are more meaningful between the tangata whai ora and the health professional (Evans et al., 2017; Jacob, 2015; Morrison-Valfre, 2017; Rapp & Goscha, 2012).

There are clear power and control imbalances, poor engagement, and unrealistic expectations of care when the recovery principles and social inclusion are not utilised by clinicians when forming therapeutic relationships (Cameron, Kapur, & Campbell, 2005; Jacob, 2015; Morrison-Valfre, 2017; Sugiura, Mahomed, Saxena, & Patel, 2020). This disempowerment perpetuates inequalities and disparities amongst Māori as key health priorities are determined by non-Māori health professionals instead of being defined with Māori (Durie & Kingi, 1997; Harris et al., 2006; McKellar & Rodrigues, 2017; MOH, 2002, 2018; Waitangi Tribunal, 2019a). Mental health and wellbeing are determined by more than just illness and diagnosis (Evans et al., 2017; Morrison-Valfre, 2017; Rapp & Goscha, 2012). Functional relationships, whānau, work / life satisfaction, financial security, personal growth and development, social and cultural equity are all significant factors in determining good mental health (Morrison-Valfre, 2017; Sheppard, 1991; Williams et al., 2017; Williams & Smith, 2019).

Durie (2011) and Williams et al., (2017) proposed a new era within MHAS provision, this has been termed as 'the fourth wave'. This change in provision signalled a shift from biomedical centric approach where illness has a pathological and disease basis to a model where there is an understanding that social determinants, culture, connection and context are all critical factors to one's mental health (Durie, 2011; Mental Health Commission, 2012; Williams et al., 2017). The philosophical base of mental health nursing is built around the principles of recovery, competence and empowerment all of which work in parallel with the concept of tangata whai ora centred care and co-design (Aitken & Shackleton, 2014; Amering & Schmolke, 2009; Barker, 1999; Evans et al., 2017; Gawith & Abrams, 2006). However, my professional experience of working in MHAS has led me to question the degree to which services in Aotearoa work with tangata whai ora and their whānau whānau to ensure collaborative care is the basis of all assessments and care plans. Or rather, do we as a health service prioritise our expertise

over that of the tangata whai ora to ensure that we meet the requirements of our governing systems which in turn do not necessarily speak to the tangata whai ora's identified needs or to our obligations under Te Tiriti o Waitangi? Over the years a predominantly paternalistic ethos within the health and medical professions saw many health professionals dismiss tangata whai ora perspectives in relation to their care (Jacob, 2015; Jones et al., 2016; Keith, 2011; Newman, O'Reilly, Lee, & Kennedy, 2015). The biomedical model offered little room for criticism, objection, or varying opinions in terms of considering tangata whai ora initiated care planning (Barker, 1999; Cameron et al., 2005; Jacob, 2015).

2.2 Background

In the context of our current MHAS in Aotearoa and why this research is important, it is noted that there have been considerable changes to the way services are delivered to the community over the years (Evans et al., 2017; Gawith & Abrams, 2006; Jones et al., 2016; Mental Health Commission, 2007b). Yet it can be argued that services continue to prioritise government key performance indicators (KPI's), the biomedical model and specialist expertise over that of the needs of individuals, including Māori who are at the centre of the care (Amering & Schmolke, 2009; Baxter, 2008; Clayton & Tse, 2003; Durie, 2011; Durie & Kingi, 1997; Oshodi & Rush, 2011). Change has comprised of services shifting from being primarily based in large, institutionalized hospital settings, to treatment and care being provided within the community or within the local hospital (Amering & Schmolke, 2009; Evans et al., 2017; Mental Health Commission, 2007b). These changes brought about greater emphasis on economic rationing and efficiency of care, due to the health care dollar being spent on managing the increasingly complex needs of those utilising health services (Mental Health Commission, 2012; MOH, 2005; Newman et al., 2015; Oakley Brown, Wells, & Scott, 2006). A significant influence within the MHAS sector has been the consumer and tangata whai ora user movement as this has

contributed considerably to changes regarding tangata whai ora participation, co-design, and recovery focused care (Amering & Schmolke, 2009; Gawith & Abrams, 2006; Kidd, Kenny, & McKinstry, 2015b; Williams & Smith, 2019).

From 1973 to 1993 the institutions which exercise public power in Aotearoa did so and the Labour Government were in Parliament to pass the Te Tiriti o Waitangi / Treaty of Waitangi Act 1975 and created the Waitangi Tribunal (Hayward & Wheen, 2004; Palmer, 2008). Then, in its first four substantive reports from 1983 to 1986 the Waitangi Tribunal developed the core of an interpretation of the meaning of the Treaty that could and should be applied in contemporary Aotearoa (Palmer, 2008). This was to enhance the relationships between the crown and Māori based on what Māori had believed and what the crown had believed and attempted to reconcile those views to find a way forward (Hayward & Wheen, 2004; Palmer, 2008; Waitangi Tribunal, 2013). The three defining Te Tiriti o Waitangi principles were integrated into Aotearoa social policy and interpreted as; article one: partnership (Kawanatanga) to define cultural practices that Māori consider important in maintaining, article two: participation (Tino rangatiratanga) to decide how Māori want to exercise their unique cultural practices and article three: protection, (Tikanga) to be self-empowered to practice what Māori consider maintains their essential cultural identity (Came, McCreanor, Manson, & Nuku, 2019; Durie, 2011; Henare, 1990). These principles have influenced disempowered relationships between mental health service users and providers underpinning other legislation such as Health and Disability Commissioner Regulations 1996, otherwise known as the Code of Health and Disability Services Consumers' Rights (Burgess, 1997; Ministry for Culture and Heritage). However inequality and institutional racism also continue to remain prevalent in Aotearoa and are evident within the healthcare, social development and education sectors which continue to be dominated by western and bio-medical discourses (Baxter, 2008; Came,

2012; Came et al., 2019; Durie, 2011; Harris et al., 2006; Pack, Tuffin, & Lyons, 2016).

Overarching and governing policies continue to exclude and under-value Māori, in terms of the development, structure, and implementation of health policies, despite Te Tiriti o Waitangi assurances to protect the welfare of Māori (Came, 2012; Cameron et al., 2005; Durie, 2011; Pack et al., 2016; Waitangi Tribunal, 2019a). More recently, the fidelity to the principles of Te Tiriti were reviewed as part of the Waitangi tribunal's 2019 hauora report which identified significant treaty breaches in terms of poor Māori health outcomes across Aotearoa (Waitangi Tribunal, 2019a). The tribunal considered the persistent health inequalities, lack of resource and support for Māori models of health and continued institutional racism to be breeches by the crown, whom they described as failing to commit to Māori health and equity of care (Waitangi Tribunal, 2019a). Recommendations have been made by the tribunal, including building upon the current treaty principles to include tino rangatiratanga, equity, active protection, options and partnership, all of which aim to foster self-determination and the right for Māori to design, deliver and monitor health services in Aotearoa (Waitangi Tribunal, 2019a).

A vital driver for increased tangata whai ora and whānau whānau participation was the Mason report which was completed in 1996 (Mental Health Commission, 2007b). The report emphasised considerable workforce issues within mental health systems including but not limited; to inadequate funding, and continued stigma and discrimination (Clayton & Tse, 2003; Mental Health Commission, 2007b). These were noted as key areas hindering services meeting the needs of those most severely affected by mental illness (Clayton & Tse, 2003; Mental Health Commission, 2007b; Shanley & Jubb-Shanley, 2007). The founding of the Mental Health Commission; Aotearoa / New Zealand, which was paradoxically later disestablished, also saw the launch of anti-discrimination organizations such

as Like Minds Like Mine (Gerard & Chris, 2004). This was a ministry funded organisation specifically aimed to reduce stigma and discrimination and work towards minimising identified barriers such as negative attitudes, beliefs, and behaviours of society (Gerard & Chris, 2004; Gordon, Davey, Waa, Tiatia, & Waaka, 2017; Thornicroft, Wyllie, Thornicroft, & Mehta, 2014). It encouraged a paradigm shift in terms of services considering the needs and preferences of tangata whai ora, whānau whānau and careers to be able to contribute to service development at both a local and national level in order to enhance quality of service provision (Gawith & Abrams, 2006; Mental Health Commission, 2007b; MOH, 2006; Thornicroft et al., 2014). For MHAS to advance in this area, services needed to be driven by the tangata whai ora (Gawith & Abrams, 2006; Ning, 2010; Rapp & Goscha, 2012).

A key objective in terms of the mental health strategy in Aotearoa was highlighted as services having increased responsiveness towards tangata whai ora needs (Gawith & Abrams, 2006; Ministry of Health, 2005, 2006). To enable this transition all aspects of service delivery, development of scopes, roles, funding, and evaluation would need to be conducted in conjunction with tangata whai ora and whānau whānau to ensure meaningful change (Mental Health Commission, 1998; MOH, 2005, 2006; Ning, 2010). This corresponded with the evolving social paradigm of recovery being the driving principles within MHAS (Mental Health Commission, 2007b; Rapp & Goscha, 2012; Stromwall & Hurdle, 2003). The recovery principles reinforced the philosophy of empowerment, tangata whai ora determination and self-directedness (Amering & Schmolke, 2009; Rapp & Goscha, 2012; Stromwall & Hurdle, 2003). It aimed to generate support networks that prioritised the goals of tangata whai ora and their health needs whilst acknowledging the impact of stigma and discrimination (Gawith & Abrams, 2006; Gordon et al., 2017; Ning, 2010).

The blueprint for mental health services in New Zealand: How things need to be (Mental Health Commission, 1998), Blueprint II: Improving mental health and wellbeing for all New Zealanders: How things need to be (Mental Health Commission, 2012) and Rising to the Challenge (Dua et al., 2017) were significant strategies focused on working towards improving services. This specifically included the reduction of stigma and discrimination, identifying the need for tangata whai ora engagement in terms of improving health outcomes and highlighting key systemic and inter-sectoral resource areas (Dua et al., 2017; Williams et al., 2017). The documents outlined social inclusion, reducing health disparities, access to physical health services, improving engagement, resources, and education as priority actions for services in terms of minimising risk to those accessing MHAS (Dua et al., 2017; McKellar & Rodrigues, 2017; Williams et al., 2017; Woltmann & Whitley, 2010). They also indicated the importance of integrated care in terms of being responsive to the population needs (Dua et al., 2017; Williams et al., 2017; Woltmann & Whitley, 2010). This included ensuring primary and secondary inter-sectoral services become more streamlined and integrated; whilst reducing disparities and decreasing the negative experiences of services (Dua et al., 2017; Mental Health Commission, 1998, 2012; Williams et al., 2017). Both Blueprint documents also highlighted the significance of empowering tangata whai ora to ensure equity of care, partnership, and resilience (Mental Health Commission, 1998, 2012).

Aotearoa MHAS mandatory Alcohol and Drug Outcome Measure (ADOM) and Health of the Nation Outcome Scale (HONOS) introduction (Evans et al., 2017; Kisely et al., 2010; Pulford, 2010; Tan et al., 2017; Te Pou o te Whakaaro Nui, 2008) found that HONOS was good for tracking changes in social functioning over time, but the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) was more suitable for treatment planning (Giovanni, Morven, & Mike, 2005; Hallebone & Callaly, 2001). When a detailed clinical characterisation of clinical and social needs of the patient

and outcomes is required, HONOS and CANSAS has been proven effective in terms of highlighting the tangata whai ora needs (Giovanni et al., 2005; Hallebone & Callaly, 2001).

In 2013, Equally Well was established to address the correlation between poor physical health and mental health and addiction problems especially in terms of inequity to healthcare services (Cassie, 2014; Roberts, 2017; Roberts, Lockett, Bagnall, Maylea, & Hopwood, 2018). Equally Well aimed to create projects across Aotearoa that improved the quality of pre-existing services, including change which was sustainable and that had positive long-term benefits for tangata whai ora without additional funding (Roberts, 2017; Wirihana & Smith, 2014; Zelmer et al., 2018). It focussed on connecting and integrating services across the health continuum, creating partnerships with those who had lived experience of MHAS, and develop a recovery orientated system of health (Cassie, 2014; Roberts et al., 2018; Zelmer et al., 2018). This is another example of healthcare development which focusses on considering the person in a whole of systems approach in terms of their mental health, physical health, and social determinants (Cassie, 2014; Roberts, 2017; Roberts et al., 2018). However again the question needs to be asked, how has the health care system addressed and delivered on these goals using a collaborative and co-design approach? Multiple agencies and providers have committed to being proponents and endorsees of Equally Well with arguably very limited evidence of actioning the intent and actions of Equally Well (Cassie, 2014; Roberts, 2017; Roberts et al., 2018). Are we able to be providing care that is deemed to have been developed in partnership with those most affected? How do we evidence assessments, care treatment plans and philosophical paradigms that are best suited to improving health outcomes for those utilising MHAS?

In 2018 the Government commissioned the He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction to better understand the needs of tangata whai ora that were not being meet by

MHAS(Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018). The inquiry came about following extensive concern being raised about the state of the MHAS systems and the call for recommendations to address these concerns (Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018). The purpose of the inquiry was to give the wider community, people with lived experience, whānau, Māori, health professionals and community partners the opportunity to have their voices heard in terms of what they saw needed to change within the health system (Britton, 2017; Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018). It aimed to identify gaps in service provision, understand the barriers to achieving equity of care, positive health outcomes and experiences, population-based disparities where outcomes are disproportionate to the rest of the population (Gunther, 2011; Mental Health and Addiction Inquiry, 2018). Wide public consultation was undertaken as part of the inquiry process and the document was made available in multiple languages and formats across Aotearoa (Mental Health and Addiction Inquiry, 2018). The University of Otago, Wellington was then commissioned to complete the report which outlined the determinants of mental health and wellbeing, population experiences of services and opportunities for service improvements (Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018). The most notable method used in the inquiry was the opportunity for tangata whai ora, whānau, and members of the community to have their voices heard (Britton, 2017; Mental Health and Addiction Inquiry, 2018). The inquiry panel noted 'the voices of the people were powerful and compelling' and acknowledged that the stories shared were deeply personal (Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018). While there have been significant shifts in the health sector's thinking in terms of understanding and utilising co-design and recovery-based principles as part of change management, this has not been demonstrated through consistent and standardised implementation plans across services (Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018; Mental Health Commission, 1998).

One of the main themes for change was the 'peoples' desire for services to see them 'as a whole person, not a diagnosis, and to be encouraged and supported to heal and restore one's sense of self' (Cunningham et al., 2018). For tangata whenua, the indigenous Māori population, recognition of intergeneration deprivation and cultural isolation was extremely important when considering recommendations (Harris et al., 2006; Mental Health and Addiction Inquiry, 2018; MOH, 2002; Nursing Council of New Zealand, 2011). Recommendations needed to support clinical approaches for cultural wellbeing focusing on identity and connection and 'ties to whānau, hapū and iwi' and Māori world views (Baxter, 2008; McKellar & Rodrigues, 2017; MOH, 2002; Morgan, 1995; S. Palmer, 2004). Māori are considerably more susceptible to poor health outcomes in terms of their physical and mental health than any other identified ethnic population in Aotearoa (McKellar & Rodrigues, 2017; MOH, 2002; Shanley & Jubb-Shanley, 2007). Historically the effects of colonial oppression and dislocation from traditional Māori practices has left Māori experiencing higher rates of social deprivation and health inequalities despite the crowns responsibilities and obligations to Māori under the Te Tiriti o Waitangi (Harris et al., 2006; MOH, 2010; Nursing Council of New Zealand, 2011; Shanley & Jubb-Shanley, 2007; Waitangi Tribunal, 2019a; Wirihana & Smith, 2014).

In regard to healthcare, Māori have been noted to be twice more likely to have gone without contact with healthcare services in Aotearoa than non-Māori (Maori Health Commission, 1998; MOH, 2002). Social and economic determinants of health have been identified as a critical priority in terms of change (Henare, 1990; MOH, 2002; Roberts et al., 2018). Many people noted that unless the government and health system confronted the current political, social, and financial disparities evident in Aotearoa no change would be made to the steadily rising numbers of people experiencing mental health and addiction issues (MOH 2002; Roberts et al., 2018; Williams et al., 2017). In Aotearoa continued links between poverty and poor health

outcomes, including poor access to services, poor education outcomes, health literacy and low-income jobs contribute to iniquitous outcomes for Māori (Henare, 1990; McKellar & Rodrigues, 2017; MOH, 2002; Shanley & Jubb-Shanley, 2007). Correlated to poverty and dislocation for Māori in Aotearoa is a continued rise in addiction related issues (McKellar & Rodrigues, 2017; Scott, Oakley Browne, McGee, & Wells, 2006) with negative impacts on the communities, whānau and children. Yet despite this being a health issue it has been predominantly viewed as a justice issue (McKellar & Rodrigues, 2017). Many whānau perceptions of the health system are they feel they are turned away when they seek help for their loved one's or feel that their concerns and distress is not heard or regarded by health professionals, or that they are judged and negatively stereotyped (Gawith & Abrams, 2006; Gehart, 2012a; Mental Health and Addiction Inquiry, 2018; Newman et al., 2015).

If we are to make future changes to our health system that aim to improve health equity of outcomes, access to services and sustainable quality care, then co-design and a cultural or holistic methodology needs to be considered as a theoretical framework for change (Aitken & Shackleton, 2014; DiGioia & Shapiro, 2017; Slattery et al., 2020). Co-design and cultural methodology aligns with the recovery model, the focus on principles of empowerment, participation and self-determination which are congruent with Te Tiriti o Waitangi obligations (DiGioia & Shapiro, 2017; Henare, 1990; Nursing Council of New Zealand, 2011; Pitama et al., 2014; Pitama et al., 2017; Rapp & Goscha, 2012). Change is also made by understanding and valuing the people's experience and using their expertise to provide solutions to areas in need of improvement (Mental Health Commission, 2004, 2007b; Oshodi & Rush, 2011). This has been explicit throughout many of the health social policy direction in Aotearoa, however arguably has failed to be systematically implemented (Mental Health and Addiction Inquiry, 2018; Mental Health Foundation of New Zealand, 2020). Key to successful implementation of assessments and recovery planning which are

co-designed with tangata whai ora, and whānau, is first understanding the current experiences of tangata whai ora in co-design and use of the recovery model within MHAS both in Aotearoa and International Organisation for Economic Co-operation and Development (OECD).

2.3 Method and search strategy

The purpose of integrative literature review methodology is to allow a researcher to summarise both available experiential and theoretical literature in order to establish a broad understanding of a particular phenomenon or problem (Grant & Booth, 2009; Hopia, Latvala, & Liimatainen, 2016; Whittemore & Knafl, 2005). Integrated literature reviews are predominantly used within the nursing and healthcare settings because they can shape, construct, and inform practice, research, and policy initiatives in relation to clinical and non-clinical practice (Grant & Booth, 2009; Hopia et al., 2016; Whittemore & Knafl, 2005). An initial problem or question relating to practice or policy is formulated; it is followed by a comprehensive search which is specific and targeted in terms of an identified theme and structure (Grant & Booth, 2009; Hopia et al., 2016; Whittemore & Knafl, 2005). This specific piece of work will utilised the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) model in terms of identifying an inclusion and exclusion criteria, and a PRISMA diagram will be included to outline the process of systematic review (Moher, Altman, Schulz, Simera, & Wager, 2014). The PRISMA diagram will identify any key search terms utilised, databases/resources used to identify records, number of records reviewed, identification of qualitative and quantitative research, and number of records included and excluded with the reason why they may have been excluded (Moher et al., 2014).

There have been several different research strategies utilised in terms of refining the above question including understanding the purpose of this

integrative literature review and the importance of the associated concepts (Whittemore & Knafl, 2005). After much deliberation, the resulting question was based on understanding the experience of tangata whai ora in terms of co-design, integration of the recovery model and incorporation of Te Tiriti o Waitangi within MHAS assessment and screening tools. Throughout Aotearoa there is an expectation for health services to deliver care that is person-centred, culturally responsive, and collaborative with interventions being in line with the principles of recovery (Anthony, 1993; Jacob, 2015; Mental Health Commission, 2004, 2007b; O'Hagen, 2001). Contemporary models of health care, specifically within MHAS endeavour to promote the notion of empowerment, resilience, and self-determination as being central to a person's wellbeing (Amering & Schmolke, 2009; Anthony, 1993; Rapp & Goscha, 2012). Inclusion should be an under-pinning principle for all tangata whai ora and their whānau in terms of any clinical interactions however the implementation of this appears varied (Mental Health and Addiction Inquiry, 2018; Newman et al., 2015; Slade, Adams, & O'Hagan, 2012). MHAS should be largely based on concepts such as the recovery model, co-design, and incorporate holistic and cultural inclusion and self-determination (Mental Health Commission, 2004; Ning, 2010; Sally & Frank, 2018; Slade et al., 2012).

2.4 Databases and key search terms

The Massey Discover database was utilised for most searches in terms of article databases, e-books, media, and other associated Massey online resources. EBSCO host allowed Discover searches included CINAHL, Medline via PubMed, Scopus, and Cochrane library. Discover was utilised as the primary search database as is has available all the University's licensed, subscribed, and scholarly material for student use. Google Scholer was utilised to access some articles in full text however was limited at times as only shares content that is publicly available.

Originally the research question was focussed on the use of care plans and risk assessments in MHAS and whether these were completed collaboratively with the tangata whai ora. Initial searches of the literature were undertaken using the following key words and terms: mental OR psychiatric AND "community approach*" OR "community care" OR "community Living" OR "community mental health" AND "safety planning" OR "care planning" OR "risk assessment". This produced 2,268 hits with several of the articles relevant in terms of content however a large number did not fit with the search terms. The search was not refined in terms of the population for consideration and to capture the essence of the initial question. To refine the search term further a second search was undertaken using the key words and terms: mental OR psychiatric AND "community approach*" OR "community care" OR "community Living" OR "community mental health" AND "safety planning" OR "care planning" OR "risk assessment" AND suicid*. This refined search took the number of hit down to 242. Several of the articles held some relevance however majority of these were not appropriate and there was significant variance in responses due to essentially using to many themes in one search i.e., safety planning, care planning and risk assessment.

The search question was further explored, suicide and safety planning were removed from and "recovery in mental health" AND "collaborative care" were added. This produced 7 hits; four of the articles were relevant to the theme of the search question however there was only a small range of articles to review. "Collaborative care" was removed and "recovery in mental health" was changed to "recover*". This produced 7,819 hits. "recover*" was replaced with "Recovery model" OR "recovery approach" OR "recovery framework" to decrease the number of relevant hits, this also provided a broader search base in terms of collaborative care. There were 3,153 hits from this search. "Recovery model" OR "recovery approach" OR "recovery framework" was truncated to "recover* model" to again provide a more specific, this reduced the number of hits to 191.

A secondary search focussing on co-design rather than the recovery model was completed. This included using the key terms: mental OR psychiatric AND "community approach*" OR "community care" OR "community Living" OR "community mental health" AND "co-design" OR "codesign" OR "co design" OR "participatory design" was utilised. There were 733 related search results. Although this search had several articles that were relevant to the topic most did not focus on how co-design and the recovery model were already incorporated into current mental health and addiction services practice.

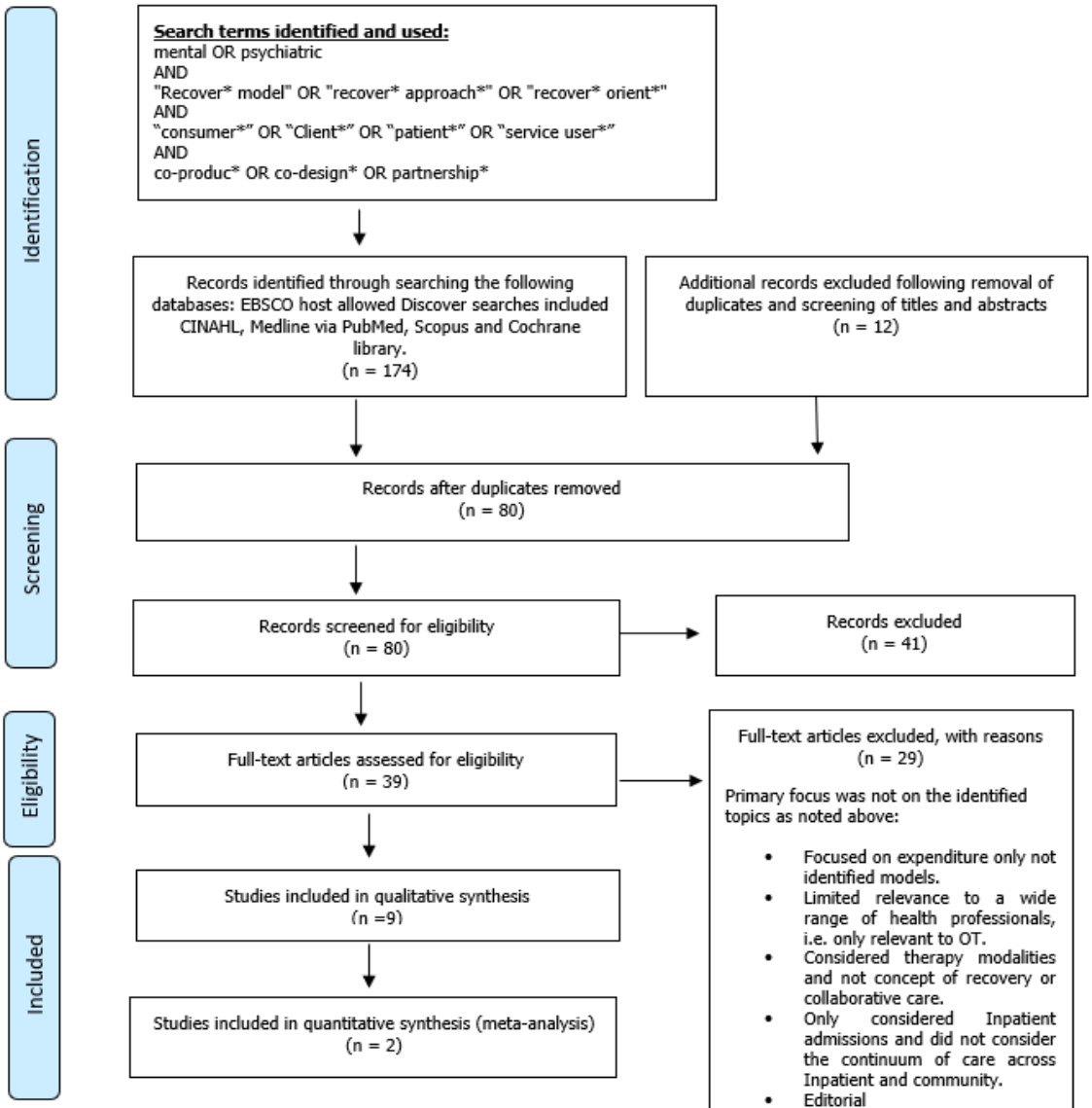
The research question was defined in terms of key components. The first component identified was that the cohort being focussed on was persons engaged with MHAS therefore the first search involved the following broad terms mental OR psychiatric. The second identified recovery therefore the initial search terms of "Recover* model" OR "recover* approach*" OR "recover* orient*" were kept as they captured good scope of responses.

The third component needed to define a secondary cohort and identify that the co-design being looked at was co-design in partnership with service users. This often comes under the indexing terms "patient participation" OR "consumer involvement" therefore consumer* was added to the terms Client* or patient* or "service user*" to again increase number of results. Using the term tangata whai ora limited the search exceptionally so this was again removed.

The fourth component identified was co-design therefore the following terms were utilised, co-produc* OR co-design* OR partnership*. The result of this search was 469 hits, the PRISMA flow diagram was then utilised to determine which articles were appropriate to the research question. The following expanders were utilised, results were limited to library collection – everything and included peer reviewed articles. The search was limited to

articles published between 2010 – 2020 and to only consider those written in English. This reduced the number of hits to 174 articles. There were 80 records after duplicates were removed and 39 after they were reviewed for eligibility

2.5 PRISMA flow diagram



Student ID: [redacted]
C.Potaka-Osborne

2.6 Limitations, inclusion/exclusion criteria

There were specific limitations in terms of finding a substantive amount of research or data that was specific to Aotearoa. Specifically, in terms of what our MHAS currently provide concerning assessments, care planning and risk management that are co-designed, recovery based and collaborative in nature. There was also lack of literature evidencing that co-design has been utilised in its truest form in terms of change management, health improvement and health policy in Aotearoa. To broaden the search, it was expanded to include OECD countries which did help to increase the number of relevant hits. Most research was carried out in the United Kingdom, however, there were also limitations in terms of diversity of participants, population ethnicities, and these being small samples so generalised in terms of population and culture.

The lack of Aotearoa specific research also highlighted limitations in terms of evidencing whether health services are meeting our obligations under Te Tiriti o Waitangi. Although co-design and recovery methods focus on cultural inclusion they do not focus on cultural identity, health, or education for indigenous peoples (Hayward & Wheen, 2004; Whitley, 2009). There is the assumption that the treaty principles are incorporated into all health care strategies and ministerial requirements however this is not explicitly evident within the literature (Came, 2012; Durie, 2011; Durie & Kingi, 1997; Morgan, 1995; Ward, 2007). There is also minimal evidence amongst the literature that Māori sit at a governance level in terms of contributing to health, assessment frameworks, models of care and recovery and co-designed methods.

Exclusion criteria included youth MHAS and intellectual disability services for both youth and adult. The search also excluded data or research that was specific to inpatient psychiatric services as these articles did not tend to evidence whether the assessment tools were then utilised once the person

was receiving community-based care. Therefore, inclusion criteria in terms of focus group or population was identified as being adults utilising community MHAS.

2.7 Review of the literature

There were several pieces of literature that were central in terms of exploring this topic. These pieces aimed to consider the limitations of current mental health and addiction assessments whilst identifying the best available evidence and contemporary strategy and policy to underpin the development of a tangata whai ora plans. Although many did not directly refer to the actual assessment tools themselves, they did consider the process required to develop meaningful assessment tools that embodied the concepts of recovery orientated care, co-design, and cultural inclusion.

2.7.1 Article 1: Consumer's perceptions of Recovery-oriented mental health services: An Australian case-study analysis

Overview: Article 1 (Hungerford & Fox, 2014), conducted a study with the aim of identifying factors that challenged the effectiveness of implementing recovery orientated services in a mental health service located in South-eastern Australia whilst considering solutions to these identified challenges (Hungerford & Fox, 2014). The study summarised that utilisation of consumers as part of mental health service delivery and quality improvement, has been promoted in western countries for more than two decades and is in fact integral to ensuring self-determination and partnership (Hungerford & Fox, 2014). It is assumed that consumers will be actively involved in all aspects of their care including treatment interventions, options and choices, and care planning written specifically for the individual (Hungerford & Fox, 2014).

Participants: All participants were recruited through advertisement, several participants also self-identified as wanting to be involved through local health services. All participants were briefed on the scope of the study and advised that they would remain anonymous and able to withdraw from participating at any time. Nine volunteers participated, three requested individual interviews, the rest attended focus groups.

Ethics: Study approval was received from two human research ethics committees in 2010 and the health organisation involved in the study.

Method: The researchers utilised a case study approach to facilitate a constructive means for building, testing, and developing theory related to the implementation of consumer-centred models of care (Hungerford & Fox, 2014). Case studies create mediums where is by ideas can be designed, tested, and analysed in a way that is specific to the idea in question (Hungerford & Fox, 2014). In line with consumer-centred approaches the research was designed in collaboration with a consumer representative and a qualitative framework was employed to support consideration of consumer lived experience (Hungerford & Fox, 2014). All discussions were digitally recorded and transcribed verbatim before being analysed using Interpretive Phenomenological Analysis (IPA) as this process explores how participants make sense of their social and personal worlds by organising the data into themes and patterns (Hungerford & Fox, 2014). Transcriptions were examined by two independent analysts, one of which did not work within mental health, and then compared to support analytical validity.

Results: Three key themes were identified by participants about recovery orientated services, these were 1) recovery, 2) challenges to recovery and 3) solutions to these challenges (Hungerford & Fox, 2014). Participants identified that 'recovery' was a state of being rather than a notion of being

'cured', as the latter was a measurable outcome achieved through pre-identified activities by health professional, services or organisations rather than the individual (Hungerford & Fox, 2014). Participants felt that operationalising recovery-orientated services implied that the consumer was key to achieving their desired state of wellbeing through partnership and collaboration (Hungerford & Fox, 2014). Several challenges were detected in the study including consumer's fear of change including their perception that health professional was also wary of change in terms of translating recovery to practice i.e. individualised care planning and relapse plans (Hungerford & Fox, 2014). One participant noted that they had had a recovery plan written for them several times without their knowledge or involvement and each time information had been incorrect yet it was shared with other health professionals as part of his treatment plan (Hungerford & Fox, 2014).

Conclusions and recommendations: This type of approach highlighted significant disconnect between the principles of recovery and health professionals' practice, participants also felt this disconnect was due to the incongruence between consumer centred recovery and the biomedical model noting that it was the biomedical model that continued to dominate models of care therefore focus did not consider bio-psychosocial issues (Hungerford & Fox, 2014). Solutions offered included consumer consultants offering peer support to consumers, involvement in service development and delivery, education regarding recovery concepts and active listening and greater collaboration and partnership between consumers and health professionals in terms of determining recovery based-care (Hungerford & Fox, 2014). The recommendations of this study do provide insights for other health organisations looking to implement recovery-orientated services.

Limitations: identified as use of case studies as they are not generalizable to all other settings, limited sample size and length of time taken to

complete the study i.e. if it had been extended then there would have been more opportunity for greater number of interviews to take place (Hungerford & Fox, 2014).

2.7.2 Article 2: Patient participation in mental health care – perspectives of healthcare professionals: an integrative review

Overview: Article 2 (Jørgensen & Rendtorff, 2018), completed an integrative review looking at patient participation in mental health care from the perspectives of healthcare professionals and identifying what they perceived to be the challenges in doing this. Recovery oriented care denotes that consumers will have the ability to work in partnership in terms of determining their treatment and that care is based on individuals, however it is noted that patient participation in not clearly defined therefore health professionals find it difficult to translate this to practice (Jørgensen & Rendtorff, 2018). In Western countries patient participation is one of the most common focuses of healthcare debate, and healthcare policy dictates that patient participation is a fixed objective with specific legal requirements mandating health professionals to ensure patients are involved in their care from start to finish (Jørgensen & Rendtorff, 2018). It is substantiated by the fact that it improves quality of life, increases sense of ownership, self-determination and management of symptoms, improves treatment process and quality of care and also reduces adverse incidents as the patient becomes the lead in their own care (Jørgensen & Rendtorff, 2018).

Participants: Seven studies meet the inclusion criteria for the review, six of these were qualitative methodologies and one a mixed method approach. The studies took place in Norway, Australia and the UK and were all based in a mental health setting.

Method: Thematic analysis was used in the analysis of the studies. An inductive coding system was then applied to ensure thorough examination of each study line by line, this formed the basis of a meta synthesis where the findings were then tested deductively (Jørgensen & Rendtorff, 2018). The themes were then validated through discussion with another researcher which facilitated with consolidating the themes (Jørgensen & Rendtorff, 2018).

Results: From the review three main themes were identified 1) patient participation as collaboration between professionals and patient, 2) challenges to participation, and 3) professional's perspectives – what expectations do patients have when participating in decision making? (Jørgensen & Rendtorff, 2018). The findings highlighted that patient participation is not clearly defined by health professionals therefore making it difficult to translate to practice, however it is noted that patient participation is expected to lead to improved recovery processes, empowerment, self-efficacy and improved quality of life (Jørgensen & Rendtorff, 2018). The integrative review then led to further two themes 1) how can patient participation be defined in mental health, and 2) what are the challenges to implementing patient participation in mental health (Jørgensen & Rendtorff, 2018).

Conclusions and recommendations: This study indicates that patients are the experts in their own lives and this can be used as an advantage when care planning and considering treatment options, these should be based on the patients perceived problems and needs and articulate the patients hopes and future goals (Jørgensen & Rendtorff, 2018). In terms of challenges it is clear that patients with more severe mental health issues are less likely to be involved in care planning, this is linked to the fact that healthcare professionals tend to concentrate more on diagnosis and symptomology rather than patient participation when completing care plans (Jørgensen & Rendtorff, 2018). Care planning provides an

opportunity for health professionals to foster patient participation and collaborative care, however there is clear indication that health professional need further education in terms of recovery-oriented practices (Jørgensen & Rendtorff, 2018).

Limitations: include use of wording. 'Inclusion' is synonymous with several other concepts in mental health therefore there is a possibility that the review did not include some eligible articles, however the researchers were clear that they examined a relevant sample size in order to obtain the above conclusions.

2.7.3 Article 3: Exploring the meaning of recovery-oriented care: An action-research study

Overview: Article 3 (Kidd, Kenny and McKinstry, 2015a), conducted an action-research study exploring the meaning of recovery-oriented care in regional Australia which was later published as a feature article in the International Journal of Mental Health Nursing (Kidd, Kenny, & McKinstry, 2015a). The purpose of the study was to inform the development of recovery-oriented services in mental health, whilst bringing together consumers, carers and health professionals to ascertain their collective understanding of the meaning of recovery and recovery oriented care (Kidd et al., 2015a). It is acknowledged that those experiencing low-prevalence illness and psychosocial disability are more likely to experience unemployment, poor accommodation, poor physical health and impaired functioning and relationships therefore services need to be working in an integrated manner that emphasizes empowerment, competency and recovery (Kidd et al., 2015a). Current services continue to be governed by the biomedical model, the result is a lack of emphasis on the person's lived experience, relationships, social and economic determinants which create environments which structurally discriminative and disabling in nature (Kidd et al., 2015a). Consumer advocates argue that healthcare

professionals continue to moderate consumers access to resources, particularly in terms of setting entry criteria's to services and supports (Kidd et al., 2015a).

Participants: the sample group utilised consisted of clinicians, consumer's, carers, and those with a history of involvement with the service. The final group consisted of 11 participants made up of six consumers, one carer and four clinicians.

Ethics: approval was granted by both the university and the health service involved.

Method: The study was conducted over a 12-month period in a regional mental health service. The service was commencing their journey in understanding recovery-oriented practices including understanding the definitions, process and outcomes which had not been considered as part of their model of care (Kidd et al., 2015a). At the time of the study there was no consumer leadership and health professionals were ambivalent as to what recovery-oriented care meant, there was a need to explore how consumer participation may be used to influence service provision and clinical practice moving forward (Kidd et al., 2015a). Participatory action research was deemed suitable because of the specific focus on practice (Kidd et al., 2015a). It enabled a space where discussions were facilitated and practical knowledge harnessed allowing the researches to address power indifferences and encourage recognition of diverse perspectives (Kidd et al., 2015a). Action research recognises that power is a basic constituent of practice and social relations and there are no power free spaces within this (Kidd et al., 2015a). Cooperative enquiry which allows participants to experience the world subjectively, objectively and intersubjectively was utilised to develop dialogue amongst participants (Kidd et al., 2015a). The relationship that the participant has with themselves, others and the world is central to understanding and

encouraging social transformation and opportunities in developing one's knowledge (Kidd et al., 2015a). The group meet 10 times over the 12-month period and followed a uniform agenda, each meeting was two hours long and was videotaped (Kidd et al., 2015a). Group actions were prioritised at the end of each meeting and transcribed records of meetings were checked by the participants prior to commencing the next group to ensure accuracy (Kidd et al., 2015a). Thematic analysis was used to then identify themes throughout the study, two further meetings were arranged in order to discuss, collate and agree as a group to the overall final themes, a global theme was then established which reflected the group's overall views (Kidd et al., 2015a).

Results: there were six themes that contributed to the overarching theme, these being recovery values and service model, clinical services having a significant impact, particular kind of communication, worker self-awareness, systemic barriers and involuntary treatment (Kidd et al., 2015a). This led to the overarching theme of 'I want services to hear me', which reflected the groups shared views that the 'voices' of consumers, carers and health professionals was important in terms of service development (Kidd et al., 2015a).

Conclusion and recommendations: The overall conclusion of the study was that participatory inclusion and co-design is central to developing recovery-oriented mental health services as it affords a structural framework in which lived experience can be utilised to advance recovery focussed services and social transformation (Kidd et al., 2015a). MHAS have a responsibility to challenge the views of society in regards to mental illness, including considering service provision, assessment frameworks and clinical methodologies are based on human rights social justice approaches (Kidd et al., 2015a). Addressing individual and systemic discrimination is essential in transforming services to one which is recovery oriented (Kidd et al., 2015a).

Limitations: include the short timeframes employed to gather the data and that the project may not be generalizable to other areas.

2.7.4 Article 4: How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model

Overview: article 4 (Winsper, Crawford-Docherty, Weich, Fenton and Singh, 2020), utilised a systemic review with a theory driven login model to better understand how recovery-oriented interventions contributed to person mental health recovery (Winsper, Crawford-Docherty, Weich, Fenton, & Singh, 2020). The growing recovery paradigm in mental health, prioritises a move towards more meaningful recovery processes, it defines recovery as a personal and unique process that has multiple touchpoints which are specifically relevant to the person at the centre of the journey (Winsper et al., 2020). There are multiple validated tools used to assist with meeting outcome measures relating to recovery (Winsper et al., 2020). They include those that concentrate on a single mechanism e.g. Quality of life index, those that consider the results of an exclusive intervention, recovery scale, those that consider a multidimensional approach, recovery assessment scale, and those that consider a multi stage approach, and stages of recovery instrument (Winsper et al., 2020). These tools vary in terms of clinical focus e.g. clinical, functional, social, existential and physical domains or care but remain relevant to the overall wellbeing of those utilising services (Winsper et al., 2020). The following research questions were asked as part of this review, 1) which recovery-oriented interventions support personal recovery including functional, existential and social, 2) how are functional, existential and social recovery domains related, 3) what are the presumed actions linking recovery-oriented interventions to long term recovery outcomes, and 4) what are

the contextual moderators of intervention mechanisms and outcomes (Winsper et al., 2020).

Method: Development of a logic model was completed in conjunction with clinicians from four National Health Services (NHS) trusts in the West midlands, United Kingdom as part of the MERIT Vanguard programme. The MERIT Vanguard programme is an innovative partnership of mental health organisations in the West Midlands, which collaborate to develop new initiatives to improve the way in which mental health services are provided (Winsper et al., 2020). Feedback was also sought from the MERIT recovery workstream which included practitioners, consumers and people working in academia, and at multi-disciplinary research forums and regional and national NHS conferences (Winsper et al., 2020). In total, 309 studies met the inclusion criteria for the review.

Results: four main intervention typologies were identified, 1) Psychoeducational: (individual/group) including wellness recovery and action planning (WRAP) and recovery colleges, 2) Peer: peer lead programmes and peer support, 3) Social inclusion: including supported employment, budgeting, strengths model, and community programmes, and 4) Pro-recovery and mental health literacy training: recovery-oriented education, collaborative recovery training and mental health first aid for the public (Winsper et al., 2020). Recovery outcomes were grouped into the following domains, 1) functional: employment, housing and education, 2) existential: self-esteem, identity and empowerment, and 3) social: social functioning and community integration (Winsper et al., 2020). Mechanisms of action were defined as the underlying process through which interventions could help facilitate recovery outcomes, considering the services user as an active participant (Winsper et al., 2020). Most data relating to mechanisms was obtained from qualitative studies, the following mechanisms of action were identified, 1) providing information and skills, 2) promoting working alliances, 3) role modelling individual

recovery, and 4) increasing choice and opportunities (Winsper et al., 2020). The purpose of the review was to establish a theoretical framework to describe how recovery-oriented interventions assisted service users to progress towards recovery, studies indicated that functional, existential and social recovery worked best when they were considered together i.e. 'gains in one influenced gains in another' (Winsper et al., 2020).

Conclusion and recommendations: the review identified that services need to utilise a structured evaluation process to assess a service user's 'readiness for recovery' and this must include the person's environmental and situational influences in terms of attaining their recovery goals (Winsper et al., 2020). the continued biomedical approach in mental health continues to provide care which is inconsistent and does not adhere to the essence of the recovery principles (Winsper et al., 2020). There is significant opportunity for transformational change in terms of the design, delivery and service provision if it was done in co-design with service user's, however there would need to be a readiness from mainstream services to challenge restrictive practices, clinical practice and cultural norms (Winsper et al., 2020).

2.7.5 Article 5: What Does Recovery Mean in Practice? A Qualitative Analysis of International Recovery-Oriented Practice Guidance

Overview: article 5 (Le Boutillier, Leamy, et el, 2011), conducted a qualitative analysis of international documents to identify the key aspects of recovery-oriented practice guidance based on international perspectives (Le Boutillier et al., 2011). The aim of this was to create a framework for clinicians to help with the translation of recovery guidance in their practice (Le Boutillier et al., 2011). Recovery provides mental health services with an opportunity for transformational change, as a philosophy is challenges

our ideas and viewpoints around the aetiology of mental health including the way in which we provide care and encourage people to live independently with meaningful and productive lives (Le Boutillier et al., 2011). Recovery employs values that command independence, empowerment, and autonomy, as a concept it does not support paternalistic or medical centric approaches (Le Boutillier et al., 2011). Health practitioners tend to view recovery in terms of symptomology therefore tend to measure recovery based on this, in turn this creates inconsistency and challenges as recovery is seen as subjective therefore interpretation by individual practitioners may be viewed differently depending on how they practice (Le Boutillier et al., 2011).

Ethics: approval, the review was completed as part of a larger piece of research which had been approved already by the joint South London and Maudsley and the Institute of Psychiatry National Health Service research ethics committee (Le Boutillier et al., 2011).

Method: thirty international documents were identified as meeting the criteria for the review, these were from the United States, England, New Zealand, Republic of Ireland, Denmark and Scotland, all documents varied in terms of guidance development, including service user involvement and document type (Le Boutillier et al., 2011). Inductive thematic analysis was employed to identify the principle themes relating to recovery-oriented practice (Le Boutillier et al., 2011). The researchers then applied interpretive analysis to group these themes into practice domains (Le Boutillier et al., 2011).

Results: there were 16 dominant themes present and these were able to be narrowed down to the following four practicing domains. Promoting citizenship: this is an essential component of recovery and involves service user's feeling as though they part of the community and being treated as equals (Le Boutillier et al., 2011). Organisational commitment: services

that support recovery-oriented practice have systems and practices that are conducive to recovery-oriented care, they adapt to the needs of the people and not the needs of the service, including policy, quality improvement, workforce planning and service provision (Le Boutillier et al., 2011). Supporting personally defined recovery: practitioners support individuals to identify their own needs and goals in terms of care planning and treatment, this includes informed choices, holistic approaches to assessments, strengths based interventions and peer support (Le Boutillier et al., 2011). Working relationships: practitioners display genuine interest in supporting services users and their family to shape their own outcomes, this is accomplished through working in partnership with the person whilst promoting hope and self-empowerment (Le Boutillier et al., 2011).

Conclusion and recommendations: overall, it is evident that the diversity of recovery-oriented guidance emphasises the difficulty of translating recovery into practice, therefore a significant challenge for MHAS is clarifying what constitutes recovery-oriented care and how this can be implemented as general business by health professionals (Le Boutillier et al., 2011).

2.8 Findings and critical analysis

All eligible articles were analysed and interpreted using a thematic analysis approach which focusses on any themes, patterns, or rich descriptive data evident within the data set being examined (DePoy & Gitlin, 2016).
Commonalities within the articles were identified and organised into the following three themes 1) the importance of lived experience and co-design, 2) biomedical and paternalistic approach to MHAS including Perceptions and Disproportionate Insights and 3) micro and macro needs within MHAS.

2.8.1 Theme 1 – The importance of lived experience and co-design

One of the more prominent themes identified within the literature review was the importance of mental health lived experience and its fundamental role in terms of mental health care reform and research. Key messages emphasized the benefits of using tangata whai ora experiences of MHAS, recovery, and service provision to inform quality improvement and service design (DiGioia & Shapiro, 2017; Ng, 2012; Ning, 2010; Slattery et al., 2020). Health professionals and overarching governmental agencies in charge of identifying health priorities will benefit directly by understanding service user's direct experiences and how mental health and recovery was for them. The literature reviewed repeatedly emphasises the importance of the recovery model with the overarching principle of recovery focussing on a person's quality of life and not being dependant on the absence of symptoms (Cameron, Hart, Brooker, Neale, & Reardon, 2018; Jacob, 2015; Rapp & Goscha, 2012; Slade et al., 2014; Watson, Thorburn, Everett, & Fisher, 2014). The key components being strengths-based interactions, instilling hope, building resiliency and the recruitment of clinicians with lived experience, or co-design in terms of quality improvement and service provision (Gehart, 2012b; Kidd et al., 2015b; Ng, 2012; Oshodi & Rush, 2011; Rapp & Goscha, 2012).

Co-design requires all stakeholders to work in partnership throughout the design process, in a systems approach (Bate & Robert, 2007; Ng, 2012) It also correlates well with the recovery model and Te Tiriti o Waitangi by embodying the recovery principles of strengths based care, empowerment, partnership, communication and by recognising that recovery is an individual journey that is holistic and unique to the person (Baxter, 2008; Durie & Kingi, 1997; Gehart, 2012b; Mental Health Commission, 2007; O'Hagen, 2001; Rapp & Goscha, 2012). The current review of the literature and the MOH commissioned inquiry (Cunningham et al., 2018; Mental

Health and Addiction Inquiry, 2018) into MHAS have both indicated that health services and Māori continue to experience poor health outcomes, high suicide rates and practice from a primarily medical focussed perspective, despite evidence indicating improved outcomes when utilising co-design and recovery based processes (Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018; Rapp & Goscha, 2012). This begs the question, if MHAS were to co-design a recovery strengths-based system / health interface with Māori utilising current MHAS, would this positively influence tangata whai ora experiences, assessment tools and frameworks, health outcomes and improve health disparities especially for Māori? The evidence would suggest it would (Jacob, 2015; Mental Health Commission, 1998, 2004, 2007; Mental Health Foundation, 2008).

The Governments vision for Māori health is centred around Pae ora (MOH, 2020c). Pae ora, is a holistic concept which outlines the governments vision for ensuring that Māori experience optimal health and wellness (MOH, 2020c). It considers the elements of Mauri ora – healthy individuals, Whānau ora – healthy families and Wai ora – healthy environments and encourages the health and disability sector to work collaboratively with Māori to strengthen the strategic direction for Māori health (Hutt Valley District Health Board, 2018; MOH, 2020c). It is underpinned by Te Tiriti o Waitangi principles and aims to ensure that these are used as the framework for all Māori strategies and initiatives (MOH, 2020c; Ministry of Social Development, 2019). Aotearoa needs to consider more readily the concept of integrated models of care i.e. Māori models combined with social models of care, and models built in partnership with the community and service user's especially in MHAS (Durie & Kingi, 1997; Haitana, Pitama, Cormack, Clarke, & Lacey, 2020; MOH, 2020c; Ministry of Social Development, 2019). If MHAS services are in fact going to provide tangata whai ora with a number of options related to change rather than being limited to the medical model, then holistic care that incorporates the whole person in a culturally inclusive manner needs to be reflected (Durie & Kingi,

1997; Naera, 2015; Rapp & Goscha, 2012; Whittemore & Knafl, 2005; William, 1993). Health services need to be conscious that options for assessment tools, treatments and interventions are tailored to provide care to the whole person, their whānau whānau and the community rather than providing care that meets government targets or goals of individuals (Hutt Valley District Health Board, 2018; MOH, 2020c; Slade et al., 2014; William, 1993). The recovery principles and co-design are methods which would facilitate change management process to be more person centred and community focused especially in terms of assessment tools and care planning (Amering & Schmolke, 2009; Eriksen, Arman, Davidson, Sundfør, & Karlsson, 2014; Evans et al., 2017; William, 1993).

Although this literature review focuses on assessment tools it is worth considering how co-design and recovery-based practices may also influence education for health professionals. In the United Kingdom these principles have informed educational approaches to undergraduate and post graduate mental health teachings through the establishment of recovery colleges and likewise in the United States through Recovery education centres (Bourne, Whittington, & Meddings, 2018; Cameron et al., 2018). The United Kingdom has made their position clear in terms of their commitment to the values of the recovery model by supporting it with organisational change, and governmental policy and reporting (Bourne et al., 2018; Slade et al., 2014; Zelmer et al., 2018). Education directly influences the growth of the workforce especially nursing in terms of instilling values standards of care, and the ethical and moral principles that individuals use to underpin their practice (Cameron et al., 2005; Hartley, Raphael, Lovell, & Berry, 2020; William, 1993; Zelmer et al., 2018). If the principles of the recovery model, co-design and in Aotearoa Te Tiriti o Waitangi educationally underpins practice then clinicians are more likely to incorporate these elements of care within the nursing assessments and interventions they use even though they may not be explicitly present.

2.8.2 Theme 2 – Biomedical and paternalistic approach to MHAS, including perceptions and disproportionate insights.

A predominant theme throughout the reviewed literature is that the MHAS sectors across the world continue to largely adhere to approaches that are paternalistic and biomedically centred. The biomedical model ultimately dictates that mental disorder is a disease and the underlying cause of all mental health difficulties (Bährer-Kohler & Bolea-Alamanac, 2019; D. Smith, 2019; Tew, 2005). It concentrates its attention on the person's biological aspects, treating factors such as psychological, environmental, and social influences as generally non-relevant (Procter, Hamer, McGarry, Wilson, & Froggatt, 2017; Smith, 2019; Tew, 2005). The model focuses on the reduction of symptoms and immediate risks rather than considering the whole person and their contextual circumstances and associated social determinants as having any bearing on mental disorder (Durie, 2011; Evans et al., 2017; Procter et al., 2017; Smith, 2019; Tew, 2005). Treatment interventions are more likely to be tailored towards managing the disease or disorder rather than supporting the person as a whole, an example of this is that tangata whai ora are more likely to be prescribed medication over the use of therapeutic modalities in the first instance (Ladd & Churchill, 2012). Use of medication as a frontline treatment contributes significantly towards the increased frequency of negative health outcomes such as metabolic disorder, increased side effects, increased mortality rates and treatment without consent (Limon, Lee, Gonzalez, Choh, & Czerwinski, 2020; Morrison-Valfre, 2017).

The Mental Health (Compulsory Assessment and Treatment) Act, 1992 (MHA) Aotearoa,provides the medical profession with a legal framework to enforce treatment therefore prioritising the biomedical model over that of a holistic approach (Bailey & Coates, 1992; MOH, 2000). The MHA prioritises medical expertise over that of tangata whai ora by authorising the medical

profession to clinically determine whether a tangata whai ora has capacity to determine which treatment they receive (Bailey & Coates, 1992; MOH, 2000; Ning, 2010; Toki, 2010). This paternalistic approach towards tangata whai ora further diminishes ones' sense of self whilst perpetuating ongoing disregard for individual's life circumstances and ability to make informed decisions based on their values and cultural needs (Elyn, 2002; Greenall, 2006; Stensrud et al., 2016; Sugiura et al., 2020; Trusty, Penix, Dimmick, & Swift, 2019). Use of the MHA and biomedical models perpetuate therapeutic alliances which are paternalistic, custodial in nature and which diminish one's autonomy or capacity to make decision based on what they feel is best for them (Fishwick, Tait, & O'Brien, 2001; McCubbin & Cohen, 1996; Watson et al., 2014). Although it can be argued that the MHA is at times useful when a person is unable to make informed decisions pertaining to their health and safety due to capacity, this also goes against the essence of what mental health nurses are taught in terms of the foundations of their practice (Fishwick et al., 2001; Hartley et al., 2020; Sibbald, 2016). The basis of a therapeutic relationship is built on trust, advocacy, autonomy, caring and doing no harm, yet use of the MHA cultivates a relationship built on paternalism, power imbalances, coercion, social control, and exclusion (Fishwick et al., 2001; Anthony John O'Brien, 2000; Anthony J. O'Brien, 2010; Sibbald, 2016). Power and control imbalances, meagre engagement and unrealistic expectations of services by individuals and the community will remain a persistent issue if the recovery principles and social inclusion are not employed by services in terms of service provision and models of care, further perpetuating inequalities and disparities across the continuum (Cameron, Kapur, & Campbell, 2005; Jacob, 2015; Morrison-Valfre, 2017; Sugiura, Mahomed, Saxena, & Patel, 2020). Therefore, it is fair to say that the MHAS sector remains primarily biomedical, prescriptive, and paternalistic in nature.

There is a disproportionate interpretation of how to communicate with diverse cultures across the world, including Aotearoa / New Zealand, as

primarily communication occurs with a western world view (Craig & Craig, 1999; Durie, 2011; Kingi et al., 2017; Toki, 2010). We have established preconceived and disproportionate views of Māori and non-Māori health literacy in terms of knowledge and understanding, including early health screening, trauma, general wellbeing, and wellness lifestyle choices (Kingi et al., 2017; Smith, Tinirau, & Smith, 2019). We tailor communication and the delivery of services to fit the 'majority' or the community as a 'singular' group and fail to recognises that this group is made up of several different ethnicity's and cultures including Māori (Craig & Craig, 1999; Kingi et al., 2017; Naera, 2015; Waitangi Tribunal, 2019a). If this is the case then it poses the question of how are we meeting our obligations under Te Tiriti o Waitangi including the Māori workforce, Tino rangatiratanga - Māori governance and Māori rights across services? (Chant, 2011a; Te Ao Māramatanga, 2015) If we are not going to use co-design to design services that are culturally appropriate and proportionate to dominant cultures, then regardless of what changes are made the minority group will always experience poorer health outcomes (Kingi et al., 2017; Sewell, 2009; Su Yeon Lee-Tauler, John Eun, Dawn Corbett, & Pamela Y. Collins, 2018).

The significance of this theme for Aotearoa is that the biomedical model does not primarily allow for culture or social determinants to factor when determining treatment options and health interventions (Hamer, Finlayson, & Warren, 2014; Whittemore & Knafl, 2005). Therefore, can we explicitly acknowledge that the principles of Te Tiriti o Waitangi are upheld within our MHAS? And how does lived-experience and cultural consideration fit into our current model of care in terms of generating change? (Byrne, Happell, & Reid-Searl, 2016; Mental Health Foundation, 1992; Whittemore & Knafl, 2005). Mason Durie's proposed fourth wave sanctioned the need for Aotearoa mental health services to move away from the biomedical model dominance and the constant pathologising of illness to instead acknowledging the impact that social determinants, relationships, and the vast context of culture which significantly impacts ones mental health

(Durie, 2011; Kendrick, 2016; Mental Health Commission, 2007b, 2012; Smith et al., 2019). Since 2011 there have been several initiatives, strategies and improvement projects aimed at improving Māori health and access to care in Aotearoa, and many of these have been outlined within He Korowai Oranga – Aotearoa Māori health strategy and whānau Ora (Chant, 2011a; King & Turia, 2002; Ministry of Health, 2001; Te Rau Matatini, 2014).

2.8.3 Theme 3 – micro and macro needs within MHAS

There is a plethora of information outlining the importance of the recovery principles and tangata whai ora engagement in terms of design, care co-ordination and formulation (Evans et al., 2017; Gawith & Abrams, 2006; Gehart, 2012a, 2012b; Jones et al., 2016; Oshodi & Rush, 2011). However, many of the articles also identify that services do not implement these effectively at service delivery level including utilising lived experience in service design and quality improvement (Cunningham et al., 2018; Mental Health and Addiction Inquiry, 2018; Mental Health Commission, 2004, 2007). Often changes are made at a micro level meaning that the change is only relevant or specific to a particular area or service. Although the intention is for an individuals or communities to have an integrated approach in terms of their care, the essence of this care may not be carried through to other services involved as they may work under a different directorate (DiGioia & Shapiro, 2017; Kirby, 2019). Systemic change across the continuum needs to be endorsed at a macro level informing government policy and health strategies so that we can establish clear direction and consistency in terms of person-centred care (Kirby, 2019; Ng, 2012; Phillips, Sandford, & Johnston, 2012). It is also clear that although some services may be well intentioned in terms of 'co-designing' a change project or process, this may not necessarily mean that the change has been exclusively co-designed with the correct cohort of people (DiGioia & Shapiro, 2017; Kirby, 2019; Ng, 2012). Often in health working with other

organisations or services is deemed as appropriate use of co-design however often we fail to include those at the centre of the change, i.e., tangata whai ora and their whānau (Aitken & Shackleton, 2014; Britton, 2017). This is generally not intentional however it does influence or control the change as being more suited to the needs of the organisation or service rather than that of the person or community (Britton, 2017; Ladd & Churchill, 2012).

If we were to consider this in the Aotearoa context then this would include Māori providing governance and insight into the establishment of Māori and mainstream services (Haitana et al., 2020; MOH, 2001; Te Rau Matatini, 2014). There is a lack of local and national research available that compares Aotearoa to other countries in terms of tangata whai ora led care, co-design and tangata whai ora focussed assessments that incorporate a culturally holistic approach. Tangata whai ora and whānau clearly continue to appeal for changes to be made to how the current MHAS are being provided for which they have also highlighted their desire be a part of (Cunningham et al., 2018; King & Turia, 2002; MOH, 2001).

The 2019 Waitangi Tribunal Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry, recommends that the Crown acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health care system to improve Māori health outcomes since the commencement of the New Zealand Public Health and Disability Act 2000 (Came, O'Sullivan, Kidd, & McCreanor, 2020; Came & Tudor, 2017; Waitangi Tribunal, 2019a). This aligns with and is applicable to all services situated within primary and secondary health services. Aotearoa needs to establish frameworks and policy that incorporates the overarching needs of Māori at a macro level (Came & Tudor, 2017). This includes equity, visibility into Māori health needs, cultural inclusion, acknowledgment of past trauma and colonisation and accountability for health outcomes at a ministerial and governmental level (Came & Tudor, 2017; Woltmann & Whitley, 2010). The

Māori Health Action Plan acknowledges that there are unfair and avoidable deficits in Māori health whilst recognising the MOH has an integral leadership role the Government's efforts to enable Māori to have healthy futures (Baxter, 2008; Came & Tudor, 2017; Ministry of Health, 2020c; Ministry of Social Development, 2019).

Environments and social circumstances are major contributors to a person being able to develop stress tolerance, positive cultural and spiritual wellbeing, and the ability to manage adversity within their everyday functioning (Gawith & Abrams, 2006; O'Hagen, 2001; Rapp & Goscha, 2012; Sheppard, 1991). Opportunities for reflection and change can be positively harnessed through collaborative assessment tools and integrated care focussing on the individual's values, care and opinion is seen central to any decision making around care planning and goal setting (Gehart, 2012a; Jobes, 2006; Mental Health Foundation, 2008; Saggese, 2005). For this to be successful, it needs to be implemented at both a micro and macro level and endorsed by the MOH and Governmental agencies (Haitana et al., 2020; Ng, 2012; Sharma, 2016). Engagement with Māori and Iwi as Te Tiriti o Waitangi partners is vital when defining change within the health sector. Decisions will be made incorporating culturally appropriate and collaborative care in turn enhancing Māori wellbeing (Came & Tudor, 2017; Haitana et al., 2020; MOH, 2001). Health will incorporate Māori world views and hold the health sector accountable for Māori health outcomes which will be self-determined by Māori for Māori with Māori (Durie & Kingi, 1997; Haitana et al., 2020; Henare, 1990; Manatū Hauora MOH, 2018; Pack et al., 2016; Waitangi Tribunal, 2019a).

2.9 Discussion and analysis

The aim of the integrated literature review was to examine the national and international literature in order to establish the limitations of current assessments and identify the best available evidence and contemporary

strategy and policy in Aotearoa to underpin the development of a new integrated assessment. Aotearoa has worked vigorously over the last decade to improve mental health service provision and improve the health outcomes of those utilising primary and secondary mental health services (Kidd et al., 2015b; King & Turia, 2002; MOH, 2006, 2018; Ministry of Social Development, 2019; Phillips et al., 2012). Several health strategies have been formulated to provide health care which is consistent and targeted at improving health outcomes for those in the community including Māori who make up a substantial quantity of the population of Aotearoa. All of which have a focus on priority actions for MHAS being centred around the recovery model and quality improvement aimed to enhance current service provision and tangata whai ora health outcomes (Chant, 2011; Gawith & Abrams, 2006; Mental Health Commission, 2012; MOH, 2001, 2002; Ministry of Social Development, 2019; Oakley Brown et al., 2006). The main themes identified through the literature review were the importance of lived experience and co-design, biomedical and paternalistic approach to MHAS, including perceptions and disproportionate insights, and micro and macro needs within MHAS.

Co-design has been identified predominantly throughout the literature in terms of the recovery model, tangata whai ora centred care and in relation to its significance to mental health and the consideration of lived experience in Mental health care reform and research (Aitken & Shackleton, 2014; DiGioia & Shapiro, 2017; Slattery et al., 2020). There is repeated emphasises on the importance of the recovery model and its overarching principles self-determination, empowerment, and hope as these are the values which enhance a person's wellbeing and person's quality of life. These principles allow a person to live their lives regardless of whether they are still experiencing symptoms, the absence of their symptoms does not determine their wellbeing (Morrison-Valfre, 2017; Oshodi & Rush, 2011; Rapp & Goscha, 2012; D. Smith, 2019; Tew, 2005; Winsper et al., 2020). This is off significant note considering that MHAS sectors across the world

continue to largely adhere to approaches that are bio medically centred and paternalistic in nature (Greenall, 2006; Holley, Chambers, & Gillard, 2016; Smith, 2019; Tew, 2005; Trusty et al., 2019). Services continue to work from a clinical basis which determines that mental disorder is a disease and the underlying cause of all mental illness, focus is on the biological aspects of a person's illness with largely no consideration to their cultural, psychological, environmental, or social influences (Elyn, 2002; Oshodi & Rush, 2011; Smith, 2019). We also continue to utilise methods of care like the MHA which perpetuate relationships which are paternalistic, custodial in nature and which continue to diminish one's autonomy and capacity to make decisions relating to their care (Fishwick et al., 2001; Smith, 2019; Stensrud et al., 2016). In Aotearoa the implications of this are that the biomedical model does not primarily allow for a person's cultural needs or social determinants to factor when determining treatment options and health interventions that do not fit with them. We continue to tailor communication and the delivery of services to fit the 'majority' and fail to recognise that Aotearoa is made up various ethnicities and cultures including largely Māori.

It is also clear from the literature that tangata whai ora with more severe mental health issues are less likely to be involved in any care planning relating to their treatment of goal planning (Hungerford & Fox, 2014; Jørgensen & Rendtorff, 2018; Kidd et al., 2015b; Le Boutillier et al., 2011; Winsper et al., 2020). Care planning affords health professionals the opportunity to foster participation and collaborative care, yet there is clear indication that health professionals require further education and guidance in terms of recovery-oriented practices and how these can be implemented within practice (Hungerford & Fox, 2014; Jørgensen & Rendtorff, 2018; Kidd et al., 2015b; Winsper et al., 2020). Health practitioners need to support tangata whai ora to identify their own health needs and goals in terms of care planning and treatment, including supporting informed choices, holistic

and cultural approaches to assessments and assessment tools, strengths-based interactions, and clear pathways to peer support.

2.10 Recommendations and implications for practice

If we are to make future changes to our health system that aim to improve health equity of outcomes, access to services and sustainable quality care, then co-design and a cultural methodology needs to be considered as a theoretical framework for change as outlined in the literature. Co-design and cultural methodology align with the recovery model and focus on principles of empowerment, participation and self-determination which are congruent with Te Tiriti o Waitangi obligations. There is a clear need for Aotearoa to consider utilising the concept of integrated models of care in terms of service provision and the development of assessment frameworks and assessment tools. Especially in terms of the integration of Māori models and social determinants of care which have capacity to be founded on the principles of the recovery model. This would include services being explicit in how they meet our obligations under Te Tiriti o Waitangi, including Māori workforce, Tino Rangatiratanga - Māori governance and Māori rights. It would also include the formulation of culturally inclusive assessment tools, treatments / interventions tailored to provide holistic care to the whole person including whānau, and the community rather than continuing to utilise frameworks which meets Governmental and service specific targets.

There is also a need for future research in terms of specifically understanding how Aotearoa employs the recovery principles within not only service provision but also within the assessment frameworks we utilise to identify current levels of wellness, risk factors, consideration of cultural components and formulation of recovery goals and health needs. There is significant opportunity for transformational change in terms of design, delivery, and service provision if it was done in co-design with tangata whai ora, whānau, Māori, and Iwi. There would need to be a readiness from

mainstream services to challenge our current restrictive practices, clinical processes, key performance indicators and cultural norms to ensure we were more open to the cultural components that should be considered.

If we are to consider this in the Aotearoa context, then this would include Māori providing governance and insight into the establishment of Māori and mainstream services health whilst recognising that the MOH has an integral leadership role in enabling Māori to have healthy futures. There are clear recommendations that MHAS need to support recovery-oriented practice by having systems and practices that are conducive to recovery-oriented care. Clinical processes need to adapt to the needs of the people and not the needs of the service, including policy, quality improvement, education, workforce planning and service provision therefore there is immense opportunity for change within the MHAS sector.

The second part of this paper will comprise of a project which will aim to co- design and produce an integrated cultural screening tool for tangata whai ora and whānau that is appropriate for the Aotearoa context, upholds Te Tiriti obligations and is based on the best available evidence.

2.11 Conclusion

In conclusion co-design is a framework that would assist with transformational change by utilising the experiences of tangata whai ora's experiences of MHAS services, recovery, cultural inclusion, and service provision to inform quality improvement and service design. The evidence indicates that current assessment and assessment tools in Aotearoa do not consistently reflect a recovery or partnership approach in terms of cultural inclusivity and Te Tiriti o Waitangi, however there is opportunity for change. Moving forward MHAS need to demonstrate a readiness to challenge the current restrictive practices that we employ within our clinical processes and start to challenge the fundamental cultural norms that we let underpin

service provision. This needs to be a bottom-up process based on our understanding of what the needs of our people / tangata whenua are from the people themselves. Change and implementation to service provision can then finally occur in a manner that is intended for and reflects what is best for the people by the people.

3. Introduction to the clinical project: Co-design of a MHAS cultural screening tool for use in Aotearoa

Throughout the years, significant changes have been achieved in terms of service provision for MHAS in Aotearoa (Cunningham et al., 2018; Government Inquiry into Mental Health and Addiction, 2018; Mental Health Commission, 1998, 2007b, 2012; MOH, 2001, 2021; Ministry of Social Development, 2019). This has included services undergoing several significant Government reviews, experiencing considerable changes to models of care including deinstitutionalisation and significant shifts in terms of tangata whai ora participation, recovery focused care and co-design (Manatū Hauora Ministry of Health, 2018; MOH, 2001, 2006, 2010, 2021; Rapp & Goscha, 2012). Yet the evidence continues to signify that current clinical assessments and assessment tools in Aotearoa do not consistently reflect that MHAS are incorporating recovery-based principles, partnership approaches in terms of cultural inclusivity and Te Tiriti o Waitangi obligations, with Māori continuing to experience health related disparities (Baxter, 2008; Durie, 2011; Harris et al., 2006; Kingi et al., 2017; MOH, 2001, 2002; Oakley Brown et al., 2006; D. Smith, 2019; Whitley, 2009).

MHAS must embark on a paradigm shift and systems redesign to ensure that service provision is focused on embedding the principles of Te Tiriti o Waitangi including Tino Rangatiratanga, equity, active protection, options, and partnership as the foundation for change and delivery of healthcare (Durie &

Kingi, 1997; Maori Health Commission, 1998; Mental Health Commission, 2004; Morrison-Valfre, 2017; Rapp & Goscha, 2012). The principles of Te Tiriti o Waitangi, as conveyed by the Waitangi Tribunal and courts, provide the framework for how we as healthcare professionals and health services will meet our constitutional obligations under Te Tiriti o Waitangi in our everyday practice (Henare, 1990; Kingi et al., 2017; Morgan, 1995; Waitangi Tribunal, 2013). This includes utilising Te Tiriti o Waitangi principles to underpin pro-equity practices embracing Te Ao Māori and principles of hauora Māori, including whānau centeredness, holistic wellbeing and whānau ora to enable health professionals to better understand individual and whānau experiences and pathways to wellness (Durie & Kingi, 1997; Maori Health Commission, 1998; Mental Health Commission, 2004; MOH, 2020d; Morrison-Valfre, 2017; Rapp & Goscha, 2012; Waitangi Tribunal, 2019b).

This is particularly evident in the MOH's most recent review of MHAS, He Ara Oranga: report of the Government Inquiry into mental health and addiction services (Government Inquiry into Mental Health and Addiction, 2018; Mental Health and Addiction Inquiry, 2018). This report and several other recent documents summarised that of most importance to Māori, was for the recognition of intergenerational deprivation and cultural isolation when considering service recommendations (Harris et al., 2006; King & Turia, 2002; Kingi et al., 2017; Mental Health and Addiction Inquiry, 2018; MOH, 2001, 2002, 2020d, 2021; Nursing Council of New Zealand, 2011). There has been significant emphasis placed on service provision and clinical approaches being inclusive of holistic methodologies and incorporating Te Ao Māori world views which emphasise ties and connections to whānau, hapū and iwi (Baxter, 2008; Durie, 2001, 2011; McKellar & Rodrigues, 2017; MOH, 2001, 2002, 2020d; Morgan, 1995; Palmer, 2004). He Korowai Oranga: Māori Health Strategy (MOH, 2001), and Whakamaua: Māori Health Action Plan 2020-2025 (MOH, 2020d) provide the strategic direction for Māori health development across the health and disability system with the intention of ensuring health and wellbeing for all Māori. Both documents argue that Māori governance and

leadership, prioritisation of Māori workforce development, system reform and participation in health care provision is of some urgency if health is to prioritise improving Māori mental wellbeing (MOH, 2001, 2020d). Priority actions for the health and disability systemof Aotearoa continue to echo the need for services to empower Māori in exercising authority over the health and wellbeing of their whānau, hapū and iwi, supporting Māori to thrive and prosper as Māori (Kingi et al., 2017; MOH, 2001, 2020d, 2021).

Co-design within the context of this current project, will allow Whanganui MHAS to position current service delivery to also include the cultural wellbeing of the tangata whai ora and their whānau that we are working with in secondary services. This would ensure that services worked within a whānau ora and pae ora approach supporting tangata whai ora and whānau wellbeing, cultural identity, and relationships within the context of their engagement with the service. Opportunities for reflection and adaptation will be utilised as part of the co-design process to ensure that during the trial, implementation, and evaluation phase of embedding this tool all aspects of the tool fit with the needs of tangata whai ora, family and whānau. When developing an integrated cultural screening tool to better identify, integrate and address issues of cultural identity, connection, equity, and connection for whānau, hapū and iwi in Whanganui, it was essential that a co-design methodology was used whilst employing a Te Ao Māori lens that is specific to the Whanganui rohe.

MHAS need to actively engage in changes to current practices which continue to restrict health professional's ability to challenge the fundamental norms that underpin service provision for Māori and perpetuate poor health outcomes (Kingi et al., 2017; MOH, 2001, 2020b, 2020d, 2021; Te Ao Māramatanga, 2015). It is essential that this process is a bottom-up process based through working with Māori to understand what the needs of tangata whenua are from the people themselves (Durie, 2001, 2011; Gunther, 2011; Kingi et al., 2017; MOH, 2020c, 2020d, 2021; Morgan, 1995). Services need

to support the acceleration and development of Kaupapa Māori and whānau centred services and tools which reinforce prioritising the immediate and long-term needs of tangata whai ora, whānau, hapū and iwi whilst maintaining connection, self-determination, and a sense of agency (Durie, 1994, 2011; King & Turia, 2002; Kingi et al., 2017; MOH, 2020b, 2020c, 2021). If models of care and clinical tools are developed using a Te Ao Māori approach, then change and implementation to service provision can subsequently occur in a way which service provision truly reflects the needs of Māori as identified by Māori (Durie, 1994; King & Turia, 2002; Kingi et al., 2017; MOH, 2020c, 2020d). The second part of this thesis is a clinical project aimed to begin to address the issues highlighted in the previous sections. The objectives of the clinical project undertaken were to co-design a MHAS screening tool for use in the Whanganui region of Aotearoa, trial it in a small pilot study and offer ideas for future research and development.

4. Background to the clinical project

Data from the MOH and Census 2018 (Statistics New Zealand, 2019; Whanganui District Health Board, 2020) estimates that the Whanganui rohe population data is broken-down into Whanganui city which has an approximate population of 46,944 and Marton, with an approximate population of 5268. These two major centres of the Whanganui rohe are further supported by five smaller towns with a population less than 2000 – Waiouru 765, Taihape 1716, Bulls 1935, Ohakune 1182 and Raetihi 1038 (Statistics New Zealand, 2019; Whanganui District Health Board, 2020). The population of Whanganui is characterised by a large percentage of Māori at 27 percent of our population, compared to the New Zealand average of 15.7 percent (Statistics New Zealand, 2019; Whanganui District Health Board, 2020). the Whanganui rohe is also home to a higher percentage of children and young people, with 20.2 percent under 15 years of age, of which 43 percent are of Māori ethnicity, this reflects the younger Māori population of

our rohe compared to the rest of the country (Statistics New Zealand, 2019; Whanganui District Health Board, 2020). Our district's high level of deprivation is the biggest factor in the health of the district as there is a direct link between socio-economic status and health, the impact on the district's overall health is significant (Statistics New Zealand, 2019; Whanganui District Health Board, 2020). We are a district of high overall deprivation with 34.8 percent of our population lives in deciles 1 and 2, and this percentage increases to 53.3 percent for Māori in our region (Statistics New Zealand, 2019; Whanganui District Health Board, 2020). Local data and reports show that Māori are overrepresented in the space of justice, mental health, family violence, alcohol and drugs, and suicide in the Whanganui rohe (Government Inquiry into Mental Health and Addiction, 2018; Knight, Krishnan, & Bissielo, 2016; Whanganui District Health Board, 2020).

My current area of speciality is Adult CMHAS which covers specialist MHAS targeted at those most severely affected by mental illness or addiction. Secondary community services comprise of general adult mental health; including follow up for those under the MHA (MOH, 2020a), addiction services, Opioid Substitution Treatment (OST), urgent response to mental health crisis, eating disorder and older persons services. The wider MHAS at WDHB also include Adult Psychiatric Inpatient Unit, Extended Term Regional Medium Secure Forensic Service, and Maternal Infant Child and Adolescent Mental Health and Addictions Service (MICAMHAS) which includes maternal mental health, youth mental health and alcohol and/or drug use and urgent assessment during work hours.

On the 30th of November 2021 the WDHB reporting server, a server-based report generating software system used by WDHB indicated, secondary CMHAS (urban and rural) had a total of 771 active cases open to adult mental health and a total of 327 active cases open to adult addiction services. MICAMHAS had a total of 329 active cases open to youth mental health and / or addiction aged 18 or under. There was a total of 109 people being nursed

on the MHA under compulsory treatment with 50.4 percent of these people identifying as Māori. Unfortunately, not all ethnicity data was available for all current active cases on this day as reporting only included new cases opened during an identified timeframe and not existing cases already open by ethnicity.

MHAS remain under significant pressure in respect to caseloads and ongoing high referral rates into secondary services which are anecdotally reported as having increasing acuity and complexity. Local services continue to experience recruitment difficulties across the secondary and primary health continuum. In secondary MHAS this includes long-term/hard to recruit vacancies for psychology, mental health and addiction clinicians, alcohol and other drug clinicians and occupational therapists. MHAS observed post two COVID-19 lockdown periods in the Whanganui rohe with a considerable increase in mental health and addiction presentations and secondary service referrals which may be linked to the long-term effects of the pandemic. Along with increasing anxiety there was an increase in the need for addictions and detox services, crisis response, psychiatric inpatient unit occupancy, respite, level 4 supported accommodation (24hour care), and an increase in domestic violence, and homelessness. Nationally that the pandemic has had a significant impact on the mental wellbeing of our communities and Māori (MOH, 2020b).

The principles of Te Tiriti o Waitangi guarantee that Māori are given the right to participate and determine system design, delivery, evaluation and service provision across health and disability services to ensure equitable health outcomes and services which are responsive to Māori's needs and aspirations (MOH, 2020c, 2020d; Reid, 2017; Waitangi Tribunal, 2019b; Williams, 2007). There are currently several initiatives underway in the Whanganui rohe that are looking at local MHAS provision with an explicit focus on equity for Māori and population wellbeing all of which are underpinned by Te Tiriti o Waitangi. The MOH has recently provided funding to the WDHB for the Whanganui rōhe

mental health and addictions collaborative redesign over this financial year, 2021/2022. This work is being backboned by Healthy Families Whanganui, Rangitikei and Ruapehu (Healthy Families WRR). It will extend on the Growing Collective Wellbeing egional suicide prevention strategy they also backboned in 2020, and will use a transformative change approach to collaborative design, elevating whānau voice, focussed on prevention, wellbeing and equity (Healthy families Whanganui Rangitīkei Ruapehu, 2020, 2021). The Mental health and addictions collaborative redesign work is the opportunity to transform existing services and encompasses all ages and all stages of mental health and wellbeing in the rohe, and is identified as one of the initiatives in the phase one traction plan for the Growing Collective Wellbeing regional suicide prevention strategy (Healthy Families Whanganui Rangitīkei Ruapehu, 2021). It is a partnership with Iwi, reflecting Te Tiriti o Waitangi and has a people-powered focus ensuring work is guided by the local people using services, their whānau, other community members and by the changes signalled in He Ara Oranga and the feedback on Kia Manawanui: Long Term Mental Wellbeing Pathway (Government Inquiry into Mental Health and Addiction, 2018; Healthy families Whanganui Rangitīkei Ruapehu, 2020, 2021; MOH, 2021). This new approach moves the Whanganui rohe towards a community wide response that requires a multilevel and systemic changes to grow collective wellbeing (Healthy Families Whanganui Rangitīkei Ruapehu, 2021).

Te Manawanui Aotearoa – Long-term pathway to mental wellbeing and He Ara Oranga: Report of government inquiry into mental health and addiction require services to both build on the strengths of our existing systems and services and to create new and different approaches to supporting mental wellbeing (Government Inquiry into Mental Health and Addiction, 2018; MOH, 2021). Services need to be committed to building the social, cultural, environmental, and economic foundations for mental wellbeing, whilst ensuring individuals, whānau and communities are equipped to strengthen their own mental wellbeing and support the wellbeing of others, especially in

the midst of the pandemic (Government Inquiry into Mental Health and Addiction, 2018; MOH, 2020b, 2020d, 2021). Te Manawanui Aotearoa provides a 10 year action plan which focusses on continued expansion of access to mental wellbeing support, ensuring our work is grounded in Te Tiriti o Waitangi and equity, is inclusive of disability and ensures our approach is flexible and adaptive so that changes are sustainable (MOH, 2021). It also aligns with Whakamaua: Māori Health Action Plan 2020-2025 moving the health and disability system towards being fair and sustainable while delivering equitable outcomes for Māori, and towards the achievement of Pae Ora – healthy futures for Māori (MOH, 2020c, 2020d). These strategies outline the importance of services being culturally competent and able to provide culturally appropriate service to tangata whai ora and whānau, therefore the development of a co-designed MHAS screening tool was necessary to help reduce inequities within the current system in the Whanganui rōhe.

5. Proposal for developing a culturally appropriate screening tool

Wairuatanga (spiritual wellbeing) and cultural wellbeing are both strongly connected to a person's physical and mental wellness and overall health, including their spiritual connection with the land, and connections to whānau, iwi and hapū (Baxter, 2008; Chant, 2011a; Durie, 1994; Kingi et al., 2017; Pere, 2006). If we considered Māori health pre colonisation and looked to utilise the key principles of how Māori live, connect, and engage then we may be able to identify opportunities that may address some of the challenges in the current inequity of outcomes (Durie, 1994, 2001; Kingi et al., 2017; MOH, 2020c, 2020d; Pere, 2006). Acknowledging the whole person, their beliefs and spirituality as part of clinical and non-clinical practice and giving choice and fostering collaboration in terms of identifying and working through health care needs can only but improve connectedness between tangata whai ora and healthcare professionals (Chant, 2011a; Durie, 1994; Kingi et al., 2017;

MOH, 2002, 2020c, 2020d). This can only be done by acknowledging all aspects of a person's wellbeing which for Māori is inclusive of their cultural and spiritual wellbeing (Chant, 2011a; Durie, 1994; Kingi et al., 2017; MOH, 2002, 2020c, 2020d; Pere, 2006). The need for whakawhanaungatanga (relationship or sense of family connection) is extremely important in Māori culture, as it leads to relationship development through shared connectedness to land, hapū and iwi (Baxter, 2008; Chant, 2011a; Durie, 1994; Kingi et al., 2017).

The Government has identified that Te Tiriti o Waitangi principles, equity and access must be the foundations of any model of care changes to service provision moving forward (Elkington et al., 2020; Government Inquiry into Mental Health and Addiction, 2018; MOH, 2002, 2020c, 2020d, 2021). The principles of tino rangatiratanga, equity, active protection, options, and partnership are fundamental in ensuring that Māori have sovereignty and self-determination in the delivery and design of all health care services, including the delivery of services in a culturally appropriate manner that supports and appreciates the use of Te Ao Māori models of healthcare (Durie, 1994; Henare, 1990; Kingi et al., 2017; Mental Health Foundation, 1992; MOH, 2020c, 2020d; Reid, 2017; Smith et al., 2019). Māori have the right to determine and manage the health of themselves and their whānau by exercising autonomy and expertise over any decision pertaining to their healthcare and overall wellbeing (Durie, 1994, 2001; Elkington et al., 2020; MOH, 2001, 2020c; Pere, 2006; Waitangi Tribunal, 2019a). This includes having the right to control over their own tikanga, knowledge and customs, and to be offered services which work together in partnership to prioritise and preserve the health of Māori through better health outcomes and equitable access (Elkington et al., 2020; Government Inquiry into Mental Health and Addiction, 2018; MOH, 2002, 2020c, 2020d, 2021). Protecting the health status of Māori is imperative and approaches need to be flexible and adaptive and embedded throughout Aotearoa's health and disability system so that any changes both short term and long term are sustainable (Durie, 1994;

Government Inquiry into Mental Health and Addiction, 2018; Kingi et al., 2017; MOH, 2020d, 2021; Whanganui District Health Board, 2020).

At a local level, the WDHB organisational strategy, He Hāpori Ora Thriving Communities, identifies WDHB services commitment to achieving equity and access, particularly for Māori (Whanganui District Health Board, 2020). This includes working closely with iwi and our community partners in care in a social governance model to enable individuals, whānau and communities to be healthy at home (Whanganui District Health Board, 2020). The strategy outlines how collectively services will work together to build resilient communities whilst empowering whānau and individuals to determine their own health and wellbeing (Whanganui District Health Board, 2020). The WDHB annual plan 2020/21 supports and provides a framework for the planning, purchasing and delivery of health services in the WDHB district area to improve Māori health outcomes and reduce inequalities in the Whanganui rohe (Whanganui District Health Board, 2020). Key stakeholder and health providers including iwi health provider organisations, primary health organisations (PHOs) and mainstream primary and secondary health services have been consulted and contributed towards the development of the WDHB annual plan and organisational strategy (Whanganui District Health Board, 2020).

Therefore, as noted in the introduction there was an opportunity and need for services to consider co-designing and developing of an integrated cultural screening tool for tangata whai ora and whānau to ensure that we as healthcare professionals are upholding our Te Tiriti o Waitangi obligations and meeting the cultural needs of those engaging in services. In doing so, there is a move towards working in partnership with Māori to identify, integrate and address issues of identity, connection, equity, and connection for whānau, hapū and iwi (Government Inquiry into Mental Health and Addiction, 2018; MOH, 2020c, 2020d, 2021; Whanganui District Health Board, 2020). It is hoped that the cultural screening tool will work to prioritise the importance of

whānau, iwi and hapū connections and accentuate the use of shared values and belief systems including tikanga and Kaupapa Māori health practices within a predominantly westernised health care system (Durie, 1994; Kingi et al., 2017; Smith et al., 2019). A focus on a hauora, a Māori view of wellbeing a including physical, psychological, social and spiritual aspects, would encourage health professionals to engage on all aspects of health including the social determinants of health, which has synergy with Māori traditional models of health and wellbeing (Baxter, 2008; Chant, 2011a; Durie, 1994; Kingi et al., 2017). It will also importantly enable Māori to have ownership over their own health by providing them with the right information, access to tools, supports, resources and services that may alongside what they already use as Māori to stay well (Baxter, 2008; Chant, 2011a; Durie, 1994; Kingi et al., 2017).

In terms of obtaining approval for this service improvement project, a localities agreement was acquired and signed with WDHB Kaiuringi Māori Health & Equity Service manager for Māori health and equity and the Chief Allied Professions Officer, Kaiuringi Primary and Community Services, who is the leadership manager responsible for CMHAS. This has secured WDHB investment in implementation of a cultural screening tool across MHAS and the wider hospital services at an executive level. The WDHB organisational strategy and the annual plan both align with and support the development and implementation of a culturally inclusive screening tool for Māori engaging in MHAS in the Whanganui rohe. Although this project presented in thesis is specific to the WDHB CMHAS (the initial trial, evaluation, and rollout of screening tool), the overall goal would be that the cultural screening tool will be implemented for use across all services at the WDHB to ensure equity and access to consistent and targeted cultural screening for Māori by all services.

6. Target population

The intended target population for the clinical project was tangata whai ora and if identified, their whānau, who were engaged with adult secondary MHAS and who identify as Māori. Service provision for Whanganui CMHAS is for adults 18 years and over, therefore minors or persons from other services were not included in the initial rollout of the cultural screening tool. Rollout to the rest of WDHB MHAS services (inpatient unit, forensic unit and MICAMHAS) and the wider hospital would be considered later once the screening tool has been trialled, reviewed, and adapted with any identified improvements where necessary.

It is anticipated that in subsequent research, that health professionals working in secondary CMHAS will utilise the cultural screening tool as part of their clinical assessment process. It is envisaged that this group will receive in-service training prior to implementation of the cultural screening tool and be involved in the trial and review stages of implementation to ensure they are included in identifying any improvements. Wider hospital rollout would include in-service training for all WDHB clinical and non-clinical clinicians who may be utilising the tool as part of their roles.

7. Methodology

The aim of this clinical project was to co-design a cultural screening tool together with Māori and WDHB MHAS staff with the aim of embedding its use into everyday practice across MHAS and then the wider WDHB services. Co-design and use of a Te Ao Māori lens ensure the incorporation of local Māori tikanga into the development of a cultural screening tool and also that the tool fits with what Māori identify as being important to Māori.

7.1 Co-design

Co-design is a methodology which allows health services and health professionals to work in a manner that places partnership with tangata whai ora, and whānau at the centre of any service planning and quality improvement initiatives (Aitken & Shackleton, 2014; Britton, 2017; DiGioia & Shapiro, 2017). Co-design closely embodies the philosophy of the recovery model by characterising the recovery principles of empowerment, strengths-based care, communication, and collaboration (Aitken & Shackleton, 2014; Gehart, 2012a; Mental Health Commission, 2007a; O'Hagen, 2001; Rapp & Goscha, 2012; Tindall, Ferris, Townsend, Boschert, & Moylan, 2021). It allows health services to understand that recovery is a personal journey which is unique to individuals (Aitken & Shackleton, 2014; DiGioia & Shapiro, 2017; O'Hagen, 2001). It also acknowledges that a person's experience is heavily influenced by their culture, spiritual beliefs, whānau support systems and social determinants (Aitken & Shackleton, 2014; Gehart, 2012a; Mental Health Commission, 2007a; O'Hagen, 2001; Rapp & Goscha, 2012; Mike Slade, Adams, & O'Hagan, 2012). The literature indicates that health services are more likely to improve health outcomes if we move away from medical focussed perspectives and rather invest in quality improvement methodologies and principles such as those derived from co-design and recovery based processes (Aitken & Shackleton, 2014; Cunningham et al., 2018; DiGioia & Shapiro, 2017; Rapp & Goscha, 2012; Slattery et al., 2020; Tindall et al., 2021).

The methodology of co-design allows health to connect with those who are engaged with or impacted by a particular service, giving insight into the person's experiences in order to describe, identify or design solutions to identified problems or issues with care (Aitken & Shackleton, 2014; Britton, 2017; Mark & Hagen, 2020; Tindall et al., 2021). Mark and Hagan who reviewed the literature relating to co-design in Aotearoa New Zealand write that "when led by Māori for Māori as an expression of Te Ao Māori values and tikanga, co-design is seen by some Māori practitioners as representing an opportunity for whānau Māori to participate in mana enhancing ways

and lead change in their own lives" (2020, pp.4-5). Having tangata whai ora, and whānau direct and participate in opportunities for service improvement and delivery of care, ensures self-determination and sovereignty in the improvement of health outcomes directly relating to Māori (Mark & Hagen, 2020; MOH, 2020d). It is well evidenced that Kaupapa Māori models of care significantly improve outcomes for Māori when these approaches are valued and integrated alongside mainstream health care (Chant, 2011b; Mark & Hagen, 2020). This is also heavily supported by the current national, regional, and local mental health and addiction strategies and action plans which highlight services need to work more closely with Māori to enable an integrated and collaborative system which focuses on honouring Te Tiriti o Waitangi and the wellbeing of Māori (Durie, 1996; Government Inquiry into Mental Health and Addiction, 2018; Kingi et al., 2017; MOH, 2020b, 2020d, 2021). The co-design approach supports the principles of Tino rangatiratanga (sovereignty), and Kawanatanga (governance) giving Māori the authority to exercise their rights over the health and wellbeing of their whānau, hapū and iwi whilst supporting more equitable outcomes (Durie, 1994; Mark & Hagen, 2020; MOH, 2020d).

Co-design requires all stakeholders to work in partnership throughout the design process and ensures that the core values of co-design; these being tangata whai ora experience and expertise, are the basis of all improvement projects (Bate & Robert, 2007). Being that a person's environment and social circumstances are significant contributors in being able to develop positive cultural and spiritual wellbeing, sense of self, and the ability to manage adversity, it makes sense that those using the service would be best positioned to design service provision in relation to a cultural screening tool (Gawith & Abrams, 2006; O'Hagen, 2001; Rapp & Goscha, 2012; Sheppard, 1991).

7.2 Te Ao Māori lens

A Te Ao Māori lens allows a world view which acknowledges and represents the collective and individual rights and interests of Māori as tangata whenua (Borell et al., 2020; Ratima et al., 2018). This ensures the beliefs, values and practices of Māori are recognised, safeguarded, supported, and invested in when developing or designing services specific to Māori (Borell et al., 2020; MOH, 2020c, 2020d; Ratima et al., 2018). As an integral part of the research approach, a Te Ao Māori lens recognises and acknowledges the relationships and interconnectedness of all living and non-living things, and this holistic approach allows us to seek to understand the total system and all its intersecting parts rather than individual pieces that don't interconnect (Borell et al., 2020; Ratima et al., 2018). Māori have collective and individual rights and interests, and the government is responsible for ensuring the active partnership with iwi and Māori is supporting sustainable methodologies and service development that reflects those rights and interests (Borell, Rewiri, Barnes, & McCreanor, 2020; Smith et al., 2019).

The WDHB as a government agency is responsible for ensuring the active partnership with whānau, hapū and iwi by supporting sustainable approaches that reduces disparities, improves health outcomes, and protects the rights and interests of all Māori (MOH, 2001, 2020d; Willing et al., 2020). It is well documented that culture can directly influence both negatively and positively the diagnostic outcomes and treatment interventions a person may receive within the health system (Durie, 1994, 2001; MOH, 2001; Stevenson, 2001; Willing et al., 2020). Therefore, recognition of cultural values, beliefs and practices is an essential component at both the assessment and management phase of intervention (Ihimaera, 2003; Pitama et al., 2014; Willing et al., 2020). Failure to consider or include the impact of cultural practices and customs with the clinical setting can often result in misdiagnosis and mismanagement of illness amongst ethnic minorities (Durie, 1994, 1996; MOH, 2020b, 2020d;

Willing et al., 2020). The WDHB is committed to ensuring that the health outcomes experienced by Māori across the rohe promote healthy living, greater life expectancy, and services that are tailored to meet the specific health needs of Māori, their whānau and wider hapū, iwi and community (Healthy Families Whanganui Rangitīkei Ruapehu, 2021; Whanganui District Health Board, 2020). Therefore, it is crucial that secondary specialist services work with Māori and iwi in a way that honours Te Tiriti o Waitangi and supports and values the use of Te Ao Māori models and holistic frameworks to support services to embed beliefs and practices that are integral to Māori well-being (MOH, 2020d; Tracy, Suzanne, Donna, Mauterangimarie, & Cameron, 2020; Whanganui District Health Board, 2020; Willing et al., 2020). It was clear that if services were going to create a cultural screening tool that prioritised the importance of whānau, iwi and hapū connections and accentuate the use of shared values and belief systems including tikanga and Kaupapa Māori health practices then both co-design and a Te Ao Māori lens would be required to ensure the tool was designed using a local Te Ao Māori context.

A secure cultural identity supports and reinforces the principles of recovery which are centred around ensuring connectedness, self-determination, culture, age, beliefs, support networks, and ensuring basic needs across the continuum are met (Durie, 1994, 1996, 2001; Pere, 2006; Rapp & Goscha, 2012; Sewell, 2009). When cultural identity is not prioritised and Te Ao Māori and Mātauranga Māori practices are not prioritised within model of care or clinical practice a tangata whai ora overall wellbeing can be diminished (Durie, 1994, 1996; Ebbett & Clarke, 2010; Pere, 2006; Stevenson, 2001). This can escalate feelings of disconnect and understanding of one's self while increasing the complex circumstances that one may already be experiencing with mental health or addiction issues (Durie, 1994, 1996; Ebbett & Clarke, 2010; Pere, 2006; Stevenson, 2001). MHAS need to consider that for Māori, cultural identity and personal experiences are the foundation of a person's wellbeing (Durie, 1996; Kingi

et al., 2017; Pere, 2006; Pitama et al., 2014; Ratima et al., 2018; Smith et al., 2019; Toki, 2010). It needs to be seen as an essential component of recovery acknowledging that at times the recovery process itself can also contribute to a person enhancing or forming their cultural identity (Durie, 1996; Kingi et al., 2017; Pere, 2006; Pitama et al., 2014; Ratima et al., 2018; Smith et al., 2019; Toki, 2010). It is essential that any culturally based screening tools or measurement tools are developed in co-design with Māori to ensure aspects of tikanga and Māori practices are at the centre of these tools.

8. Ethics

This project was commenced pre-COVID pandemic and was intended to have tangata whai ora and whānau involvement from the beginning of the assessment tool development. The ethics application was prepared to include this. However, with the multiple lockdowns and restrictions placed upon face-to-face meeting with clients and their whānau, this stage was not undertaken for this study. These delays have been protracted across the two and half years since this study commenced. Thus, for the purposes of this thesis, a locality agreement was approved, and a desk audit of the proposed cultural screening tool was undertaken with members of the MHAS as the first stage of development, this included in total of 29 staff over a number of hui, 9 of whom identified as Māori. The co-design process with staff is discussed in the next section of this paper.

Four tangata whai ora that identify as Māori will give initial feedback on the proposed screening tool however the revised intention is to include tangata whai ora and whānau more extensively in the second stage of the assessment tool development as part of the internal quality improvement process of the WDHB. Therefore, actual implementation of the assessment tool will be undertaken within the WDHB and will no longer form part of this study. Massey ethics was notified of this change. In the next section the

methodology is discussed as it will be followed across all the stages of the assessment tool development, addressing this thesis remit, but also continuing beyond it and into its implementation at the WDHB post-master's study.

9. Co-design partners

In co-designing a cultural screening tool to identify the holistic needs of tangata whai ora and as well as reflecting a Te Ao Māori and Whanganui context, it was imperative to involve several key stakeholders as part of the process. These key roles and services would be pivotal in terms of the co-design and implementation phase of this project. Key stakeholders include tangata whai ora, (specifically those who identified as Māori and who were currently utilising secondary MHAS), Executive Lead endorsement, WDHB Māori health and CMHAS leadership working group who would be endorsing and facilitating the co-design of this tool as a WDHB assessment tool, WDHB Māori health workforce, and the CMHAS workforce who would be key to the early implementation and initial trial of the screening tool.

<u>Stage One</u>

- Development of project outline:
    - Action - consultation with academic supervisor to endorse project scope

- Consultation executive manager for CMHAS and Kaiuringi – Māori health and equity services:
    - Action - clinical Project endorsed by senior management team as a quality improvement initiative for CMHT Community MH&AOD services

- Establishment of core leadership team:
    - Action - core leadership team roles identified

- Development and consultation of the assessment tool with Te Hau Ranga Ora Māori Health Service and Māori health and equity team, tangata whai ora and workforce:

- Action - first draft Screening tool established for consultation.

- Development of education plan for the workforce:
  - Action - education plan developed

- Initial presentation to a smaller clinical group was completed to test the efficacy of the education session plan:
  - Action - Seventeen clinicians attended the first test session of the education plan. Feedback informed required changes to education plan.

Stage Two

1) Primary implementation of Te Ao Māori screening tool at CMHAS:
   Action - services to lead the trial, review, and implementation of the screening tool (external to writers' studies) in line with current WDHB quality improvement process.

9.1 Executive lead endorsement

Co-design and implementation of the Te Ao Māori screening tool was endorsed and supported by both the WDHB Kaiuringi Māori Health and Equity Service manager for Māori Health and Equity, and the WDHB Chief Allied Professions Officer - Kaiuringi Primary and Community Services and Executive Lead responsible for CMHAS. Endorsement by both leadership roles was pivotal in securing WDHB investment in the co-design and implementation of a cultural screening tool across MHAS and then later wider hospital services at an executive level. A locality agreement was completed prior to this work commencing (see Appendix A for details).

9.2 Māori health and CMHAS leadership working group

The WDHB Māori health and CMHAS leadership working group who oversighted this project, were fundamental in the planning stages, facilitation

of the co-design sessions, consultation, and the development of the education package and initial training of the Te Ao Māori screening tool.

WDHB Māori health and CMHAS leadership working group:

- Kaitakitaki - Cultural Advisor / Educator Māori Health and Equity,
- Kaitakitaki - Māori Health Workforce, Māori Health, and Equity,
- Haumoana - Māori Health and Equity,
- Clinical Nurse Manager – CMHAS,
- Registered Nurse and Clinical Co-ordinator - CMHAS (researcher/author).

9.3 WDHB Te Hau Ranga Ora Māori Health Service

There were several objectives identified as part of this project, firstly being to design a cultural screening tool in conjunction with Te Hau Ranga Ora Māori Health Service and the local Māori Health and Equity team that fits with Whanganui tikanga. Te Hau Ranga Ora is a WDHB based Māori health service available to all whānau during the day, on call after hours and in the weekends. The team of Haumoana (navigators) are integrated into the health care teams, assist whānau centred care by working alongside clinicians to support and engage with Māori whānau, participate in multidisciplinary teams, discharge planning and work with whānau to advocate, navigate to improve and self-determine their health journey and facilitates links back to services in the community to ensure that whānau are supported when discharged home. Kaumātua and kuia (elders) are also an integral part of the service and provide guidance and support to haumoana, staff and tangata whai ora, as required. Te Hau Ranga Ora Māori Health Services and our Māori Health and Equity team will be essential in terms of ensuring this tool is specific to Whanganui Iwi and rohe.

Tino rangatiratanga, equity, active protection, partnership, and options are the principles outlined in Te Tiriti o Waitangi which also align with the principles and values of the WDHB in terms of service provision and systems improvement. These principles support active and equitable participation in

any service improvement projects across services whilst protecting information, tikanga and beliefs in a culturally safe manner (Hiha, 2016; Hutchings, Potter, & Taupo, 2011; Kingi et al., 2017; Sales & Folkman, 2000). Māori will play a significant role in the development, implementation, and evaluation of this clinical project therefore it is imperative that the WDHB's Māori Health and Equity team are involved to ensure all processes are following tikanga and meet the needs of tangata whenua and Whanganui iwi.

9.4 Tangata whai ora

Essential to the implementation and evaluation of the effectiveness of the cultural screening tool is the partnership with tangata whai ora engaged with MHAS who identify as Māori. It will be tangata whai ora and their whānau who help to build and provide feedback as to how the screening tool is developed, how it translates into practice and whether there will be recommendations for improvements for change during the implementation. Tangata whai ora and whānau involvement ensures that the process to establish this tool is completed by Māori for Māori with Māori, with a Kaupapa Māori lens instead of being created by a healthcare system which is predominantly medico centric (Chant, 2011b; Durie, 1996; Kingi et al., 2017; MOH, 2020d). It was also reiterated that a tangata whai ora perspective would be critical in terms of the trial, refinement, and evaluation of the screening tool during the implementation phase.

9.5 CMHAS workforce

The long-term objective (post completion of project write-up and submission) of this project is to embed the cultural screening tool as 'standard practice' across all services. This would initially include CMHAS and extend to the Mental Health Inpatient Unit, Forensic Unit and MICAMHAS, which combined make up secondary MHAS in Whanganui. The intention would then be that the tool would be further implemented across the wider hospital to include

the general wards, emergency department and outpatient tangata whai ora services.

10. Screening tool design - Stage One

Initially the leadership team looked at how clinicians might capture the narratives they needed from the tangata whai ora and whānau using the frameworks they already had in terms of assessment and screening tools. During each contact clinicians are required to complete a mental state assessment and dependant on risk and presentation, a risk assessment. There was discussion around how clinicians could utilise these clinical frameworks they already used to incorporate in a concept such as Te whare tapa wha, so they could ascertain a history and narrative of the persons while wellbeing including mental, spiritual, physical, and social aspects of where they were at. We needed to allow for tangata whai ora to identify areas within Te Ao Māori that they would like to strengthen or would like help to connect with. On looking at the existing clinical tools already endorsed or being used within the service i.e., risk assessments, comprehensive assessment, and outcome measurement tools HonOs and ADOM, it was clear they were not user friendly or consistent in capturing authentic person-centred information from a cultural perspective. None of these tools offered specific screening or questioning around a person's cultural needs, rather they touched on the question being asked by the person completing the assessment or screening therefore relying on the person to understand the questions that may need to be asked. With no framework or structure in place to support clinicians with cultural screening or questioning, the quality and validity of the information gathered may be inconsistent and disconnected in terms of truly identifying a person's cultural needs.

It was at this point the team brainstormed and formulated some guiding questions, descriptors and rating mechanism for clinicians that would allow a clinician to start considering Te Ao Māori cultural and spiritual aspects of a

person's wellbeing. This initially produced a complex two-page document that clinicians would struggle to incorporate on top of their normal day to day work. The team discussed what key aspects or areas should be included when trying to gather information around a person's connections with the cultural and spirituality and the two-page document was condensed into a smaller one-page framework that asked for the same information but in a more concise way. It also provided a scale mechanism so that at the end of the conversation or screening the tangata whai ora and clinician would have an indication of the strengths someone may have in these key areas or identify areas which they may feel need to be strengthened (identified by the tangata whai ora).

It was decided early on that all key areas would be aligned to the WDHB values as clinicians would be familiar with these as part of their orientation when starting with WDHB or through mandatory training which has been named Hapai Te Hoe. Both trainings and WDHB's He Hāpori ora, thriving community's strategy document (WDHB, 2020), discuss in depth WDHB's guiding values for health care in the Wanganui rohe. Linking these values into the screening tool meant that clinicians were able to understand the importance and intentions behind each key area regardless of whether they understood Te Ao Māori or whether they were Māori or non-Māori as these are taught as part of our organisational values which incorporates Te Tiriti o Waitangi principles.

The Te Ao Māori screening tool aligned with our organisational values of Wairuatanga, Whanaungatanga and Tino rangatiratanga. Each of these principles is outlines below:

Wairuatanga – is distinctive to Māori spirituality and aligns to spiritual wellness, relationships, and beliefs. It also encompasses the spiritual synergy of the collective with which that individual identifies. Wairuatanga is as an essential requirement to health and therefore vital to the wellbeing and

identity of Māori (Berghan et al., 2017; Durie, 1994; Hayward & Wheen, 2004; Reid, 2017; Whanganui District Health Board, 2020).

Whanaungatanga – is centred around the forming and upholding relationships and strengthening the connections between whānau and communities. This value is essential as it is what brings people together and provides the foundation for unity, connection and cohesion within relationships which are central to Māori wellbeing. Knowing who you are and where you belong (Durie, 1994, 2001; Mental Health Foundation, 1992; Waitangi Tribunal, 2019a; Whanganui District Health Board, 2020).

Tino rangatiratanga - is associated with absolute sovereignty, self-determination, leadership, and autonomy to make decisions pertaining to oneself or whānau, iwi and hapū. The value of us overseeing our own destiny with the help of others to get us there (Durie, 1994, 1996; Morgan, 1995; Pack et al., 2016; Whanganui District Health Board, 2020).

Co-design was a key aspect in the process of developing this screening tool. It was at this point the group engaged the wider Te Hau Ranga Ora haumoana team in the space to understand the key areas for the screening tool and contribute to how these may be structured, ease and flow of this tool was a core component of clinicians being able to confidently work through the tool with tangata whai ora. Haumoana were able to look at the tool from several perspectives including a Te Ao Māori lens, from a whānau perspective (several haumoana had whānau previously or currently engaged in secondary MHAS services), from a lived experience perspective and from a professional lens (depending on professional roles i.e., clinical/nonclinical roles). The team were able to speak in this space to identify the key aspects of holistic wellbeing, including cultural, spiritual, physical, mental, and social aspects of wellbeing. The key areas connect and interlink and contribute to overall wellness. For the purpose of the screening tool, they have been defined as the following:

Wairua – Spiritual wellness.

Meaning two waters – bringing two things together our spiritual side with our physical side. Connection, beliefs, and spiritual practices.
It is aligned with the value Wairuatanga.

Wairua – Inner self.

How people feel about themselves or sense of self. This may not be religious, but they may feel a spiritual kinship. In Maoridom if your wairua is not strong you need to find a way to feed it to bring it back up into balance.
It is aligned with the value Wairuatanga.

Whānau, Hapū and Iwi.

Connection and knowledge to one's whānau, hapū and iwi and where they belong. It is aligned with the value Whanaungatanga.

Whānau/Family contact - Whakapapa whānau Kaupapa whānau.

Connection to one's whānau and understanding of one's whakapapa
Whakapapa whānau refers to bloodlines whilst kaupapa whānau refers to those other families that a person may be associated with or deem to be whānau i.e., friends, neighbours, clubs, gangs, groups.
It is aligned with the value Whanaungatanga.

Taha Tinana - Physical aspects of health.

It is aligned with the value Tino Rangatiratanga.

Taha Hinengaro - Health aspects of the mind.

It is aligned with the value Tino Rangatiratanga.

Mātauranga, Te Reo me ona Tikanga – Education.

Refers to the reo (language), the knowledge, the tikanga, and the persons connections to these.

It is aligned with the value Tino Rangatiratanga.
Alongside these key areas sit the indicators that reflect where a tangata whai ora feels they sit in each key area. They offer the opportunity to seek clarity about what each area means to the individual and whether they want cultural support with same. The following terms were identified by Te Hau Ranga Ora team as being fitting in the context of the screening tool.

Whakawai: The person aware but does not practice in these spaces. They are maybe unhappy with themselves in this space or in the process of change. They may feel disconnected or have little understanding or connection in a particular key space. Wellness may be low, or they may be finding that the journey to wellness is slow. In this space if they are not seeking to strengthen the key area referral to haumoana for cultural support is not required.

Whakanoa: knowing that the person has a bit of understanding of who they are. They may have some spiritual belief or affiliation with groups but may not be practicing. They are open to or are considering change in this space and becoming more connected with a particular key area. Wellness may be present however some more healing may be required. In this space a person may want to or is seeking to have a better understanding or connection culturally. They may need some help navigating this and request referral through to haumoana for cultural support with same.

Whakawātea: The individual is in a space where they feel good or ok. They know who they are and where they belong. They have the connections, tikanga, karakia, knowledge in this space to actively be engaged or connected. There is no predisposing risk factors health wise both physically or mentally and the person is maintaining wellness. They need the support from health services, but they don't need or require and support culturally within the key area being discussed.

Throughout the co-design process there were several key areas of recommendations noted by the Te Hau Ranga Ora team including:

- Changing the name of tool to remove "cultural" and to name as Te Ao Māori Screening tool.
- Reviewing descriptors and screening process - removing a point rating scale (i.e., rating 1 = no connection to key areas to 5 = well connected in key areas) and shifting this instead to a wellness focus using the key terms Whakawai, Whakanoa and Whakawātea.

Identifying the referral process for haumoana support once the screening tool was completed and discussions with the leadership group and Te Hau Ranga Ora around the outcome of screenings including the referral process. From these conversations it was decided that the simplest way for clinicians to action a referral was once the screening tool was completed and a referral indicated that clinicians completing the screening would peer review with one of the Te Hau Ranga Ora haumoana working with CMHAS. This may result in the haumoana working with an individual or whānau to either further explore the persons cultural needs are, they work alongside the person or the whānau to build connections and knowledge in theses space or they may refer the person or the whānau through to other services or supports. If the tangata whai ora was not going to remain open to secondary MHAS, then they would be referred to services in the community.

Once the initial concept of the screening tool was developed it was important to then sit down with tangata whai ora to see if they felt the screening tool was reflective to what they viewed as being important in the context of being Māori. Due to Covid-19 restrictions and time limitations the researcher was unable to engage wider community co-design with Māori as part of the initial design process for a draft cultural screening tool. However, due to the screening tool being specific to Māori, it is WDHB's process to include Māori health and equity lens to any quality improvement projects including consultation with Māori as per the WDHB codesign process. Four tangata whai

ora who were currently engaged with CMHAS, and who identified as Māori were asked if they would like the opportunity to verbally reflect on the draft cultural screening tool, to which they agreed. All four spoke into their thoughts around the cultural screening tool without questioning or prompting from the researcher to allow narrative without bias to be obtained, this was done face to face and in an informal environment as requested by the four that provided feedback. Key points were noted and clarified by the researcher throughout the conversations to capture voice and narrative. Two tangata whai ora identified themselves as having a secure cultural identity and connection to their whakapapa, iwi and hapū. One was currently on the journey of self-discovery in terms of their whakapapa and what it meant for them to be Māori, and one identified as Māori but was not currently engaged in who they were or where they fit in being Māori. All four identified from the outset that the process of completing the screening tool would need to be flexible and fluid in nature allowing them to complete it as a narrative rather than a yes / no tick box scenario. It was important to them that clinicians recognised if they were completing the screening tool with Māori then they would also need to prioritise the time and allow for whakawhanaungatanga (getting to know each other, building the relationship) before completing the screening tool. Building rapport and connection prior to tangata whai ora sharing their stories would be an essential part of this process. It was also important to them that clinicians recognised that the screening tool may not be completed in one session but rather over a period of sessions, and that for some they may want their whānau or support persons involved.

All four tangata whai ora felt the screening tool flowed well in terms of the key areas of conversation and three felt as though the key areas identified within the screening tool covered aspects deemed to be important to them as Māori. Three of the tangata whai ora felt the screening tool was a visually easy to look at and interpret, they saw benefit in clinicians being able to sit down with tangata whai ora and whānau and work through the tool both visually and verbally so that those involved had points for discussion and

narratives. They felt the three indicators were simple and acknowledged well the three spaces a person may sit in terms of their connection to their culture. For the tangata whai ora who identified as not currently being connected to their whakapapa, they felt being able to visually see the key areas on the screening tool would allow them to still sit down and talk through each section with prompting around discussion.

There was concern from the group that some clinicians may find the cultural screening tool hard to work their way through if they did not have a good grounding our understanding in Te Ao Māori concepts. They wondered if this may limit some clinicians in terms of using the tool with Māori if they were not feeling confident in doing so. There were discussions where the group identified the importance of having Te Hau Ranga Ora haumoana available to assist with completing of the screening tool if clinicians did not feel confident to do so themselves so that the essence of the tool was not diminished. It was also important to them that if they did not feel the clinician was the right person to complete the screening tool with them that they were able to ask for one of the haumoana or a Māori health professional who understood Te Ao Māori to do it with them instead. They identified this needs to be a flexible and easy process so that Māori did not feel intimidated or worried about the power dynamics of the tangata whai ora/clinician relationship or possible negative consequences of having asked for another person to complete the screening tool with them. The two tangata whai ora who identified as having a secure cultural identify and connection to Te Ao Māori identified that perhaps there was opportunity in this space for them to help navigate and educate the clinicians on what it meant to them to be Māori as part of the process of completing the tool. They felt that clinicians may benefit from their expertise in this space as an opportunity for learning, however acknowledged that for some it may not.

Equally on several occasions it was identified by two of the tangata whai ora the importance of them being able to own the information that they had given

services by being able to take a copy of the screening tool home with them. Both felt that often when it came to health services that they were not privy to their information and had no ownership or sovereignty of information shared with health professionals that they deemed important to them. All four queried where this information would be kept and who would have access to it. It was discussed that the intention was that the screening tool will be uploaded into the tangata whai ora patient file and shared with the tangata whai ora so that they and clinicians can follow the person's journey during their time of engagement with services. This included tangata whai ora having a copy of the information gathered as part of the screening and then them determining whether or not they wanted any support or input from haumoana or other appropriate persons across any of the areas. All agreed that too often decisions were not made in partnership with tangata whai ora which often led to distrust in health services. All tangata whai ora were in agreeance of the importance of having a cultural screening tool available to tangata whai ora engaged with secondary services as long as it was completed in a meaningful and well-intentioned manner. There were no suggestions around the current content or layout of the screening tool, and all agreed that a two-month trial should occur with the view to review any feedback or suggestions once the screening tool had been trialled with a larger group of tangata whai ora and whānau. All four were happy to be involved in any discussions or further co-design on the screening tool once the initial trial had been completed. A draft document of the screening tool was formatted as a draft for use.

Draft Te Ao Māori screening tool:

TE AO MĀORI – Screening Form

NAME NHI AGE GENDER DATE

	WHAKAWAI	WHAKANOA	WHAKAWĀTEA	COMMENTS
Wairua *Spiritual Wellness* *Value: Wairuatanga*	Is aware and does not practice No belonging not against	Has belief and not practicing Belongs but does not attend	Practices spirituality Karakia, Ruruku, Attends church	
Wairua *Inner self* *Value: Wairuatanga*	Unhappy with self In process of change	Considering a change Open to change	Content and happy with self Maintaining Wairuatanga	
Whānau, Hapū and Iwi *Value: Whanaungatanga*	Unsure of Whānau, Hapū, Iwi Very little or No Connection	Knows some of Whānau, Hapū, Iwi Wants to know connection	Knows Whānau, Hapū, Iwi Knows and connected	
Whānau/Family contact *Whakapapa whānau* *Kaupapa whānau* *Value: Whanaungatanga*	Whānau/Family disconnected Very little to no contact	Some Whānau/Family connection Irregular contact	Whānau/Family connected Regular contact with Whānau/family	
Tinana Health *Physical aspects of health* *Value: Tino Rangatiratanga*	Wellness is low Journey to wellness is slow	Wellness is present however healing required Moving into wellness	No predisposing risk factors Maintaining Wellness	
Hinengaro Health *Health aspects of the mind* *Value: Tino Rangatiratanga*	Wellness is low Journey to wellness is slow	Wellness is present however healing required Moving into wellness	No predisposing risk factors Maintaining Wellness	
Mātauranga, Te Reo me ona Tikanga *Education* *Value: Tino Rangatiratanga*	Very little or no understanding Disconnected	Has some understanding Wants to connect	Understanding Content	

11. Primary implementation of Te Ao Māori screening tool at CMHAS

It is envisioned that once the Te Ao Māori screening tool has been trialled by CMHAS and reviewed for any changes, it will be submitted to the WDHB form committee for sign off and actioned through People and Performance (Human Resources), and the Executive Leadership team as part of all WDHB clinician mandatory training and orientation process.

The education plan (utilising the WDHB education plan template) and Te Ao Māori screening tool has been developed as a draft. The trial, review, and implementation aspect of this project, will be completed by the leadership team and Māori health services and will follow normal WDHB process for quality improvement at a later date. Once the trial is completed a review with tangata whai ora, clinicians and the Te Ranga Ora Māori services will be

completed to identify any areas that may need to be adapted or improved to ensure that the screening tool is meeting the needs of tangata whai ora and their whānau and is aligned the Te Tiriti principles and values of WDHB. This will include reviewing the pathway for referral for cultural input and follow up so that pathways to cultural support when indicated are consistent and responsive to the needs of those using the service.

If a second round of change is required, then this will be completed with further review before the Te Ao Māori screening tool is rolled out to the wider MHAS. As indicated previously it is then envisioned this screening tool will be adopted by the wider WDHB including the mandatory training schedule and orientation for new clinicians so that we are using one tool consistently across services.

11.1 Education sessions for clinicians

To follow is the education plan that was trialled using the draft screening tool. The evaluation of the education session is presented in the next section.

Education Session Plan: (see Appendix B for details).
Te Ao Māori Screening tool and referral pathways to Haumoana service

Session outline:

1. Open with karakia
2. Introductions/whakawhanaugatanga
3. Intro to Te Ranga Ora Māori services
4. Copies of screening tool
5. Background and purpose of the Te Ao Māori screening tool, including translation of the Māori kupu (words), local narrative and tikanga which informed how the tool was developed.
6. Using the screening tool. Who, when, and why should the tool be used?
7. Evaluating the screening tool, providing feedback, and deciding whether to refer.

8. The referral process including estimated response time and face to face contact with Haumoana.

Presenters: Haumoana
Length of session: 1 hour
Audience: WDHB clinicians, up to 10 - 15 people per session.

11.2 Initial evaluation and feedback of clinician's education sessions

An initial presentation to a smaller clinician group was completed to test the efficacy of the education session plan including identifying any opportunities for improvement, identified areas that would need more explanation or kōrero, and to ensure that discussion around kupu/words and their meanings were well understood by the participants. For clinicians to be able to meaningfully use the Te Ao Māori screening tool they would need to understand the values underpinning the tool and the meaning behind the kupu chosen within a Whanganui Māori context.

Seventeen clinicians attended this session based on the session plan outlined above. The group was a mixture of clinicians working in both urban and rural MHAS, and was made up of Registered Nurses, Dapaanz registered addiction clinicians (Dapaanz – the addiction practitioners association of Aotearoa NZ), psychologists and social workers. Of the 17 clinicians who attended, nine completed the provided feedback from (form is a standardised form used at WDHB). The feedback form (see Appendix C for details) included four questions (rating scales, thoroughly agree, agree, neutral, disagree), and two questions with the opportunity to provide written feedback. All feedback received is presented in the tables below:

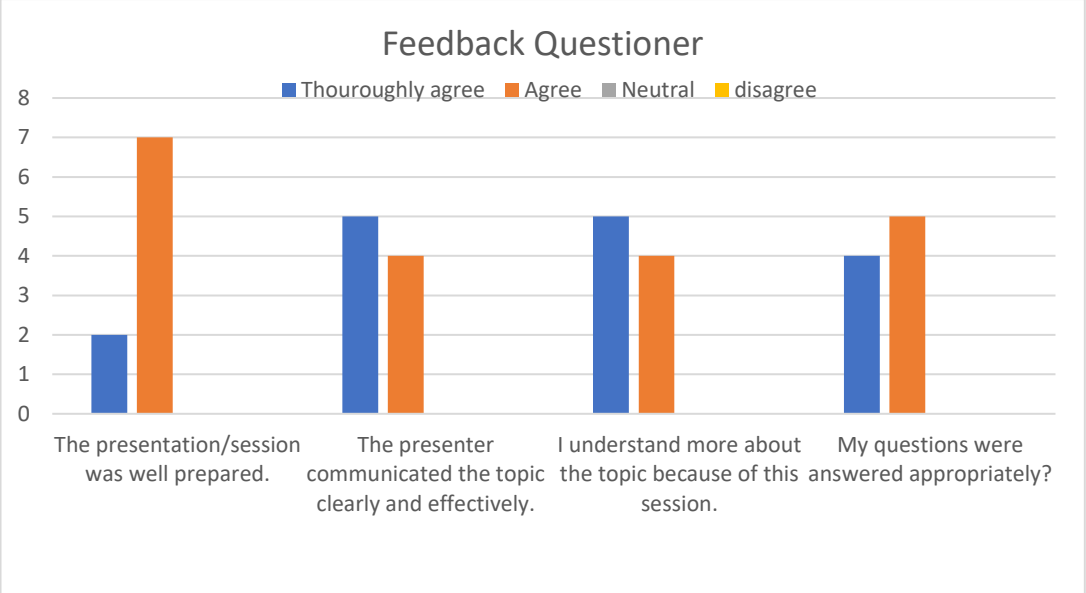


Table 1: *Evaluation and feedback form responses*

How did this education session enhance your knowledge and skills?
• Clear expectations given, good refresher of DHB values. • Made me aware of the need to bring down barriers • Gained knowledge of meaning of some key words such as Tino rangatiratanga, wairuatanga and tinana.

Table 2: *Question 1 written feedback*

How could this education session have better enhanced your knowledge of skills?
• Maybe a video of a patient being screened, good example of how to ask the questions would be helpful. • Could use this with OST clients who identify as Māori in their initial assessment and case management.

Table 3: *Question 2 written feedback*

This feedback allowed the WDHB Māori health and CMHAS leadership working group to make changes to the education session including adding the opportunity for clinicians to see how the tool may be used (demonstrated by presenters) and the option to pair up and work through the screening tool

while asking any questions clarifying process and kupu. It was felt that supporting clinicians with this process would enhance their confidence and competence in being able to use the screening tool within their roles with tangata whai ora. Several smaller education sessions were rolled out shortly after with the remaining CMHAS clinicians across the urban and rural teams and was inclusive of all professions sitting within this team.

12. Recommendations

12.1 Extended Implementation

Complete a two-month trial of the Te Ao Māori screening tool and review the trial with the CMHAS, Te Ranga Ora Māori services and tangata whai ora involved in the initial development of the screening tool. If indicated revise the tool and then complete a second trial of change with the team with further review before the Te Ao Māori screening tool is rolled out to the wider MHAS for embedding as part of standard practice.

Once this is completed consider phased roll out of Te Ao Māori screening tool to all services within the WDHB. This will be completed in conjunction with Te Ranga Ora Māori services, People and Performance (human resources), the WDHB education centre and the Leadership teams.

12.2 WDHB education requirements

Mandatory Training:

It is envisioned that the Te Ao Māori screening tool once rolled out to the wider areas of the WDHB will become a pivotal and permanent part of the WDHB clinicians mandatory training schedule. All clinicians working at the WDHB are required to complete mandatory training on a two-yearly basis as part of health and safety and as per contracts.

WDHB Orientation:

It is also intended that the Te Ao Māori screening tool training will also be incorporated into our orientation package Te Hāpai te hoe which is presented by the Te Hau Ranga Ora Team over two days so that all new clinicians have a sound knowledge and understanding of tikanga Māori. It is a requirement at WDHB that all new clinicians must complete the Te Hāpai Te Hoe orientation process prior to commencing their new roles at the hospital.

12.3 Quality assurance WDHB

It has been agreed that once the Te Ao Māori screening tool is standardised (post two-month trial) then an audit system will be set up to monitor use and outcomes. This will include auditing to ensure that all tangata whai ora who identify as Māori and who are currently involved with services have it documented in their files that they have been given the option to complete the Te Ao Māori screening tool or have a completed screen on file. From this we will also look to capture the numbers of referrals being made to Te Hau Ranga Ora – Māori Health services for haumoana engagement.

Training and education updates will be captured by People and Performance (human resources) as part of clinicians mandatory training requirements.

13. Limitations

The education rollout of the Te Ao Māori screening tool to CMHAS completed by October 2021, to allow for two months of trial and review before finalising the document and rolling out to the wider MHAS at WDHB by the end of 2021. Unfortunately, there have been several external factors including COVID, both national lockdowns and clinician's illness, workforce vacancy and recruitment and change in roles and leadership within the service that have delayed this process and placed limitations around completing this work within timeframes. It was identified that the scope of the project would focus on the co-design of the cultural screening tool and education plan only. It was agreed that the leadership team and Māori health services would lead the trial,

review, and implementation of the screening tool at a later date (external to researcher's studies) and in line with their current WDHB quality improvement process. To date we have completed the co-design of the tool, developed the education plan and Te Ranga Ora Māori services have commenced the training with CMHAS clinicians.

Several changes to writer's role have also contributed to the delay in implementing the Te Ao Māori screening tool for trial at CMHAS. Writer was initially based at CMHAS as a clinical co-ordinator which gave a direct line to engaging in all service and quality improvement within this space, however, has since moved into a service improvement role for the wider WDHB Primary and Community team and to Te Oranganui, an Iwi Primary Care service as a lead for the mental health collaborative design work for the Whanganui rohe. The trial and review are now being led by Te Ranga Ora Māori services and the CMHAS leadership team who will be involved in the two-month review of the screening tool and any work completed around adaptions and improvement and then the wider implementation of the screening tool across services.

13.1 Reflections

I thoroughly enjoyed working closely with those involved in the co-design of the cultural screening tool. It provided me with an opportunity to enhance my own knowledge and understanding around the use of Te Ao Māori and Mātauranga Māori practices, and better understand how these approaches could be amplified within the context of MHAS. The development of the tool and the journey that specific members of the Te Ranga Ora Māori team took us on, allowed for me to personally link in with my own whakapapa and connections to the river, as part of the process of understanding tikanga and cultural wellbeing within the context of the Whanganui rohe. This was an invaluable experience.

On another note, I didn't anticipate how difficult it may be to introduce a cultural screening tool into a clinical environment that is predominantly influenced by a western medical model of care, especially when the workforce is primarily pakeha/European. Being that MHAS clinicians are well versed in recovery and strengths-based models and holistic models of care I was surprised to find that a large portion of professionals found it difficult to consider a Te Ao Māori worldview within this context. I do however feel this was related to people's anxiety around their own cultural competence and fear of not asking the right questions or being seen as culturally inappropriate. It highlighted to me the importance of clinicians having access to cultural supervision, and access to clinicians in kaupapa Māori services or haumoana as the experts in this space.

In terms of positively influencing the system, it was a privilege to work alongside a group of people who were passionate, and more than comfortable sitting in the space of challenging social and clinical "norms" of practice. Challenging CMHAS to being a service which is more holistic and culturally inclusive, and person whānau centred. I would have liked to have been able to continue on with this mahi in terms of the testing, review, and implementation process, however a change of roles means that I will be sitting outside of the WDHB. I do intend however to keep updated with this piece of work and will endeavour to consider how this Te Ao Māori screening tool could be utilised within my new role. Leaning into opportunities for change around the use of Te Ao Māori and Mātauranga Māori practices alongside clinical is essential if we are to provide equity for Māori within health.

14. Conclusions

It is well evidenced that Māori experience significantly worse health outcomes in almost all areas of health when compared to non-Māori, and that Māori will predominantly not be offered or have kaupapa Māori health services or Māori

models of care as a first option when seeking to engage with health services. Inequities to Māori accessing health care are complex in nature and are not simply related to physical health status, rather they are made up of multiple factors including tangata whai ora and whānau whole of wellbeing, social determinants, previous experiences of health care providers and their ability to access services which are heavily influenced by the medical model, particularly within MHAS. Current models of care and clinical assessment tools do not reflect that MHAS are encompassing recovery-based practices or partnership approaches in terms of cultural inclusivity and Te Tiriti o Waitangi obligations, this further perpetuates inequity and health related disparities. If we are to improve health outcomes for Māori then health services need to acknowledge that the cultural identity, beliefs, values, and connection are the foundation of tangata whai ora and whānau wellbeing.

Co-design as a methodology would allow services to understand, identify and design process of transformational change for Māori, by Māori, with Māori ensuring that MHAS service provision is person and whānau centred, culturally inclusive and recovery focussed. A Te Ao Māori lens would strengthen the co-design process by making sure that the cultural and spiritual aspects of a person's wellbeing are also considered when working with Māori. It is essential that healthcare prioritise Te Tiriti o Waitangi principles so that Māori have sovereignty, self-determination, and ownership over the health of themselves, their iwi and hapū, including governance and insight into the establishment of Māori and mainstream services health.

15. References

Aitken, J., & Shackleton, D. (2014). *Co-creation and co-design: applied research methods in healthcare service design*: SAGE.

Amering, M., & Schmolke, M. (2009). *Recovery in mental health: reshaping scientific and clinical responsibilities*: Wiley-Blackwell.

Bährer-Kohler, S., & Bolea-Alamanac, B. (2019). *Diversity in global mental health: gender, lifespan, access to care, treatment and social strata*: Springer.

Bailey, D., & Coates, C. (1992). *A user's guide to the Mental Health (Compulsory Assessment & Treatment) Act 1992*: The Dept.

Barker, P. (1999). *The philosophy and practice of psychiatric nursing*: Churchill Livingstone.

Bate, P., & Robert, G. (2007). *Bringing user experience to healthcare improvement: the concepts, methods and practices of experience-based design*: Radcliffe Pub.

Baxter, J. (2008). *Māori mental health needs profile: a review of the evidence*: Te Rau Matatini.

Baxter, J., Kingi, T. K., Tapsell, R., Durie, M., & McGee, M. A. (2006). Prevalence of mental disorders among Maori in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian & New Zealand Journal of Psychiatry, 40*(10), 914-923. 10.1080/j.1440-1614.2006.01911.x

Berghan, G., Came, H., Coupe, N., Doole, C., Fay, J., McCreanor, T., & Simpson, T. (2017). *Te Tiriti o Waitangi-based practice in health promotion*: STIR.

Bourne, P., Whittington, A., & Meddings, S. (2018). An evaluation of service use outcomes in a Recovery College. *Journal of Mental Health, 27*(4), 359-366. 10.1080/09638237.2017.1417557

Britton, G. M. (2017). *Co-design and social innovation: connections, tensions and opportunities* (1 Edition ed.): Routledge.

Burgess, M. E. (1997). *Complying with codes in the health sector: the Code of Health and Disability Services Consumers' Rights; the Health Information Privacy Code*: Rakaunui Publications.

Byrne, L., Happell, B., & Reid-Searl, K. (2016). Lived experience practitioners and the medical model: world's colliding? *Journal of Mental Health, 25*(3), 217-223. 10.3109/09638237.2015.1101428

Came, H. (2012). *Institutional racism and the dynamics of privilege in public health : a thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Management at the University of Waikato*: University of Waikato.

Came, H. (2012). *Institutional racism and the dynamics of privilege in public health: a thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in Management at the University of Waikato*: University of Waikato.

Came, H., McCreanor, T., Manson, L., & Nuku, K. (2019). Upholding Te Tiriti, ending institutional racism and crown inaction on health equity. *New Zealand Medical Journal, 132*(1492), 61-66.

Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2020). The Waitangi Tribunal's WAI 2575 Report: Implications for Decolonizing Health Systems. *Health & Human Rights: An International Journal, 22*(1), 209-220.

Came, H., & Tudor, K. (2017). Unravelling the whāriki of Crown Māori health infrastructure. *New Zealand Medical Journal, 130*(1458), 42-47.

Cameron, D., Kapur, R., & Campbell, P. (2005). Releasing the therapeutic potential of the psychiatric nurse: a human relations perspective of the nurse–patient relationship. *Journal of Psychiatric & Mental Health Nursing*(1), 64.

Cameron, J., Hart, A., Brooker, S., Neale, P., & Reardon, M. (2018). Collaboration in the design and delivery of a mental health Recovery College course: experiences of students and tutors. *Journal of Mental Health, 27*(4), 374-381. 10.1080/09638237.2018.1466038

Cassie, F. (2014). Dying unequally: striving for mental health patients to be equally well. *Nursing Review (1173-8014), 14*(3), 4-6.

Chant, L. (2011a). WHĀNAU ORA. *AlterNative: An International Journal of Indigenous Peoples, 7*(2), 111-122. 10.1177/117718011100700204

Chant, L. (2011b). Whanau ora: Hauora Maori models for kotahitanga/co-operative co-existence with non-Maori. *AlterNative: An International Journal of Indigenous Peoples, 7*(2), 111-122. 10.3316/informit.704973762977883

Chow, W. S., & Priebe, S. (2013). Understanding psychiatric institutionalization: a conceptual review. *BMC Psychiatry, 13*(1), 1-14. 10.1186/1471-244X-13-169

Clayton, J., & Tse, S. (2003). An educational journey towards recovery for individuals with persistent mental illnesses: A New Zealand perspective. *Psychiatric Rehabilitation Journal, 27*(1), 72-78. 10.2975/27.2003.72.78

Craig, A. B., & Craig, A. (1999). Mental health nursing and cultural diversity. *Australian & New Zealand Journal of Mental Health Nursing, 8*(3), 93-99. 10.1046/j.1440-0979.1999.00138.x

Cunningham, R., Kvalsvig, A., Peterson, D., Kuehl, S., Gibb, S., McKenzie, S., . . . Every-Palmer, S. (2018). *Stocktake report for the Mental Health and Addiction Inquiry: a background report prepared for the Inquiry panel*: EleMent Research Group with colleagues from the Departments of Public Health, Psychological Medicine, and the Suicide Prevention Research Group University of Otago.

DePoy, E., & Gitlin, L. N. (2016). *Introduction to research: understanding and applying multiple strategies* (5th ed ed.): Elsevier Health Sciences.

DiGioia, A. M., & Shapiro, E. (2017). *The Patient-Centered Value System: Transforming Healthcare through Co-Design* (First edition ed.): Taylor and Francis.

Dua, T., Sharma, A., Patel, A., Hanna, F., Chowdhary, N., & Saxena, S. (2017). Integrated care for mental, neurological and substance use disorders in non-specialized health settings: Rising to the challenge. *World Psychiatry, 16*(2), 216-217. 10.1002/wps.20430

Durie, M. (1994). *Whai ora: Māori health development*: Oxford University Press.

Durie, M. (1996). *Māori cultural identity and its implications for mental health services*: Dept. of Maori Studies, Massey University.

Durie, M. (2001). *Mauri ora: the dynamics of Māori health*: Oxford University Press.

Durie, M. (2011). Indigenizing mental health services: New Zealand experience. *Transcultural Psychiatry, 48*(1/2), 24-36. 10.1177/1363461510383182

Durie, M., & Kingi, T. K. R. (1997). *A framework for measuring Māori mental health outcomes: a report*: Massey University, Dept. of Māori Studies.

Ebbett, E., & Clarke, D. (2010). Maori identification, alcohol behaviour and mental health: A review. *International Journal of Mental Health and Addiction, 8*(2), 214-231. 10.1007/s11469-009-9200-x

Elkington, B., Jackson, M., RKiddle, R., Ripeka Mercier, O., Ross, M., Smeaton, J., & Thomas, A. (2020). *Imagining decolonisation*: Bridget Williams Books Ltd.

Elyn, R. S. (2002). *Refusing Care: Forced Treatment and the Rights of the Mentally Ill*. Chicago: University of Chicago Press.

Eriksen, K. Å., Arman, M., Davidson, L., Sundfør, B., & Karlsson, B. (2014). Challenges in relating to mental health professionals: Perspectives of persons with severe mental illness. *International Journal of Mental Health Nursing, 23*(2), 110-117. 10.1111/inm.12024

Evans, K., Nizette, D., & O'Brien, A. J. (2017). *Psychiatric and mental health nursing* (4th edition ed.): Elsevier.

Fishwick, M., Tait, B., & O'Brien, A. (2001). Unearthing the conflicts between carer and custodian: Implications of participation in Section 16 hearings under the Mental Health (Compulsory Assessment and Treatment) Act (1992). *Australian and New Zealand Journal of Mental Health Nursing, 10*(3), 187-194.

Gawith, L., & Abrams, P. p. a. c. g. n. (2006). Long journey to recovery for Kiwi consumers: Recent developments in mental health policy and practice in New Zealand. *Australian Psychologist, 41*(2), 140-148. 10.1080/00050060600657988

Gehart, D. R. (2012a). The Mental Health Recovery Movement and Family Therapy, Part I: Consumer-Led Reform of Services to Persons Diagnosed with Severe Mental Illness. *Journal of Marital & Family Therapy, 38*(3), 429-442. 10.1111/j.1752-0606.2011.00230.x

Gehart, D. R. (2012b). The Mental Health Recovery Movement and Family Therapy, Part II: A Collaborative, Appreciative Approach for Supporting Mental Health Recovery. *Journal of Marital & Family Therapy, 38*(3), 443-457. 10.1111/j.1752-0606.2011.00229.x

Gerard, V., & Chris, H. (2004). 'Like Minds, Like Mine': a New Zealand project to counter the stigma and discrimination associated with mental illness. *Australasian Psychiatry*(2), 113.

Giovanni, S., Morven, L., & Mike, S. (2005). Routine use of mental health outcome assessments: choosing the measure. *The British Journal of Psychiatry*, 146.

Gordon, S. D., Davey, S., Waa, A., Tiatia, R., & Waaka, T. (2017). *Social inclusion and exclusion, stigma and discrimination and the experience of mental distress: Aotearoa/New Zealand*: Mental Health Foundation of New Zealand.

Government Inquiry into Mental Health and Addiction. (2018). *He ara oranga: report of the Government Inquiry into Mental Health and Addiction*: Government Inquiry into Mental Health and Addiction.

Greenall, P. (2006). The barriers to patient-driven treatment in mental health: why patients may choose to follow their own path. *International journal of health care quality assurance incorporating Leadership in health services, 19*(1), xi-xxv.

Gunther, S. (2011). Disparity in mental health provision for Maori and Pacific: a nursing response. *Whitireia Nursing Journal*(18), 39-43.

Haitana, T., Pitama, S., Cormack, D., Clarke, M., & Lacey, C. (2020). The Transformative Potential of Kaupapa Māori Research and Indigenous Methodologies: Positioning Māori Patient Experiences of Mental Health Services. *International Journal of Qualitative Methods, 19*, 1.

Hallebone, E. L., & Callaly, T. (2001). Introducing the routine use of outcomes measurement to mental health services. *Australian Health Review, 24*(1), 43-50.

Hamer, H. P., Finlayson, M., & Warren, H. (2014). Insiders or outsiders? Mental health service users' journeys towards full citizenship. *International Journal of Mental Health Nursing, 23*(3), 203-211. 10.1111/inm.12046

Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Effects of self-reported racial discrimination and deprivation on Māori health and inequalities in New Zealand: cross-sectional study. *Lancet, 367*(9527), 2005-2009. 10.1016/S0140-6736(06)68890-9

Hartley, S., Raphael, J., Lovell, K., & Berry, K. (2020). Effective nurse–patient relationships in mental health care: A systematic review of interventions to improve the therapeutic alliance. *International Journal of Nursing Studies, 102* 10.1016/j.ijnurstu.2019.103490

Hayward, J., & Wheen, N. R. (2004). *The Waitangi Tribunal = Te Roopu Whakamana i te Tiriti o Waitangi*: Bridget Williams Books.

Health and Disability System Review. (2019). *Health and disability system review: interim report = pūrongo mō tēnei wā*: Health and Disability System Review.

Healthy families Whanganui Rangitīkei Ruapehu. (2020). *Insights report growing collective wellbeing Whanganui, Rangitīkei, Ruapehu rohe: A whole of community, whole of systems approach to the p[revention of suicide 2020-2021*. Healthy families Whanganui Rangitīkei Ruapehu.

Healthy Families Whanganui Rangitīkei Ruapehu. (2021). *Growing Collective Wellbeing: A whole of community whole of systems appraoch to the preventin of Suicide 2021-2024*. Healthy Families Whanganui, Rangitīkei, Ruapehu.

Henare, M. (1990). *The Treaty of Waitangi and its significance for social and health policy development*: Catholic Commission for Justice, Peace and Development (Aotearoa-New Zealand).

Hiha, A. A. (2016). Kaupapa Maori Methodology: Trusting the Methodology through Thick and Thin. *Australian Journal of Indigenous Education, 45*(2), 129-138.

Holley, J., Chambers, M., & Gillard, S. (2016). The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: a qualitative investigation. *Journal of Mental Health, 25*(4), 315-322. 10.3109/09638237.2015.1124402

Hungerford, C., & Fox, C. (2014). Consumer's perceptions of Recovery-oriented mental health services: An Australian case-study analysis. *Nursing and Health Sciences, 16*(2), 209-215. 10.1111/nhs.12088

Hutchings, J., Potter, H., & Taupo, K. P. T. (2011). *Kei Tua o Te Pae hui proceedings : the challenges of kaupapa Māori research in the 21st century, Pipitea Marae, Wellington, 5-6 May 2011*: New Zealand Council for Educational Research.

Hutt Valley District Health Board, R. P. H. (2018). *Strategic directions 2018 - 2023: Pae Ora: Healthy futures for the Greater Wellington Region*: Hutt Valley District Health Board, Regional Public Health.

Ihimaera, L. V. (2003). *He ara ki te ao mārama: a pathway to understanding the facilitation of taha wairua in mental health services : a thesis submitted in partial fulfilment of the requirements for a Masters of Arts, Massey University, Palmerston North, New Zealand*.

Jacob, K. S. (2015). Recovery Model of Mental Illness: A Complementary Approach to Psychiatric Care. *Indian Journal of Psychological Medicine, 37*(2), 117.

Jobes, D. A. (2006). *Managing suicidal risk: a collaborative approach*: Guilford Press.

Jones, J. S., Fitzpatrick, J. J., & Rogers, V. L. (2016). *Psychiatric-Mental Health Nursing, Second Edition: An Interpersonal Approach* (Vol. Second edition). New York, NY: Springer Publishing Company.

Jørgensen, K., & Rendtorff, J. D. (2018). Patient participation in mental health care – perspectives of healthcare professionals: an integrative review. *Scandinavian Journal of Caring Sciences, 32*(2), 490-501. 10.1111/scs.12531

Keith, E. (2011). What prevents one to one care? *Nursing Times*(1), 25.

Kendrick, S. (2016). *Addressing spiritualty in New Zealand mental health practice: a research report presented in partial fulfilment of the requirements of the degree of Master of Applied Social Work at Massey University, Albany, New Zealand*: Massey University.

Kidd, S., Kenny, A., & McKinstry, C. (2015a). Exploring the meaning of recovery-oriented care: An action-research study. In (Vol. 24, pp. 38-48).

Kidd, S., Kenny, A., & McKinstry, C. (2015b). The meaning of recovery in a regional mental health service: An action research study. *Journal of Advanced Nursing, 71*(1), 181-192. 10.1111/jan.12472

King, A., & Turia, T. (2002). *He korowai oranga*: Manatū Hauora.

Kingi, T. K. R., Durie, M., Elder, H., Tapsell, R., Lawrence, M., & Bennett, S. (2017). *Maea Te Toi Ora: Maori Health Transformations*. Wellington, Aotearoa New Zealand: Huia Publishers.

Kirby, J. (2019). Balancing competing interests and obligations in mental health-care practice and policy. *Bioethics, 33*(6), 699-707. 10.1111/bioe.12575

Kisely, S., Campbell, L. A., Cartwright, J., Cox, M., Campbell, J., Kisely, S., . . . Campbell, J. (2010). Do the Health of the Nation Outcome Scales measure outcome? *Canadian Journal of Psychiatry, 55*(7), 431-439.

Knight, G., Krishnan, A., & Bissielo, A. (2016). *The transformation of NZ Police crime statistics : new measures and trends*: New Zealand Police Ngā Pirihimana o Aotearoa.

Ladd, P. D., & Churchill, A. C. (2012). *Person-centered diagnosis and treatment in mental health: a model for empowering clients*: Jessica Kingsley Publishers.

Le Boutillier, C., Leamy, M., Bird, V., Davidson, L., Williams, J., & Slade, M. (2011). What Does Recovery Mean in Practice? A Qualitative Analysis of International Recovery-Oriented Practice Guidance. *Psychiatric Services, 62*(12), 1470-1476. 10.1176/appi.ps.001312011

Limon, V. M., Lee, M., Gonzalez, B., Choh, A. C., & Czerwinski, S. A. (2020). The impact of metabolic syndrome on mental health-related quality of life and depressive symptoms. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care & Rehabilitation, 29*(8), 2063-2072. 10.1007/s11136-020-02479-5

Manatū Hauora Ministry of Health. (2018). *Achieving equity in health outcomes: highlights of important national and international papers*: Manatū Hauora Ministry of Health.

Maori Health Commission. (1998). *Tihei mauri ora*: Maori Health Commission.

Mark, S., & Hagen, P. (2020). *Co-design in Aotearoa New Zealand: a snapshot of the literature*: Auckland Co-design Lab.

McCubbin, M., & Cohen, D. (1996). Extremely unbalanced: Interest divergence and power disparities between clients and psychiatry. *International Journal of Law and Psychiatry, 19*(1), 1-25. 10.1016/0160-2527(95)00028-3

McKellar, D., & Rodrigues, A. (2017). Access to Healthcare for People Living in Aotearoa with a Serious Mental Illness: A Social Justice Issue. *Whitireia Nursing & Health Journal*(24), 53-57.

Mental Health and Addiction Inquiry. (2018). *Government inquiry into mental health and addiction oranga tangata, oranga whānau: public consultation on mental health and addiction in Aotearoa New Zealand now, and into the future: a chance to have your say* (English version for download ed.): [Mental Health and Addiction Inquiry].

Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand: how things need to be*: Mental Health Commission.

Mental Health Commission. (2004). *Our lives in 2014: a recovery vision from people with experience of mental illness, for the second mental health plan, and the development of the health and social sectors*: Published with the assistance of the Mental Health Commission.

Mental Health Commission. (2007a). *Te haererenga mo te whakaoranga 1996-2006 : the journey of recovery for the New Zealand mental health sector*: Mental Health Commission.

Mental Health Commission. (2007b). *Te haererenga mo te whakaoranga 1996-2006: the journey of recovery for the New Zealand mental health sector*: Mental Health Commission.

Mental Health Commission. (2012). *Blueprint II: improving mental health and wellbeing for all New Zealanders*: Mental Health Commission.

Mental Health Foundation. (1992). *Why the Treaty of Waitangi is important*: The Foundation.

Mental Health Foundation. (2008). *Destination, recovery = Te ūnga ki uta, te oranga: future responses to mental distress and loss of well-being, a discussion paper from the Mental Health Advocacy Coalition*: Mental Health Foundation of New Zealand.

Mental Health Foundation of New Zealand. (2020). *Submission on the draft disability employment action plan /c Mental Health Foundation, Mauri Tū Mauri Ora, Like Minds Like Mine, Hāpai Te Hauora Māori Public Health*: Mental Health Foundation of New Zealand.
Ministry for Culture and Heritage. Health and disability consumer rights. In: Ministry for Culture and Heritage.
Ministry of Health (MOH). (2000). *Guidelines to the Mental Health (Compulsory Assessment & Treatment) Act 1992*: Ministry of Health.
Ministry of Health. (2001). *He korowai oranga: Māori health strategy: discussion document*: Ministry of Health.
Ministry of Health. (2002). *Reducing inequalities in health*: Ministry of Health.
Ministry of Health. (2005). *Tauawhitia te wero = Embracing the challenge: national mental health and addiction workforce development plan 2006-2009*: Ministry of Health.
Ministry of Health. (2006). *Te Kōkiri: the mental health and addiction action plan, 2006-2015*: Ministry of Health.
Ministry of Health. (2010). *Service delivery for people with co-existing mental health and addiction problems: integrated solutions*: Ministry of Health.
Ministry of Health. (2020a). *Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992*: Ministry of Health, Manatū Hauora.
Ministry of Health. (2020b). *Kia kaha, kia māia, kia ora Aotearoa : COVID-19 psychosocial and mental wellbeing plan* (Revised edition ed.): Ministry of Health.
Ministry of Health. (2020c). *Pae tū, pae ora: pathways to pae ora*: Ministry of Health.
Ministry of Health. (2020d). *Whakamaua Māori Health Action Plan, 2020-2025*: Ministry of Health.
Ministry of Health. (2021). *Kia manawanui Aotearoa: long-term pathway to mental wellbeing*: Ministry of Health.
Ministry of Social Development. (2019). *Te pae tata: te rautaki Māori me te mahere mahi = Māori strategy and action plan*: Manatū Whakahiato Ora.
Mold, J. (2017). Goal-Directed Health Care: Redefining Health and Health Care in the Era of Value-Based Care. *Cureus, 9*(2), e1043. 10.7759/cureus.1043
Morgan, J. (1995). The road to Maori `sovereignty'. *Dominion Post, The*, 10.
Morrison-Valfre, M. (2017). *Foundations of mental health care* (6th ed ed.): Elsevier.
Naera, R. L. (2015). *Te hui kotahitanga mo te whaka-ora i roto i nga matauranga o te mate hinengaro: The intergenerational transmission of healing from the experience of mental illness: a thesis completed in partial fulfilment of a Master of Philosophy in Māori Studies*.
Newman, D., O'Reilly, P., Lee, S. H., & Kennedy, C. (2015). Mental health service users' experiences of mental health care: an integrative literature review. *Journal of psychiatric and mental health nursing, 22*(3), 171-182. 10.1111/jpm.12202
Ng, K. K. (2012). Reforming mental health care in the people's direction: The power of consumer participation in achieving systemic change. *Parity, 25*(4), 20.
Ning, L. (2010). Building a 'User Driven' Mental Health System. *Advances in Mental Health*(2), 112.
Nursing Council of New Zealand. (2011). *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice* (Rev. ed ed.): Nursing Council of New Zealand.
O'Brien, A. J. (2000). *The therapeutic relationship: perceptions of mental health nurses: a thesis presented in partial fulfilment of the requirements for the degree of Master of Philosophy in Nursing at Massey University, Albany campus, New Zealand*.

O'Brien, A. J. (2010). Capacity, Consent, and Mental Health Legislation: Time for a New Standard? *Contemporary Nurse: A Journal for the Australian Nursing Profession*(2), 237.

O'Hagen, M. (2001). *Recovery competencies for New Zealand mental health workers*: Mental Health Commission.

Oakley Brown, M., Wells, J. E., & Scott, K. M. (2006). *Te rau hinengaro: the New Zealand mental health survey*: Ministry of Health.

Oshodi, A., & Rush, G. (2011). Recovery from mental illness: changing the focus of mental health services. *Irish Journal of Psychological Medicine, 28*(3), 161.

Pack, S., Tuffin, K., & Lyons, A. (2016). Reducing racism against Maori in Aotearoa New Zealand. *New Zealand Journal of Psychology, 45*(3), 30-40.

Palmer, M. (2008). *The Treaty of Waitangi in New Zealand's law and constitution*: Victoria University Press.

Palmer, S. (2004). Homai te Waiora ki Ahau: A tool for the measurement of wellbeing among Māori - the evidence of construct validity. *New Zealand Journal of Psychology, 33*(2), 50-58.

Pere, L. M. (2006). *Oho mauri : cultural identity, wellbeing, and tangata whai ora/motuhake : a thesis presented in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Māori Studies at Massey University, Wellington, Aotearoa/New Zealand.* (Thesis), Massey University, Retrieved from http://ezproxy.massey.ac.nz/login?url=https://search.ebscohost.com/login.aspx?direct=true&AuthType=sso&db=ir00033a&AN=massnz.10179.1567&site=eds-live&scope=site&authtype=sso&custid=s3027306

Phillips, P., Sandford, T., & Johnston, C. M. R. G. N. (2012). *Working in mental health: practice and policy in a changing environment*: Routledge.

Pitama, S., Huria, T., & Lacey, C. (2014). Improving Māori health through clinical assessment: Waikare o te Waka o Meihana. *New Zealand Medical Journal, 127*(1393)

Pitama, S. G., Bennett, S. T., Waitoki, W., Haitana, T., Valentine, N., Pahina, J., . . . McLachlan, A. (2017). A proposed hauora Māori clinical guide for psychologists: Using the hui process and Meihana model in clinical assessment and formulation. *New Zealand Journal of Psychology, 46*(3), 7-19.

Procter, N. G., Hamer, H. P., McGarry, D., Wilson, R. L., & Froggatt, T. (2017). *Mental health: a person-centred approach* (Second edition ed.): Cambridge University Press.

Pulford, J. (2010). Development of a routine outcome monitoring instrument for use with clients in the New Zealand alcohol and other drug treatment sector: the alcohol and drug outcome measure (ADOM). *New Zealand Journal of Psychology*

Rapp, C. A., & Goscha, R. J. (2012). *The strengths model: a recovery-oriented approach to mental health services* (3rd ed ed.): Oxford University Press.

Ratima, M. T., Paterson, L., Rewi, P., Reilly, M., Leoni, G., Carter, L., & Duncan, S. (2018). *Te kōparapara : an introduction to the Māori world*: Auckland University Press.

Reid, P. (2017). Achieving health equity in Aotearoa: strengthening responsiveness to Māori in health research. *New Zealand Medical Journal*

Roberts, R. (2017). Equally Well. Physical health and mental illness. *Australian Journal of Rural Health, 25*(6), 324-325. 10.1111/ajr.12404

Roberts, R., Lockett, H., Bagnall, C., Maylea, C., & Hopwood, M. (2018). Improving the physical health of people living with mental illness in Australia and New Zealand. *Australian Journal of Rural Health, 26*(5), 354-362. 10.1111/ajr.12457

Saggese, M. L. (2005). Maximizing Treatment Effectiveness in Clinical Practice: An Outcome-Informed, Collaborative Approach. *Families in Society: Journal of Contemporary Social Services, 86*(4), 558-564. 10.1606/1044-3894.3461

Sales, B. D., & Folkman, S. (2000). *Ethics in research with human participants*: American Psychological Association.
Scott, K. M., Oakley Browne, M. A., McGee, M. A., & Wells, J. E. (2006). Mental–physical comorbidity in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry*(10), 882.
Sewell, H. (2009). *Working with ethnicity, race and culture in mental health: a handbook for practitioners*: Jessica Kingsley Publishers.
Shanley, E., & Jubb-Shanley, M. (2007). The recovery alliance theory of mental health nursing. *Journal of psychiatric and mental health nursing, 14*(8), 734-743. 10.1111/j.1365-2850.2007.01179.x
Sharma, S. (2016). Impact of globalisation on mental health in low- and middle-income countries. *Psychology and Developing Societies, 28*(2), 251-279. 10.1177/0971333616657176
Sheppard, M. (1991). *Mental health work in the community: theory and practice in social work and community psychiatric nursing*: Falmer Press.
Sibbald, B. (2016). A clearing for narrative practice. *CMAJ: Canadian Medical Association Journal, 188*(17-18), 1267-1268. 10.1503/cmaj.160753
Slade, M., Adams, N., & O'Hagan, M. (2012). Recovery: Past progress and future challenges. *International Review of Psychiatry, 24*(1), 1-4. 10.3109/09540261.2011.644847
Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., . . . Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12-20. 10.1002/wps.20084
Slattery, P., Saeri, A. K., & Bragge, P. (2020). Research co-design in health: a rapid overview of reviews. *Health Research Policy and Systems, 18*(1) 10.1186/s12961-020-0528-9
Smith, D. (2019). *Medicine over mind: mental health practice in the biomedical era*: Rutgers University Press.
Smith, T., Tinirau, R., & Smith, C. (2019). *He ara uru ora: traditional Māori understandings of trauma and well-being*: Te Atawhai o te Ao.
Statistics New Zealand. (2019). *2018 Census: interim coverage rates, collection response rates, and data sources*: Stats NZ.
Stensrud, B., Høyer, G., Beston, G., Granerud, A., Landheim, A., Stensrud, B., . . . Landheim, A. S. (2016). "Care or control?": a qualitative study of clinicians experiences with outpatient commitment orders. *Social Psychiatry & Psychiatric Epidemiology, 51*(5), 747-755. 10.1007/s00127-016-1193-8
Stevenson, B. (2001). *The relationship between Māori cultural identity and health: a thesis submitted in partial fulfilment of the requirements for the degree of Master of Arts, Massey University, 2001*.
Stromwall, L. K., & Hurdle, D. (2003). Psychiatric Rehabilitation: An Empowerment-Based Approach to Mental Health Services. *Health & Social Work, 28*(3), 206-213. 10.1093/hsw/28.3.206
Su Yeon Lee-Tauler, P. D., John Eun, B. A., Dawn Corbett, M. P. H., & Pamela Y. Collins, M. D. M. P. H. (2018). A Systematic Review of Interventions to Improve Initiation of Mental Health Care Among Racial-Ethnic Minority Groups. *Psychiatric Services, 69*(6), 628-647. 10.1176/appi.ps.201700382
Sugiura, K., Mahomed, F., Saxena, S., & Patel, V. (2020). An end to coercion: rights and decision-making in mental health care. *El fin de la coerción: derechos y toma de decisiones en la atención de la salud mental., 98*(1), 52-58. 10.2471/BLT.19.234906
Tan, S., Chin, W., Qui Ling, T., Wong, C., Tay, J., Sue-Anne, T., . . . Yee Wei, L. (2017). Understanding the psychosocial, behavioural and environmental factors behind frequent hospital admissions. *International Journal of Integrated Care (IJIC), 17*, 1.

Te Ao Māramatanga. (2015). *Māori mental health nursing: growing our workforce*: Te Rau Matatini.
Te Pou o te Whakaaro Nui. (2008). *PRIMHD summary report - HONOS: Health of the Nation Outcomes Scales working age adults report for New Zealand*: Te Pou o te Whakaaro Nui.
Te Rau Matatini. (2014). *Whanau Ora workforce development: a literature review*: Te Rau Matatini.
Tew, J. (2005). *Social perspectives in mental health: developing social models to understand and work with mental distress*: Jessica Kingsley.
Thornicroft, C., Wyllie, A., Thornicroft, G., & Mehta, N. (2014). Impact of the "Like Minds, Like Mine" anti-stigma and discrimination campaign in New Zealand on anticipated and experienced discrimination. In (Vol. 48, pp. 360-370).
Tindall, R. M., Ferris, M., Townsend, M., Boschert, G., & Moylan, S. (2021). A first-hand experience of co-design in mental health service design: Opportunities, challenges, and lessons. *International Journal of Mental Health Nursing, 30*(6), 1693-1702. 10.1111/inm.12925
Toki, V. (2010). Therapeutic jurisprudence and mental health courts for Maori. *International Journal of Law and Psychiatry, 33*(5-6), 440-447. 10.1016/j.ijlp.2010.09.014
Tracy, H., Suzanne, P., Donna, C., Mauterangimarie, C., & Cameron, L. (2020). The Transformative Potential of Kaupapa Māori Research and Indigenous Methodologies: Positioning Māori Patient Experiences of Mental Health Services. *International Journal of Qualitative Methods, 19* 10.1177/1609406920953752
Trusty, W. T., Penix, E. A., Dimmick, A. A., & Swift, J. K. (2019). Shared decision-making in mental and behavioural health interventions. *Journal of Evaluation in Clinical Practice, 25*(6), 1210.
Waitangi Tribunal. (2013). *Waitangi Tribunal WAI 261 concerning the Treaty of Waitangi Act 1975 and the Auckland Hospital Endowments claim: interim report to the Minister of Māori Affairs and to the Ministers of Health and Justice*: Waitangi Tribunal.
Waitangi Tribunal. (2019a). *Hauora: report on stage one of the Health Services and Outcomes Kaupapa Inquiry* (Pre-publication version ed.): Waitangi Tribunal.
Waitangi Tribunal. (2019b). *Hauora: report on stage one of the Health Services and Outcomes Kaupapa Inquiry*: Legislation Direct.
Watson, S., Thorburn, K., Everett, M., & Fisher, K. R. (2014). Care without coercion - mental health rights, personal recovery and trauma-informed care. *Australian Journal of Social Issues, The*(4), 529.
Whanganui District Health Board. (2020). *He hāpori ora = thriving communities: strategy document, 2020/2023*: Whanganui District Health Board.
Whitley, R. (2009). The Implications of Race and Ethnicity for Shared Decision-Making. *Psychiatric Rehabilitation Journal, 32*(3), 227-230. 10.2975/32.3.2009.227.230
Whittemore, R., & Knafl, K. (2005). The integrative review: Updated methodology. *Journal of Advanced Nursing, 52*(5), 546-553. 10.1111/j.1365-2648.2005.03621.x
William A, A. (1993). Recovery From Mental Illness: The Guiding Vision of the Mental Health Service System in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11-23. 10.1037/h0095655
Williams, C. (2007). *More power to do the work: Maori and the health system in the twentieth century*: Treaty of Waitangi Research Unit, Victoria University of Wellington.
Williams, M. W., Haarhoff, B., & Vertongen, R. (2017). Mental Health in Aotearoa New Zealand: Rising to the Challenge of the Fourth Wave? *New Zealand Journal of Psychology, 46*(2), 16-22.

Williams, T. M., & Smith, G. P. (2019). Laying new foundations for 21st century community mental health services: An Australian perspective. *International Journal of Mental Health Nursing, 28*(4), 1008-1014. 10.1111/inm.12590

Willing, E., Paine, S.-J., Wyeth, E., Te Ao, B., Vaithianathan, R., & Reid, P. (2020). Indigenous voices on measuring and valuing health states. *AlterNative: An International Journal of Indigenous Peoples, 16*(1), 3-9. 10.3316/informit.094133789422878

Winsper, C., Crawford-Docherty, A., Weich, S., Fenton, S.-J., & Singh, S. P. (2020). How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model. *Clinical Psychology Review, 76* 10.1016/j.cpr.2020.101815

Wirihana, R., & Smith, C. (2014). Historical trauma, healing and well-being in Māori communities. *MAI journal*

Woltmann, E. M., & Whitley, R. (2010). Shared decision making in public mental health care: Perspectives from consumers living with severe mental illness. *Psychiatric Rehabilitation Journal, 34*(1), 29-36. 10.2975/34.1.2010.29.36

Zelmer, J., van Hoof, K., Notarianni, M., van Mierlo, T., Schellenberg, M., & Tannenbaum, C. (2018). An Assessment Framework for e-Mental Health Apps in Canada: Results of a Modified Delphi Process. In (Vol. 6).

16. Appendix

Appendix A: Locality agreement

Locality Agreement for clinical project to be undertaken at

Whanganui District Health Board (DHB)

Written request to undertake a research project within WDHB's Community Mental Health and Addiction Services as part of a Master's in Health Science and Quality improvement in improving equity, accessibility and cultural inclusive for Māori within secondary Mental health Services.

Project Summary:
In terms of the integrative literature review completed prior to this proposed research report, there were several pieces of literature that were significant regarding exploring this matter and informing my project. The literature review aimed to identify the current constraints of mental health and addiction assessments in terms of cultural inclusiveness whilst identifying the best available evidence and contemporary strategy and policy to underpin development of a tangata whaiora plans. Although the literature did not directly refer to actual assessment tools, they did reflect on the processes required to develop assessment tools that were meaningful and embodied the concepts of recovery orientated care, cultural inclusion, and co-design.

Aim of the project:
This clinical project aims to co-design and develop a local integrated cultural assessment screening tool for tāngata whai ora and whānau for use within a secondary community mental health and addiction service that is appropriate for the Aotearoa/New Zealand context, upholds Te Tiriti obligations and is based on the best available evidence.

Methodology:
This project uses a Co-design methodology with a Te Ao Māori lens. The aim is to co-design a cultural assessment tool together with Māori and WDHB Māori health services with the aim of embedding its use into everyday practice. Co-design and use of a Te Ao Māori lens ensure that local Māori tikanga is incorporated into the cultural screening tool but also that the tool fits with what Māori are identifying as being important to Māori.

Co-design partners:
In co-designing a cultural screening tool that reflected a Te Ao Māori and Whanganui context, it is imperative to involve several key stakeholders as part of the process.
Key stakeholders include

1) tāngata whai ora (specifically those who identified as Māori and who were currently utilising secondary MH&AOD services).
2) WDHB Māori health and CMHAS leadership working group who will be endorsing and facilitating the co-design of this tool as a WDHB assessment tool,
3) WDHB Māori health workforce (Haumoana).
4) Community mental health workforce

Timeframes:
It is proposed that the development of a screening tool and education plan is completed ready for submission date to Massey University is February 2022.

It is agreed that this research project will take place as part of Quality improvement for Mental health and Addiction Services at Whanganui District Health Board. We are aware that the findings of this research may be published at a later date.

Cheyenne Potaka-Osborne
Completing Research / Employee of WDHB

Alex Kemp
Chief Allied Professions Officer,
Executive Manager - Community Mental Health and Addictions Services
WDHB

Rowena Kui
Kaiuringi - Māori Health & Equity Services
WDHB

Appendix B: Education session plan

Education Session Plan

Name: Te Ao Māori screening tool

Workplace: Community Mental Health and Addictions

Date:

Session topic: Screening tool for referrals to Haumoana service

Rationale for topic: Implementation of a screening tool for CMH key workers

Presented to (audience and number): 10 - 15 clinicians per session

Length of session: 1 hour

Venue or setting: The CMH Group room

Learning objectives	Main points	Resources needed/ delivery method
Purpose of the screening tool	Translation of the Māori kupu (words)	The screening tool / Electronic screen
Using the screening tool	Who, when, and why should the tool be used	The screening tool / Electronic screen
Evaluating the screening tool	Providing feedback and deciding whether to refer	The screening tool / Electronic screen
The referral processes	Estimated response time	Haumoana referral process / Verbal

Appendix C: Feedback form

Session Topic: Te Ao Māori screening tool

Presented by: Haumoana (name of presenter)

Date of Presentation:

Q1: The presentation was well prepared.

Thoroughly Agree	Agree	Neutral	Disagree

Q2: The presenter communicated the topic clearly and effectively

Thoroughly Agree	Agree	Neutral	Disagree

Q3: I understand more about the topic because of this session.

Thoroughly Agree	Agree	Neutral	Disagree

Q4: My questions were answered appropriately.

Thoroughly Agree	Agree	Neutral	Disagree

Q5: How did this session enhance your knowledge or skills? Please be specific.

Q6: How could this education session have better enhanced your knowledge of skills? Please be specific?
