Tikanga Framework for Improving Māori Mental Health and Well-being: Localised Development and Application

A thesis presented in partial fulfilment of the
requirements for the degree of

Master of Science
in
Psychology (Health Psychology Endorsement)

Massey University, New Zealand

Kimberley Grace Te Rangi Smyth
(Ngāti Tūwharetoa, Ngāpuhi, Pākehā)

2023

Abstract

Many mental health approaches used in Aotearoa, New Zealand are predominately Global North top-down approaches and do not adhere to Te Tiriti o Waitangi because they do not have substantive consultation and collaboration with Māori. Top-down approaches risk perpetuating culturally unsafe practices that do not achieve improved mental health outcomes for Māori clients. Community-based approaches that collaborate with Māori, empower them to build upon their own cultural strengths to benefit their mental health and well-being. This master's thesis explores what a tikanga-informed, culturally safe framework for mental health could look like from a localised perspective. There were two research aims. The first aim was to identify tikanga-informed values for improving mental health and well-being for Māori specific to Bream Bay. The second aim was to develop a localised tikanga-informed framework for improving Māori mental health and well-being, which can be used by the Bream Bay Community Support Trust (BBCST) to provide culturally safe support for their clients. This study is based on Kaupapa Māori theory and utilises a Kaupapa Māori research qualitative approach via semi-structured interviews and hui. Thirteen participants were interviewed. They were experts in mātauranga Māori, tikanga Māori, and mental health or education. The study identified five tikanga-informed values that could contribute to improving the mental health and well-being of Māori in Bream Bay. These values were foundational in developing a strengths-based mental health and well-being framework, Māwhaiwhai Kaupapa. Notably, this project demonstrates how localised tikanga-based approaches can be developed collaboratively for the benefit of a community. This study contributes to new knowledge by joining the small pool of bottom-up Indigenous studies for mental health and well-being. This research is further significant because this knowledge can provide a template for other Māori health providers as a basis for developing their own tikanga models of health.

Acknowledgements

I want to acknowledge my sincere appreciation to the following individuals who have been crucial in completing this thesis.

Dr Kathryn McGuigan

Immense gratitude goes to my academic advisor, Dr Kathryn McGuigan, for her unwavering support and encouragement, continued guidance, prompt communication, and insightful feedback. Her expertise has been an instrumental pou throughout this thesis.

Dr Kyle Eggleton

My deepest appreciation goes to my research supervisor, Dr Kyle Eggleton, for his passion for the project and the community of Bream Bay. His knowledge and whanaungatanga was instrumental in shaping the direction of this research project. Dr Eggleton provided invaluable guidance and support to ensure excellence throughout the cultural and academic commitments this project required.

Sharon Russell

I would not have had the opportunity to conduct this project without the support and recommendation of Sharon Russell as the Bream Bay Community Service Trust Manager. I greatly appreciate her unwavering support and dedication to improving health outcomes for the local community.

Cultural Advisory Group

I am genuinely thankful for the local cultural advisory group that awhi and supported this research. Their mātauranga Māori expertise, insightful feedback, and resources were paramount to ensuring the success of this thesis.

Family

My heartfelt thanks to my husband Steven Smyth, whose constant encouragement and belief in my ability as a researcher have been a rock of stability. To Stephanie Dau for her unwavering support and academic excellence; she took the time to provide insightful reflections and challenged me to become a better writer. To my mother Karen Grammer and mother-in-law Marie Rayner, I am genuinely grateful for all the hours you have put into babysitting my beautiful son and for providing me the time to complete this thesis. To my son Ardie Awhi, you are the source of my motivation and the driving force to hope for better mental health services for the next generation.

This thesis was made possible through the support of these individuals and others. I am deeply grateful for the whakawhanaungatanga that has shaped this research journey.

Glossary of terms

Throughout this thesis I have made a conscious effort to use specific terms and exclude others. The reason for this is twofold. One is that mātauranga Māori is an oral knowledge that places high importance on how something is said or described. The second is that tikanga Māori must be precise about the terms being used. The glossary will outline other terms that may be unfamiliar to the reader.

Colonisation: Colonisation is the ongoing process of establishing control and domination over territories to increase the power of the coloniser's empire (Paradies, 2016). It may involve the exploitation and elimination of Indigenous people. Colonists use mechanisms such as war, removal of lands, eradication of culture and spiritual practices, removal of children and banning of cultural customs (Paradies, 2016).

Cultural Safety: I have used the term cultural safety to recognise the power imbalance between the healthcare service provider and their Māori client (Kaphle et al., 2022). The term was founded in the early 1990s to represent the health inequities found for Māori and other Indigenous groups in Aotearoa, New Zealand.

Health Service Providers: Throughout this thesis, I have used the term Health Service Provider to represent a range of health professionals such as psychologists, counsellors, therapists, social workers, and community liaisons. Through conscious effort, I have not separated the terms because many professionals may use a mental health framework within their scope of practice.

Historical Trauma & Intergenerational Trauma: This thesis uses the term historical trauma to represent the impact and accumulation of emotional and psychological experiences that derive from past injustices and historical events such as war and colonisation (O'Neill et al., 2018). Intergenerational trauma is a related concept that focuses on the effects of past trauma impacting the psychology of subsequent generations (Kiyimba & Anderson, 2022).

Kaupapa Māori Research: Kaupapa Māori research is the type of research physically conducted under the epistemology of Kaupapa Māori theory. It is research that must be conducted by Māori, with Māori, for the benefit of Māori.

Kaupapa Māori Theory: In this thesis, Kaupapa Māori theory is the scientific positioning that Māori culture, worldview, ethics, and knowledge are normal, legitimate and validated

without comparing against any mainstream Western scientific theory (Hansen, 2012). It holds the assumption that Māori have ownership of the way Māori knowledge is shared and known. It is considered a decolonisation of Māori knowledge (Haitana et al., 2020).

Mātauranga Māori: Is a te reo term that is used to describe the complete knowledge and values held within the Māori culture (Waitoki, 2016). The term is pre-colonial and encapsulates all knowledge of Māori throughout the generations, including newly gained ways of being.

Patient versus Client: I have deliberately chosen the term client in this thesis when describing a person obtaining care, or in need of care. I made a conscious effort not to use patient because the word patient can induce the concept of illness, or unwellness, which points to the uneven power balance of the service provider and the person in need of obtaining support. The client may be unwell in one area of their life and need assistance from a health provider. However, in many other aspects, they are strong and healthy. The term client assigns agency and self-autonomy to the person asking for help and equalises the power relationship.

Tikanga Māori: Tikanga Māori is the concept that there is a right way of doing things. The base principle of tikanga is to uphold practical actions that are right and correct with genuine action (Mead, 2016). The concept is founded in *Mātauranga Māori* (Māori knowledge). In te reo Māori “tika" means right or ethical. So the term implies that there is a right and ethical way of ensuring that Mātauranga Māori is applied, presented and shared.

Te Tiriti o Waitangi v The Treaty of Waitangi: In this thesis I have made the conscious effort to use the term Te Tiriti o Waitangi (or Te Tiriti) in reference to the Treaty of Waitangi signed in February 1840. Te Tiriti is considered the nation's founding document and was signed by 46 Māori rangatira and 43 British residents (Mutu, 2019). There were two copies of Te Tiriti, one in te reo Māori and one in English. The Māori signed the te reo Māori translation, while the British residents signed the English translation (Orange, 2021). There are discrepancies between te reo Māori translation and the English text. Therefore, because Māori only signed Te Tiriti text, I am acknowledging that the te reo Māori version is the correct and accurate version our nation should uphold.

Glossary of Māori Words

Au	Core of a person
Ao Māori	Māori world view
Aotearoa	New Zealand
Hapū	Kin, pregnant, to be connected with life
Hinengaro	Mind, consciousness
Hui	Meeting
Iwi	Tribe
Kanohi ki te kanohi	Face to face
Karakia	Prayer
Kaupapa	Topic, plan, programme, methods, purpose
Kawa	Protocol
Kete	Basket
Kōrero	Conversation
Maimai	Song of affection for the dead
Mate	Ill or sick
Mātauranga	Complete knowledge of Māori that encompasses wisdom, understanding, skills and education.
Ngahere	Forest
Noa	What is ordinary
Pono	To be authentic or genuine in action
Pūrākau	Mythical stories or ancient legends
Rangatira	To be noble or of high rank
Rongoā	Medical treatment
Rōpū	Party of people, committee, organisation
Tamariki	Children
Tangata Whenua	People of the land, Indigenous people
Mana Whenua	People of a specific area of land
Tapu	What is sacred
Te reo Māori	Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi
Te Whatu Ora	Health New Zealand
Tika	To be right or correct
Tikanga	The ethical and right way of being; ethics and values

Tinana	Self, person, reality
Tohunga	Skilled person, chosen expert, healer
Whakarongo	Intuitive active listening
Whakawhanaungatanga	Establishing relationships
Whānau	Family
Whare	House, building
Whenua	Land

Table of contents

Abstract 2
Acknowledgements 3
Glossary of terms 4
Glossary of Māori Words 6
Table of contents 8
Chapter 1: Introduction 11
Colonisation 12
Statement of the Problem 16
Aim of the Research 18
Positionality 18
Bream Bay 19
Conclusion 22
Chapter 2: Literature Review 23
Section One 23
The Beginning of Colonisation - Doctrine of Discovery 28
Declaration of Independence 28
Te Tiriti o Waitangi 29
Impact of Colonisation on Healthcare in Aotearoa, New Zealand 31
Section Two 40
Mental Health and Well-being in Aotearoa, New Zealand 40
Māori Health Models 44
Conclusion 51
Chapter 3: Methodology 53
Kaupapa Māori Research 53
Research Procedures 59
Interviews 63
Ethics 64
Data Analysis Approach 66
Reflexivity 68
Chapter 4: Findings 70
Section One 70
Ā Wairua 71
Whakarongo 78

Kia Ngāwari 82
Mana Rangatiratanga 88
Whakawhanaungatanga 93
Conclusion Section One 99
Section Two 99
Initial Framework 109
Māwhaiwhai Kaupapa Framework Development 111
Final Framework 112
Māwhaiwhai Kaupapa Assessment Tool Creation 114
Conclusion Section Two 115
Chapter 5: Discussion 116
This Study as it Relates to Western Health Perspectives 116
This Study as it Relates to Māori Models of Health 118
This Study as it Relates to Kaupapa Māori 120
Strengths and Contributions 122
Limitations 123
Reflexivity 125
Recommendations for Future Research 126
Practical Implications 126
Psychological Implications 127
Section Two Conclusion 127
References 129
Appendix A: Participant Information Sheet 144
Appendix B: Hui Participant Consent Form 146
Appendix C: Individual Consent Form 147
Appendix D: Interview Schedule 148

List of figures and tables

Figure 1 A Topographic Map Image of Bream Bay and surrounding areas 20
Figure 2 A Topographic Map Image of Towns Within Bream Bay 21
Figure 3 The Meihana Model 49
Figure 4 Research Design Part One 61
Figure 5 Research Design Part Two 61
Figure 6 Five Tikanga-informed Values Grounded in Tāne-mahuta 70

Figure 7 Initial Hui Presentation of Framework Concept 110
Figure 8 Initial Hui Presentation of Framework Concept of Broken Māwhaiwhai 111
Figure 9 Final Māwhaiwhai Framework 113
Figure 10 Final Māwhaiwhai Framework Broken Web 114
Figure 11 Māwhaiwhai Kaupapa Assessment Tool 115

Table 1 Tikanga-informed Values / Themes and Subthemes 71
Table 2 Framework Themes and Subthemes 100

Chapter 1: Introduction

Tukua te wairua kia rere ki ngā taumata
Hai ārahi i ā tātou mahi
Me tā tātou whai i ngā tikanga a rātou mā
Kia mau kia ita
Kia kore ai e ngaro
Kia pupuri
Kia whakamaua
Kia tina! TINA! Hui e TĀIKI E

Allow one's spirit to exercise its potential
To guide us in our work as well as in our pursuit of our ancestral traditions
Take hold and preserve it
Ensure it is never lost
Hold fast
Secure it
Draw together! Affirm!

This introduction seeks to identify the inequities between Māori mental health and well-being and other population groups living in Aotearoa, New Zealand. It will identify why colonisation over the last two hundred years plays a large role in the current state of mental health and well-being for Māori today. The importance of moving away from Westernised frameworks and utilising Māori mental health frameworks will be discussed and why adhering to Māori *tikanga* (ethics and values) is fundamental when working with Māori. Finally, the need for localised frameworks that align with Māori values will be established. In conjunction, the introduction will acknowledge the purpose of this research project and its significance to the field of psychology.

Like many Indigenous people worldwide, Māori are highly overrepresented in negative statistics, including poverty, life expectancy, mental and physical health outcomes and unemployment (Anderson et al., 2016). Poorer health outcomes for Māori compared to non-Māori are well-known in Aotearoa, New Zealand health statistics (Ministry of Health, 2022). In addition, in 2022, Aotearoa Key Statistics identified that Māori are the most likely group of people to experience mental distress or illness in Aotearoa, New Zealand and it is estimated that approximately 38% of all Māori are expected to have experienced mental distress or illness in their lifetime (Mental Health Foundation, 2022). One clear indicator of poor mental health and well-being is suicide rates (Ministry of Health, 2023). Māori rates of

suicide are disproportionately high, being 15.9 per 100,000 compared to the national average of 10.2 per 100,000 (Chief Coroner Report, 2022). According to the Chief Coroner report (2022), Māori males have had the highest rates of suspected self-inflicted deaths since 2008. By 2022, the suicide rate for Māori males was 23.9 per 100,000, approximately 1.4 times higher than that of non-Māori males. Māori female suicide rates were also much higher 9.2, per 100,000, almost double that of non-Māori females ("Te Whatu Ora," 2022). The most affected age group for the Māori population nationally is 25-44 years of age, which is 2.4 times more likely to commit suicide than non-Māori of the same age group. Although many groups are impacted by inequitable access to mental health services, it is the responsibility of the Crown to address the inequities for Māori, as per Te Tiriti o Waitangi.

Colonisation

Many would argue that the inequities in mental health and well-being outcomes for Māori are more than a national health crisis extending a heavy burden of shame, carried by the New Zealand Government (Waitangi Tribunal, 2019). This ignominy is strongly connected to the generational effects of colonisation in Aotearoa, New Zealand over the last 200 years. Colonisation is the process of establishing control over foreign territories for cultivation to increase the power of the coloniser's empire (Paradies, 2016). It shreds the fabric of traditional societies, beliefs and ways of living through multiple means, such as suppression, regulation, and war (Gracey & King, 2009). Often, those societies were well-established and had been thriving for thousands of years before colonists arrived. Traditional societies had specific laws, customs, languages, spiritual beliefs, rituals, healers and doctors, and worldviews. Through legalised disruption and control, traditional societies become marginalised and institutionalised (Reid et al., 2014). Historically, throughout the world, marginalisation is conducted by brutal dispossession of traditional lands, increased poverty, low or no education, exploitation and a need for dependence on the new political power for welfare (Gracey & King, 2009).

Colonisation Today

It is widely recognised that Western colonisation has impacted colonised states detrimentally across generations (Yacoub, 2023). Colonisation continues to negatively affect the way many societies live today, with the most significant group impacted being Indigenous people (Green, 2022). By the time the era of British colonisation had ended, countries such as

Aotearoa, New Zealand had been radically transformed (Ertan et al., 2016). Because of the economic exploitation of resources and removal of lands from Indigenous people, many economic inequalities can be identified in the disparities of wealth between the living legacies of colonisers and the colonised (Ertan et al., 2016). However, the impact of colonisation is not only financial but cultural. Due to the removal of Indigenous languages and cultural and societal norms, many colonised groups still struggle to reclaim their sense of culture and sense of identity (Choate, 2019). Often, colonised nations push for a nationalised identity; however, many colonised groups struggle with this concept because of all they have lost through the generations (Green, 2022). It is hard to form a united perspective when the inequities of colonialism are still obvious (Curtis et al., 2010). The impact of colonisation still affects Aotearoa, New Zealand's economy, legal systems, language and social infrastructure including healthcare (Signal & Raeburn, 2015).

Colonisation in Aotearoa, New Zealand

Colonisation sequentially weakened the foundations of Māori health by undermining Māori confidence in their own health perspectives and health autonomy (Signal & Raeburn, 2015). Māori had worldviews, cultural beliefs and systems to manage health and well-being (Mooney et al., 2020). Kingi states that, prior to colonization Māori did in fact have well-developed mechanisms for health protection and health promotion, and a comparatively advanced knowledge and understanding of how diseases were transmitted (Kingi, 2005, p. 8). Māori consulted their own medical and spiritual practitioners called tohunga (Stephens, 2001). They also used advanced medicines from *rongoā (*Māori traditional healing system), which included plant and herb medicines, massage and *karakia* (prayer) (Smith, 2015). Prior to colonisation, Māori traditional views on health and well-being stemmed from holistic approaches that covered a wider range of considerations than the European health perspectives that came with colonisation (Signal & Raeburn, 2015).

Colonisation resulted in *tangata whenua* (Indigenous people) occupying a vulnerable position in Aotearoa, New Zealand society (Reid et al., 2014). Much of the traditional land that Māori inhabited was removed through force, confiscation, war and purchasing. In some cases, colonisation involves the complete elimination of Indigenous groups, however, in Aotearoa, New Zealand, colonisers used various approaches to assimilate Māori into British culture (Haukamau et al., 2021). Colonising mechanisms included eradicating Māori culture, wars, banning social, health and spiritual practices, displacement (spiritually, physically, and

culturally), child removal, and residential schools (Paradies, 2016). One mechanism that created an extreme loss of culture was the removal of *te reo Māori* (Māori language). The government enforced policies that led to the deterioration of Māori traditional social structures. They enforced the Tohunga Suppression Act in 1907, where Māori health practitioners could no longer practice traditional medicine (Stephen, 2001). The government removed Māori from their traditional lands where Māori would live in *hapū* (subtribe) and *iwi* (tribe) settlements. These were vital to their way of life, with *whānau* (family) living in a community with a meeting house and large areas of land to grow food. The government discouraged Māori from speaking te reo Māori- an oral language- in schools, public and workplaces (Ryks, 2018). This limited Māori ways of communicating and passing on their cultural traditions, laws, rituals, values, and ways of being, thereby causing an immense degeneration of culture. This in turn removed the cornerstone of *mātauranga Māori* (Māori knowledge).

In Western mainstream mental health, it has been recognised since the 1980s that humans experience psychological reactions to events and experiences that cause great distress. Often, that distress creates a wounding in the *au* (core of an individual) that can be passed down generationally. This is referred to as generational trauma. Colonisation was a traumatic event for Māori throughout history. A lot of tikanga Māori got lost through colonisation (Moewaka-Barnes, 2015). Because of this, many Māori today feel displaced and lack a sense of belonging to their culture, affecting their mental health and well-being. There is more coverage of the impact of colonisation specifically in healthcare in the literature review.

Historical and Intergenerational Trauma

Historical trauma and intergenerational trauma have gained recognition from the scientific field in recent years (Schwartz & Sweezy, 2019). The histories of colonisation worldwide, including Australia, Canada, the United States and New Zealand, offer clear accounts of war, loss of life, and the suppression and removal of culture that induced historical trauma on the Indigenous groups within those nations (O'Neill et al., 2018). Societies such as Māori, who experienced traumatic upheaval due to colonisation, which included war, residential schooling, land loss and racism, may experience the effects and presentations of historical trauma they did not experience firsthand (O'Neill et al., 2018). This trauma has been transmitted unintentionally from one generation to another, causing

survival brain responses based on ancient emotions that involve real and perceived threats (Fishbane, 2019). Unfortunately, vulnerabilities and survival strategies can be formed in childhood in order to compensate, and they can continue into adulthood (Fishbane, 2019). The ongoing reverberations of historical trauma, colonisation, systemic racism, poverty, and government policies are directly linked to intergenerational trauma and can affect the mental health and well-being of Māori today (Yehuda & Lehrner, 2018). The impact on Māori will be further discussed in the literature review.

Cultural Safety

Another reason for the inequitable outcomes for Māori in mental health can come from unsafe cultural practices within the mental health field in Aotearoa, New Zealand. Most education and training for healthcare services are based on Western frameworks (Eggleton, 2020). While the foundation of the training is essential, it also limits the providers' understanding of individuals with different cultural identities and worldviews. Such identities influence a client's ability to interact with service providers and other professionals because their lens of understanding differs from that of the provider. As a result, clients can feel disempowered and do not receive high-quality care (Tremblay et al., 2020).

The term ‘cultural safety’ originated in Aotearoa, New Zealand, in the early 1990s as a response to concern regarding healthcare for Māori and other Indigenous groups over the representation of health inequities (Kaphle et al., 2022). A significant shift in understanding the realities and effects of unequal power relationships in healthcare settings has occurred since the concept was created. Cultural safety aims to ensure that service providers are equipped with enough knowledge and understanding of other nationalities' (explicitly Māori) values, beliefs, and worldviews to be able to provide quality care to the client (O’Hagan & Eggleton, 2023). Cultural safety also requires providers to reflect on how their health perspectives and biases can impact their practice. For mental health providers to truly honour Te Tiriti o Waitangi, they should adhere to tikanga by following the principles outlined below.

Mātauranga Māori

One way to improve cultural safety within mental health is through understanding mātauranga Māori, which encompasses authentic Māori knowledge (Pihama, 2015). It is an epistemology and understanding through a Māori worldview (Waitoki, 2016). The term mātauranga is often referred to as the complete knowledge of the values and attitudes of

Māori as far back as pre-colonisation (Mead, 2012). Mātauranga Māori is based on ethical rules that encapsulate the culture through *tapu* (what is sacred) and *noa* (what is ordinary) (Penehira, 2015). The *kete* (basket) of knowledge is tapu to Māori. Mātauranga Māori does not belong to pre-colonisation alone but also includes acquired knowledge developed over time that has become Māori tradition. This pool of knowledge has increased throughout the years, creating a kete full of traditions and values. As discoveries are made, new innovations and old strategies should be tested and amended through new insight (Mead, 2016). Each new piece of knowledge is added to the kete.

Tikanga

Another way of ensuring cultural safety is to adhere to tikanga Māori. Tikanga is a Māori concept that is underpinned by the values and practices of mātauranga Māori (McLachlan et al., 2017). Tikanga refers to the notion that there is a right way of doing things and every practical action must be conducted with the intention of doing the right or correct thing (Mead, 2016). Some principles and values are akin to the practical application of tikanga. These principles and values are not set in stone but are adaptable to each situation. There are two parts to evaluate the practical aspect of tikanga. The first is *tika* (the right and ethical way of conducting oneself). The second is the concept of *pono* (to be authentic or genuine in action) (Wilson et al., 2020). Therefore, when applying tikanga practically, the intention must be to ensure that Māori principles and values are authentic and uphold the Māori culture.

Statement of the Problem

Māori are disproportionately suffering from high rates of mental health distress yet are less likely to seek mental health support (Theodore et al., 2022). This thesis explores developing a culturally safe framework specific to localised tikanga, for improving mental health and well-being for Māori in the Bream Bay community of Northland, Aotearoa, New Zealand.

This research takes a Kaupapa Māori approach established in Kaupapa Māori theory to obtain Māori perspectives. These perspectives give voice to the participants' lived experiences and challenges of mental health, while seeking to understand personal accounts through a mātauranga Māori lens of what more could be done to improve the mental health

and well-being of Māori in the local community. This approach ensures that tikanga is upheld throughout the process.

Multiple Māori-focused mental health and well-being frameworks have been created since the early 1990s to aid and work to address the inequitable mental health outcomes for Māori in Aotearoa, New Zealand. The frameworks are beneficial and have created space for Māori views on mental health to be more understandable to service providers. A greater understanding of Māori health perspectives has allowed for an increase in cultural safety within the practice of mental health providers. However, although there are Māori-focused frameworks available to aid and improve mental health for Māori, there is space for more. In te ao Māori people are tribal. Traditionally, each hapū and iwi had their ways of doing what was right for their community. Each iwi has its tikanga and *kawa* (protocols) for conducting healing, rituals, ceremonies and hui. Because of this tribal perspective, Māori cannot be put into a box as a collective group that shares the same perspectives. Although much of their mātauranga Māori is the same, it can often be applied differently depending on the area and region. This is partially due to colonisation's effects on different areas, iwi and hapū.

This study is grounded in Kaupapa Māori epistemology. This study has a unique opportunity to use Kaupapa Māori research to allow Māori perspectives to be heard in a specific regional area (Mahuika, 2015). Furthermore, this study holds practical importance by providing a culturally safe and usable mental health and well-being framework backed by scientifically collected data, using qualitative research methods. This study is purposefully conducted, by recruiting participants who are connected to the Bream Bay community to gain a local perspective of the needs of Māori in the area. The mental health and well-being staff of BBCST will use the framework as a means to improve healthcare outcomes for Māori clients. The framework allows local Māori to be validated in a way that honours their unique health perspectives.

This study utilises a bottom-up approach to identify the individual mental health and well-being needs of Māori in Bream Bay. A bottom-up approach focuses on individual behaviours and experiences of people within a group and draws conclusions for the group they represent (Eaton et al., 2018). In contrast, a top-down approach seeks to extend the findings of the study in order to make generalisations about larger groups. The bottom-up approach is exploratory and works with the individuals who will engage with the framework

to identify tikanga principles that align with localised Māori values. This study is conducted by local Māori, in collaboration with local Māori, and is for the local Māori community.

Aim of the Research

The aims of this study are as follows:

1. To identify tikanga-informed values for improving mental health and well-being for Māori specific to Bream Bay.

2. To develop a localised tikanga-informed framework for improving Māori mental health and well-being, that the Bream Bay Community Support Trust (BBCST) can use to provide culturally safe support for their clients.

Positionality

In the following section, I describe who I am, the history of my family and my experience in this research project. This acknowledgement is so that readers can understand the researcher's motivation and reasoning to undertake this project. This section aims to outline my journey and recognise how this research project has broadened my perspective as a researcher. It has also deepened my understanding of the local community, as it pertains to who I am within the confines of Māori culture.

Pepeha

The pepeha section describes my cultural links to Aotearoa through Ngāti Tūwharetoa by acknowledging the mountain beneath which my ancestors settled, the waka that brought my whānau to this land, the water that fed my ancestors, and the marae which my whānau calls home. It also describes my acknowledgement of my ancestors. Although I am not from Bream Bay, I have a kinship to this area that my heart now calls home.

Ko Pihanga tōku maunga
Ko Tongariro tōku awa
Ko Taupō tōku roto
Ko Arawa tōku waka
Ko Awhi Terrance Petera Te Rangi tōku rangatira
Ko Hīrangi tōku marae

Ko Tūrangi tōku whenua
Ko Ngāti Tūrangitukua tōku hapū
Ko Ngāti Tūwharetoa tōku iwi
Ko Manaia te maunga te ru nei taku ngākau
Ko Bream Bay te moana e mahea nei aku māharahara
E mihi ana ki ngā tohu o nehe o Ngātiwai e noho nei au
Ko Kimberley Te Rangi Smyth tōku ingoa he uri ahau no Ngāti Tūwharetoa engari kei Waipū āhau e noho ana.

My Journey

I am one of many urbanised Māori living in Bream Bay. Although my ancestors are from Tūrangi, I have always called *Te Tai Tokerau* (Northland) my home. I was 19 when I moved into a renovated cowshed in One Tree Point on Pyle Road East with a friend. The ocean breeze and sunshine soon convinced me that I had found my place of belonging. I married a man of Scottish descent who was born and raised in Waipū. We opened a restaurant in Marsden Cove Marina on the coast of Bream Bay. It was then that I fell in love with the community. We hired 26 hospitality staff and got to know the staff and customers well. Through years of conversations, I began to scratch the surface of our community's history and current needs. We saw many people hurting, lonely and in mental distress. After selling the business, I decided to be part of a solution but did not know where to start. I began studying psychology, which led me here. I was offered the research assistant role under lead researcher Dr Kyle Eggleton through the BBCST. I initially took the research position for the Trust as part of my health psychology practicum, but in discussion with Dr Eggleton and my Massey University academic supervisor, Dr Kathryn McGuigan, it was decided to use the experience and data for my master's research thesis. This allowed me to lead the interviews and hui for the research and to analyse the results under Dr Eggleton's guidance. After completing my practicum, I developed an attachment to the research and felt it was my responsibility to the participants to complete the study. This master's thesis is the findings and conclusions of that study.

Bream Bay

Bream Bay is an expanse of water on the Northland coast of Aotearoa, New Zealand, 30 kilometres south of Whangārei. The bay sits within the tribal area of Ngātiwai and

Patuharakeke. The head of the bay is the northernmost point and marks the entrance of Te Renga Paraoa, the Whangārei Harbour ("*National Library*," 2023). The ten-kilometre-long cape sits 495 metres above sea level, forming one of the country's most striking coastal skylines. Twenty-two kilometres south of Bream Head is the tail-shaped Bream Tail. Extending the length of the bay is a succession of white sandy beaches that include Langs Beach, Waipū Cove, and Ruakākā (see Figure 1).

Figure 1

A Topographic Map Image of Bream Bay and surrounding areas

Bream Bay was named by Captain James Cook whose ship arrived in 1769 (O'Malley, 2006). The ship's crew caught copious amounts of fish they presumed were bream, hence the name (Waipū Scottish Migration Museum, 2023). The following is an extract from Captain Cook's journal regarding his first voyage:

> *On Saturday, November 25, 1769, at 7.30. p.m., the Endeavour anchored in a bay. As soon as the vessel had anchored, fishing was commenced, and between 90 and 100 bream were caught. Cook says: 'This occasioned my giving this place the name of Bream Bay. . .. At the bottom of it, there appears to be a freshwater river . . . the land*

between Point Rodney and Bream Head, which is 10 leagues, is low and wooded in Turfs (tufts, or scattered clumps, is believed to be meant), and between the sea and the firm land are white sand banks. (Northern Advocate, 24 March 1943, p.5).

Three adjoining towns are located across the Bay: One Tree Point, Ruakākā and Waipū (Figure 2). The total population for the three towns combined, according to the 2018 census, is 8191 people, with 1695 residents being of Māori descent ("*Statistics New Zealand*," 2023).

Figure 2

A Topographic Map Image of Towns Within Bream Bay

Ngātiwai / Patuharakeke

Ngātiwai iwi *whakapapa* (genealogy) comes from Manaia; Ngāti Manaia were originally the main inhabitants of the eastern coast of Te Tai Tokerau (Northland) (Waipū Scottish Migration Museum, 2023). The term Ngātiwai means people of the sea and describes the coastal environment of those living there (Eggleton, 2020, p. 148). According to the Ngātiwai Trust Board, the iwi boundaries extend north as far as Rakaumangamanga, across to

Aotea, South to Takatu Point and return to Rakaumangamanga (Waitangi Tribunal, 2017). Fourteen hapū are included in the membership of the Ngātiwai iwi; however, there is limited unity between these entities. Some distinct boundaries and entities acknowledge their affiliation to Ngātiwai through intermarriage while others contest their affiliation to the iwi altogether. Patuharakeke is one hapū that acknowledges intermarriage affiliation but chooses to stand alone.

Patuharakeke is the hapū that inhabits the Bream Bay area. They are the *mana whenua* (customary Indigenous authority of a specified land area) of the land and are therefore the *kaitiaki* (caretakers) (Hudson, 2010). Takahiwai is the ancestral *kāinga* (village) of Patuharakeke. It is found on the edge of the One Tree Point between the northern forest of Takahiwai Hills and the shore of Te Renga Paraoa (Whangārei Harbour) on the edge of Bream Bay (Kepa et al., 2019). According to a local Patuharakeke scholar, before Patuharakeke and Pākehā arrived in the area, other iwi resided there such as Ngā Tāhuhu, Ngāti Ruangaio, Ngāti Tū and Te Parawhau (Ngāpuhi) (M. Keppa, personal communication, July 13, 2022). Although remnants of these iwi are still presently living in Bream Bay, there remains only one marae, which belongs to Patuharakeke.

Conclusion

This thesis seeks to identify what a localised tikanga-informed framework would look like for improving the mental health and well-being of Māori in the Bream Bay community. This chapter has introduced the inequitable mental health statistics for Māori in Aotearoa, New Zealand. It has identified some of the underlying causes that must be considered when trying to improve mental health outcomes for Māori. These causes include the process of colonisation and its effects on whānau through historical and intergenerational trauma, the lack of cultural safety and the need for greater understanding of mātauranga and tikanga Māori. It is essential to develop and apply more Māori mental health frameworks to achieve better outcomes for Māori mental health and well-being (Kaphle et al., 2022).

Chapter 2: Literature Review

This chapter seeks to deliver a body of information that is immersed in the work of scholarly practitioners in the field of psychology by contextualising the history of colonisation in Aotearoa, New Zealand, as it pertains to Māori. The first section of this chapter will identify critical aspects of Māori culture pre-colonisation. The second section will focus on current frameworks and how they are being used in mental health settings across Aotearoa, New Zealand. This section will also highlight the need for cultural safety within mental health or well-being frameworks. Finally, well-used Māori mental health models will be presented to establish the importance and impact of frameworks that align with the client's values to benefit and improve their mental health and well-being outcomes.

Although this research study is based on current-day statistics, many psychology researchers believe that the backstory of Māori history is imperative to improving the mental health and well-being of Māori today (Smith, 1999; Cram, 2013; Tiakiwai, 2015). For this reason, colonisation will be discussed as a matter of importance in this thesis. By obtaining significant knowledge about colonisation and the history of Aotearoa, New Zealand, a newfound understanding of the current mental health statistics for Māori is brought to light. With greater understanding, new actions can take place to create better resources that can potentially improve the mental health statistics for Māori in Te Tai Tokerau.

Section One

The trajectory of Māori health has changed since the beginning of colonisation in 1840 (Reid et al., 2014). Prior to colonisation, Māori were considered a physically strong and resilient people (Kingi et al., 2017). In 1934, Elsdon Best wrote a book called 'The Māori as he was,' which aimed to preserve the pre-colonial understanding of who Māori were before the effects of colonisation (Best, 1952). He noted how positive their outlook on life was even into old age. He also identified that, because of their strong oral history, Māori had advanced memory skills. In an extract from his book, Elsdon shares in detail an example of an older man from Tūhoe who could recall and recite an impressive amount of information:

> *The Māori is mentally acute and possesses remarkable powers of comprehension. His powers of memory are undoubtedly great and sometimes appear marvellous to us. Thus an old man of the Tūhoe Tribe recited to the writer no less than 406 songs from*

> *memory. Another old fellow recited from memory the genealogy of his clan, a task that necessitated the repetition of over 1,400 personal names. Such powers of memorising are the result of long centuries of training, of the lack of a written tongue, combined with a strong desire to perpetuate certain forms of knowledge (Best, 1952, p. 8).*

Historians can trace the arrival of Māori onto New Zealand's shores somewhere between the 12th and 14th centuries (Cashmore, 2002). After Europeans such as the British and French arrived in Aotearoa, New Zealand, in the 1700s, there was a significant decline in the Māori population (Reid et al., 2014). Much of the early decline in population numbers was from transmitted diseases to which Māori had no immunity (Miller & Ruru, 2008). Māori arrived from Eastern Polynesia on *waka* (Māori canoes) (Durie, 1994). Māori were highly skilled navigators and explorers; they used the stars to guide their journeys as seafarers across the oceans. Māori were also skilled hunters, gatherers and farmers (Macfarlane, 2016). They harvested food from the ocean, rivers, forests and streams. Māori deeply understood the natural elements and fished with the guidance of the moon, planting and harvesting by following the astrological movements of stars (Milne, 2010). Pre-European Māori designed extensive garden systems and *rua kūmara* (underground storage pits). They also built *pātaka* (food storehouses) for long-term food storage (Sterling et al., 2021). Traditionally, Māori were proficient offshore travellers whose excursions led them to various islands where they traded their goods and products with other iwi (Orange, 2021).

Mātauranga Māori - Cosmology

Although multiple versions of the Māori creation story exist, they all have similar origins and themes (Marsden, 2003). Generally, the creation story begins with Io-matua-kore (Creator, the parentless one) (Rangiwai, 2022). Io brought into existence two *atua* (gods), Papatūānuku (Earth Mother) and Rangi-nui (Sky Father). These two are the female and male beings from which everything created is derived (Reilly, 2018).

Rangi-nui desired to be close to Papatūānuku. He came down from the heavens to be close to her. Their embrace was inseparable. Rangi-nui held onto Papatūānuku so tightly that there was no room for light to shine between them (Rangiwai, 2022). As a result, they lived in *te pō* (complete darkness). The pair created 77 children who lived trapped in the darkness of their parent's embrace. Some of their children were Tāwhirimātea (atua of the weather),

Tāne-mahuta (atua of the forest and birds), Tangaroa (atua of the ocean, lakes and rivers), and Tūmatauenga (atua of war and food cultivation).

The children of Rangi-nui and Papatūānuku grew tired of living in darkness from their parents' tight embrace and discussed how to live in the light. Tūmatauenga decided to kill his parents (Reilly, 2018). However, Tāne-mahuta argued that it was better to divide the parents. This way, Rangi-nui would be a stranger to his children in the sky, and Papatūānuku would lovingly remain close to the embrace of her children below. The children failed to isolate their parents from one another until it was Tāne-mahuta's turn (Reilly, 2018). He lay on his back with his shoulders on his mother and his feet on his father. He pushed and pushed and finally pried his parents apart. The atua groaned in pain but finally separated, sending Rangi-nui towards the heavens and pushing Papatūānuku beneath the children, allowing light to shine in the space between the atua.

Io, Rangi-nui, Papatūānuku, and their sons became the guardians of creation (Rangiwai, 2022). Tāne-mahuta is recognised as the creator of humanity and the father of the *ngahere* (forest) because the trees keep the sky and earth apart (Reilly, 2018). Tāne-mahuta became the guardian of everything derived from the ngahere, including food, shelter, birds, medicines, spiders, and insects. It is believed that he fashioned Hine-ahu-one, the first woman, from clay and breathed life into her being.

As a group, Māori value the importance of the natural environment such as the *whenua* (land), *moana* (ocean), *awa* (river) and *maunga* (mountain). The importance of the creation story within mātauranga Māori must be acknowledged because it is the foundational understanding of how Māori connect to the elements of creation (Phillips et al., 2017). In one survey across Aotearoa, New Zealand, 69% of Māori believe the natural environment is very important to them and their well-being. In Te Tai Tokerau 73.7% of the Māori population believe the same (Te Kupenga, 2018). Māori have a strong connection to the elements of creation, such as the stars, the sea, the cycles of change and the creatures that live within the forest and oceans (Marsden, 2003). The knowledge of fishing, hunting, planting and gardening is connected to the environment and the spirit through atua.

In Te Tai Tokerau having mātauranga Māori is important for Māori. According to Te Kupenga: 2018 the Tatauranga Aotearoa Stats NZ's survey of Māori well-being, 91% of Northland Māori know their iwi and 98.5% have attended a marae at some point (Te

Kupenga, 2018). At a national population level, 22.1% Māori believe it is very important to be engaged in their Māori culture, whereas in Te Tai Tokerau, an estimated 29.8% of Māori believe participating in cultural activities is extremely important.

Tikanga Māori – Māori Values

Māori believe there is a right and ethical way of conducting all practices – this is called tikanga (Mead, 2012). There are multiple underpinning values that provide understanding of the concept of tikanga, such as manaakitanga (Mead, 2016). Manaakitanga can be understood to some degree as nurturing relationships, showing hospitality, and treating all people with respect (McLachlan et al., 2017). *Manaaki* means to demonstrate support, while tanga means to action support. One cannot manaakitanga in theory, as it must be demonstrated by physical action. For example, when I initially approached mana whenua about participating in the BBCST research project, I was welcomed onto the Takahiwai Marae by Patuharakeke hapū before any interviews began. The invitation aimed to uphold tikanga by demonstrating my intention to the mana whenua. By inviting hapū representatives to collaborate in the research, I maintained the spirit of Te Tiriti o Waitangi by recognising Māori sovereignty over their knowledge and ensuring equity by upholding equal rights to Māori (Came & Tudor, 2016). The Patuharakeke tikanga process for collaborating with the research was to welcome me onto the marae to *whakawhanaungatanga* (the process of building relationships) me and the mana whenua who are *kaitiaki* (caretakers) of the land the research is being conducted on.

Another value of tikanga Māori is *whanaungatanga* (maintaining relationships, kinship and a sense of belonging) the embrace of whakapapa with a central focus on maintaining relationships (McLachlan et al., 2017). The term whakawhanaungatanga is often used in connection with whanaungatanga (Duncan & Rewi, 2018). Individuals within this community expect to obtain support from their whānau, their collective group, and community members. In Te Tai Tokerau 35.4% of Māori found it easy to obtain relational support from whānau and community, while 22.6% found that they felt lonely in the last month and struggled to obtain support (Te Kupenga, 2018). Furthermore, within the value of whanaungatanga comes the *kanohi ki te kanohi* principle (face-to-face), which indicates kinship is formed through bonds of connection when in the presence of one another (Smith, 2021). This principle honours an individual's *mana* (prestige, authority, honour and respect) by taking time and being present to connect in person.

Mana is a fundamental value within tikanga Māori and is multifaceted in its meaning. The concept relates to prestige, power, influence and authority (Mead, 2016; Wilson et al., 2020). Moreover, mana is understood to hold a supernatural element of strength and energy (Smith, 2021). Mana can be inherited through one's rangatira, or it can be acquired through achievements or taking leadership roles (Mead, 2016). Mana is not solely used to describe individuals but is also used in relation to whānau, groups and events. Moreover, mana describes elements of Papatūānuku, such as maunga and awa concerning their power and strength (Wilson et al., 2020).

Tapu is important in all tikanga (Patterson, 1991). It represents the knowledge that something or someone is sacred and set apart - that there is a value of great significance in the physical and the *wairua* (spiritual) alike. Every element can have a form of tapu: people, places, buildings and even words (Russell, 2018). It is important to note that tapu is inseparable from the identity of being Māori. Tapu is at the core of mātauranga Māori and mana, giving significance and sacredness to cultural practices (Mead, 2016). The opposite of tapu is *noa* (Duncan & Rewi, 2018). This term is used to indicate when something is ordinary and not sacred. Although most Māori are aware that there are elements that pertain to tapu, those who are disconnected from their culture, don't always know which elements are tapu or noa. This can induce a sense of *whakamā* (shame) for a Māori who has a limited cultural understanding of tikanga (McLachlan et al., 2017).

Another significant value to understand within tikanga is the concept of *utu* (avenge) (Mead, 2016; Rangiwai, 2022). Utu stems from the understanding that all actions have consequences. Māori understand utu as a type of justice where the response to the perceived violation is payment to equalise the wrong. Utu involves seeking revenge for a violation of misconduct against a person or group. Because Māori are a collective culture by nature, it is understood that utu extends not only to the person wronged, but to the whānau and sometimes even their wider community such as iwi. If an individual is wronged, the victim's whānau will ensure utu on their behalf as reprobation (Patterson, 1988). Utu can be negotiated in compensation and does not always include violence. When someone or a group is wronged, utu is used to restore the balance through retribution and reciprocity (Duncan & Rewi, 2018).

Many tikanga practices today remain focused on showing respect and care for the spaces and environment protected by the atua (Mead, 2016). The practices continue to honour Tāne-mahuta bravery and courage to provide light and care for creation. These practices are

demonstrated through using nature to nourish and provide health and care for Māori using the provision in the ngahere.

The Beginning of Colonisation - Doctrine of Discovery

One of the central psychological beliefs underpinning colonisation is the Doctrine of Discovery, a principle of colonial law (Miller & Ruru, 2009). This doctrine is steeped in colonial-biased rhetoric that ostracized Indigenous people while simultaneously creating opportunities that favoured the British colonisers (Reid, 2010). It iterated the colonisers as a superior race, which was enforced through religious interpretations and laws that were largely derived from the biases of European Christian settlers. The people who subscribe to this doctrine believe they have the right to enforce their religion and law over peoples and cultures that are less superior, such as minority groups and Indigenous nations (McNeil, 2016). Colonists who practised the Doctrine of Discovery believed their God-given duty was to assume control over native inhabitants, as well as their lands, in order to advance their religious regimes (Reid, 2010). Indigenous people were considered inferior races and seen as 'heathens' (Miller & Ruru, 2009). Colonisers who adhered to the Doctrine of Discovery considered Indigenous lands and settlements to be *terra nullis* (empty) and ready to be taken (Reid, 2010, p.349).

The Doctrine of Discovery had devastating consequences for Māori and other Indigenous populations worldwide (Miller & Ruru, 2009). Through colonisation, the effects of the doctrine of discovery, led to cultural destruction and the suppression of mātauranga Māori traditions and practices. The doctrine is responsible for the extreme removal of identity and is part of the racism that has fundamentally underpinned colonisation, which privileges colonisers over the Indigenous people (Eggleton, 2020). This has rippled through history into every area of life for Māori, even today, including their health, mental health and well-being (McNeil, 2016).

Declaration of Independence

To many Māori *He Whakaputanga o te Rangatiratanga o Nu Tirene* (The Declaration of Independence) is considered the founding document that declared them the official Indigenous people of Aotearoa, New Zealand (O'Malley, 2017). It was created to obtain sovereignty and independence for Māori and was signed at Waitangi on 28 October, 1835 (Ross, 1980). Māori wanted to separate themselves from the interference and control of

French and British powers (Ross, 1980). According to historian John Ross (1980), James Busby, a British resident and a crown consultant with the Māori, had received a letter from the French baron Charles de Thierry stating his intention to establish sovereignty over Aotearoa, New Zealand. It was Busby's intention to help Māori become identified as the Indigenous people of Aotearoa and to build their alliance with the British. The Declaration declared Aotearoa, New Zealand to be an independent state with British protection. This allowed the establishment of Māori as autonomous and self-governing people of Aotearoa, New Zealand who were able to negotiate treaties and trade agreements with foreign nations (O'Malley, 2006). Thirty-five chiefs from the Northern regions of Aotearoa, New Zealand, signed Te Tiriti (Turton, 2009). There was enough support for the Declaration that it granted Māori the ability to trade with foreign nations.

Te Tiriti o Waitangi

Te Tiriti o Waitangi, considered the nation's founding document, was signed on the Waitangi grounds in the Bay of Islands, on February 6, 1840 (Mutu, 2018). There were multiple reasons that Te Tiriti o Waitangi was required. One of the main reasons was to maintain a clear future path for commercial development and trade for both Māori and British settlers (Orange, 2021). Another primary driver for Māori to sign Te Tiriti was their desire for the British Crown to govern their own British settlers (Lands, 1928). The Crown had a vested interest in securing Te Tiriti to manage colonisation and expand the British Empire (O'Malley, 2017). Other nationality groups were arriving in Aotearoa, New Zealand and hoping to establish their colonies which would greatly impact the British ability to control the South Pacific. Te Tiriti was meant to establish British governance over New Zealand while recognising and protecting the rights and ownership of land for the Māori (Pool, 2015). Another reason Te Tiriti was required by the Crown was due to the arrival of the New Zealand Company, led by Edward Wakefield, an Englishman who intended to buy or take over land from Māori and sell it at a profit to settlers for financial gain. Wakefield and others held that Māori societies could only claim lands they physically occupied and cultivated while all other lands became lands owned by the Crown making them available for sale without need of native title (Pool, 2015). The Missionaries and the Aboriginals Protection Society argued against Wakefield's plans and voiced their concern regarding the severe impact of colonisation on land. The groups fought for Māori to have native property titles to

all land that they laid claim to. These among many disputes were the reasons a clear treaty was required (Waitangi Tribunal, 1999 p. 252-53).

Terms of the Treaty

Te Tiriti was signed by 46 Māori rangatira and 43 British residents. There were two documents, one in te reo Māori (Te Tiriti o Waitangi) and the other English (The Treaty of Waitangi). Māori signed the te reo Māori translation, while the British signed the English translation (Orange, 2021). After the initial signing of Te Tiriti o Waitangi, the document was taken around Aotearoa, New Zealand to gather more Māori rangatira signatures and finally gained a total of 500 Māori signatures. Māori signed the English text only once, that occasion being at Waikato Heads at Manukau ("*Waitangi Tribunal*," 2023). One of the main issues within Te Tiriti o Waitangi is the discrepancies between the Māori and the English translation. Te Tiriti has four articles, three written and one oral, while the English text has only three written articles; what is more, the differences in language caused variances in the comprehension of Te Tiriti meaning (Eggleton, 2020).

Te Tiriti o Waitangi is comprised of a preamble and three articles that establish the rights of Māori. There is believed to be a fourth article that was oral and not translated into the English text (O'Sullivan et al., 2021). The preamble asserts that the purpose of Te Tiriti is to protect Māori interests and establish a British government to maintain peace and order for the expanding British settler colonies ("*Waitangi Tribunal*," 2023). Article One relates to the new governance provision for the British Queen to govern over all lands of Aotearoa, New Zealand. Te reo Māori text states 'te Kāwanatanga katoa o ratou whenua' which can be translated to subordinate leadership and governance of all lands (Browning, 2022). This does not mean Māori gave ownership of the land to the Crown but authority to manage their own British affairs on Māori land. Article Two aims to protect Māori interests and assets. Māori were guaranteed to retain possession, chiefship and sovereignty over their lands, forests, fisheries and treasures. The article also gave the Crown the first right of refusal for land purchases from Māori. Article Three ensures the Crown offers the same equal rights to Māori and the British. This includes new trade opportunities and trade routes, access to crown capital relationships and court, improved treatment of workers and the assurance of no slavery. Article Four was an additional oral article that ensured the rights of religious freedoms and customs and that they will be protected by law (O'Sullivan et al., 2021). The Crown did not acknowledge the oral article, and it was not included in the Treaty of Waitangi

English (Eggleton, 2020). In 1907, the Crown passed the Tohunga Suppression Act which made it illegal for Māori health practitioners to use traditional Māori healing practices that possessed supernatural or spiritual elements (Mooney et al., 2020). This law had gone directly against the Te Tiriti Article Four and removed religious freedoms and Māori cultural customs from protection.

The interpretations and understanding of Te Tiriti are an ongoing debate to this day. The differences between the Māori and the English version have led to complex issues throughout Aotearoa, New Zealand's history ("*Waitangi Tribunal*," 2023). The implications have continued to shape the social, political and legal landscape. Throughout history, the Crown has implemented the English text of understanding, while many Māori hold that the English text is not the true Te Tiriti signed by their rangatira (Orange, 2021).This historical event is highly contentious, so much so that in 1975 the Waitangi Tribunal was created as a government department to aid in the efficacy of adhering to the spirit in which both parties had agreed to sign Te Tiriti o Waitangi in 1840 (Treaty of Waitangi Act, 1975). The primary aim was to be a commission of inquiry where Māori could make claims and recommendations regarding any governmental policies or actions of the Crown that breach the intentions of the Te Tiriti o Waitangi.

Impact of Colonisation on Healthcare in Aotearoa, New Zealand

During the colonial era, traditional Māori health systems were well established and were considered successful for that time (Signal & Ratima, 2015). British immigrants have noted that Māori were considered to be in good health. Māori health systems were based on holistic methods that considered a person's individual well-being and the well-being of the collective community (Durie, 1994). In the 1700s it was recorded that there was an estimated population of 100,000 Māori in Aotearoa, New Zealand. Between 1769 and the early 1900s, the Māori population declined to an estimated 40-45% of the population prior to Captain Cook's arrival (Pool, 2015). Much of the decline came from the unintended consequences of being exposed to new illnesses, however further decline came from the transfer of resources from Māori to settlers which lead to poor living standards which impacted Māori well-being (Pool, 2015). Unfortunately, colonisation progressively depleted the traditional Māori health system through immigrants and physicians who had vastly different perspectives on health. European health perspectives shunned the Māori healthcare system and through political

oppression, the introduction of new diseases and the alienation of Māori land, Māori confidence in their own way of being was weakened (McLean, 1964).

During the early colonisation era of Aotearoa, New Zealand, the British provided medical practitioners with a variety of qualifications (Eggleton, 2020). Western public health systems quickly became the overarching health systems in Aotearoa, New Zealand. Throughout the early 1900s, the colonial government invited Māori health professionals such as Dr Māui Pōmare and Dr Peter Buck (Te Rangi Hiroa) to provide a bridging gap between Māori realities and Western perspectives of health (Signal & Ratima, 2015; Pool, 2015). The aim was to build a bridge between the Crown and iwi. However, the initiative was short lived, and the role of Māori health professionals was replaced by non-Māori community-based medical practitioners (Hay, 1989). The early practitioners received a monetary fee for their service which created a capitalist product that impacted and limited the ability to access healthcare for Māori.

The colonial government identified that there were financial barriers for Māori to access healthcare and the government allowed several medical practitioners to register as Native Medical Officers (NMOs) (Eggleton, 2020). These NMOs received a salary provided by the government to provide Western healthcare to Māori at no charge. Historians have identified that the quality of the practitioners' characters was questionable and reports of inappropriate behaviour towards Māori women, alcoholism and poor practice were identified (Dow, 1999). The NMO came under intense scrutiny and did not last long. In parliament, many parliamentarians reported wanting only Māori who could not afford healthcare to receive treatment from NMOs. There were further reports of NMOs refusing to treat Māori patients if they believed they could afford to pay a fee (Dow, 1999).

By the late 1800s, the Māori population had plummeted so drastically that their continued existence came into question (Pool, 2015). The decline in numbers was predominantly due to exposure to life-threatening, infectious diseases. Over 40% of Māori deaths, throughout the 1900s, were due to the contraction of infectious diseases (Kingi et al., 2017). Simultaneously, in the early twentieth century, Māori were also afflicted with detrimental conflicts that included: land wars, extreme poverty, and displacement (Orange, 2021). They were introduced to alcohol, which deeply disrupted a people group who had limited to no understanding of the ramifications of this substance (O'Malley, 2006). The

impact of colonisation propelled controlled mechanisms, which resulted in a drastic decline in mental, physical and emotional health for Māori (Eggleton, 2020).

In the 1980s, the Department of Health had a Māori Health Committee that put forward the recommendation that Te Tiriti o Waitangi should be considered the foundation for obtaining good health in Aotearoa, New Zealand (Durie, 1999). By 1988, the Royal Commission on Social Policy of the New Zealand government decided that Te Tiriti was relevant to not only health promotion, but also to all future social and economic policies (Signal & Ratima, 2015). These new developments were the beginning of including Te Tiriti in health legislation.

Impacts of Colonisation in Bream Bay

Colonisation impacted every area of Aotearoa, New Zealand. In Bream Bay, the impacts of colonisation were detrimental to the local iwi and hapū. One way colonisation devastated Māori and their culture was the loss of their land (Pool, 2015). The Crown managed to take ownership of land from Māori through negotiating land purchases with only one or a few of the multiple native landowners (O'Malley, 2006). If the owners did not want to sell, the Crown would often confiscate the land due to obtaining ownership from other parties, leaving the refusing owners to forgo compensation (Walker, 2013). John Grant Johnson was appointed by the Crown as a land purchase agent to negotiate Māori land deals in the Whangārei district, which includes Bream Bay. In January of 1854, Johnson negotiated the purchase of 60,000 acres of land north of Mangawhai, including Ruakākā and Waipū (O'Malley, 2006). Johnson negotiated the land at the request of the Highland and Nova Scotian immigrants who arrived with Reverend Norman McLeod. John Grant Johnson reported on this block:

> *The difficulty I had to contend with in this block was the confining the natives into a reasonable reserve in the valley of the Ruakākā, as they insisted on keeping the most valuable tract back for themselves, to which I could not consent, for Mr McLeod, one of the leading men of the Highlanders, having arrived, and our inspecting the valley and district together, he quite agreed with me that, unless the natives could be confined to a limited reserve, the valley could not be made available as their settlement (O'Malley, 2006, p. 87).*

According to Vincent O'Malley's 2006 Northland Crown Purchase Report, the Crown purchased Ruakākā for £100 from mana whenua rangatira. The initial purchase was made in agreement with the first Māori chiefs who came forward, while other claimants did not receive any form of payment (O'Malley, 2006). John Grant Johnson, the District Land Commissioner, noted in his journal that the crown reserved £250 for other owners if they ever made a claim. However, the sale went ahead with only the initial chiefs ever being paid out for Ruakākā (O'Malley, 2006). Another example of the Crown's abuse of purchasing power was in 1854, where the Crown demanded a cession (the formal giving up of rights, property, or territory by a state) where a large 1000-acre block of Māori land was involuntarily mandated to the Crown, due to *tāua muru* (a form of fighting to settle disputes) (Rigby, 1998). The land was signed out of Native Title and became Crown land. The 1000-acre block is attached to Takahiwhai and is now known as Marsden Point and Marsden Cove. Another incident occurred with the land exchange in 1854 when Chief Te Pirihi of Patuharakeke claimed compensation and acknowledgement that there had been a massacre of the hapū on the Waipū land that was being offered for sale by the Crown (Waipū Scottish Migration Museum, 2023). John Grant Johnson acceded to the payment (O'Malley, 2006). In 1963, an archaeological survey was conducted along a group of Waipū hill tops and an *urupā* (Māori burial ground) was discovered. The survey unearthed Māori bones that had calcified into the limestone and acknowledged that there are many more urupā in the cliffs of the hills. (Waipū Scottish Migration Museum, 2023). Thus, Bream Bay has seen declining numbers of Māori due to significant loss of lands with little or no compensation.

Urbanisation of Māori

There are still hundreds of hapū groups living within their ancestral whenua. While many have relocated, they remain connected to hapū, iwi and land, because ancestral land is extremely important for Māori (Durie, 2011). The urbanisation of Māori increased due to the British colonisation of Aotearoa, New Zealand and the detrimental impact it had on land being taken away from Māori through various means, as stated above. After World II, the migration from rural community living to urban areas for Māori became one of the most well-recognised internal migrations by a population to date (Kukutai & Taylor, 2016). Māori often found themselves having to accommodate the new societal norms that were far removed from their rural communities (Houkamau et al., 2021). Large portions of traditional land became privatised by the crown and sold. This diaspora left many Māori displaced and

forced to migrate to more urban centres (Ryks et al., 2018). By the 1960s, collective living within a hapū had become a thing of the past for many Māori due to urbanisation (Kututai & Taylor, 2016). A significant portion of this migratory urbanisation stemmed from economic changes as the introduction of farming practices and new large-scale industries caused changes to traditional ways of living (Kepa et al., 2021). Māori who migrated and those left in remote rural communities, experienced significant social, emotional and financial disadvantages.

Urbanisation came with many challenges. Māori faced cultural disconnection from being away from their hapū and whānau whenua (Kututai & Taylor, 2016). Their lives as they knew them through collective living and upholding hapū tikanga were gone. When moving into urban areas, many Māori struggled with discrimination, racism, significant socio-economic disparities, limited work opportunities and intergroup anxiety (González et al., 2022; Simmonds et al., 2015). Urbanised Māori communities contribute significantly to the cultural diversity in the country's social fabric. Many urbanised Māori communities have blended traditional cultural practices to function in a contemporary urban lifestyle that is different from historic Māori traditions.

New government policies significantly encouraged urbanisation by assimilating Māori into British societal norms, such as personal land ownership and English school education (Orange, 2021). Urbanisation increased through industrialisation and the growth of towns and cities that demanded labour. Bream Bay drew urbanised Māori into the community for economic prospects through the Marsden Oil Refinery and North Sawn Lumber Sawmill ("*1960's key events*," 2022).

Urbanisation affects cultural identity, family and community relationships through geographical distance therefore many urbanised Māori struggle to find a sense of belonging (Houkamau et al., 2021). Urban and rural Māori today experience disproportionately worse health outcomes than other groups in Aotearoa, New Zealand (Ryks et al., 2018). Many are experiencing the long-term effects of economic disadvantage, poor education and the removal of socio-cultural norms (Robson & Harris, 2007).

Intergenerational and Historical Trauma

Intergenerational theory holds that each person is linked to the generations above them (Fishbane, 2019). From DNA to cultural rituals, values, and other legacies, there is a

multigenerational chain that connects a person to those who have gone before them (Schwartz & Sweezy, 2019). Advancements in neuroscience have found that stress is intergenerationally transmitted (Champagne, 2008). Newer studies have found similar outcomes in holocaust survivors and their children (Yehuda & Lehrner, 2018). These advances, while positive, continue to focus on biomedical markers of trauma as opposed to *te Ao Māori* (the Māori worldview).

New research in the field of neurobiology has discovered that using magnetic resonance imaging (MRI) and brain scans through positron emission tomography (PET) has helped conceptualise intergenerational and historical trauma as a tangible and visible impact on the body (O'Neill et al., 2018). Using this advanced medical technology can show changes in multiple brain systems and circuits, due to the effects of stress, tension and anxiety (Teicher et al., 2006). This technology allows neurobiologists to study how brain structures may develop differently under personal traumatic conditions as well as historical traumatic conditions that one's *tūpuna* (ancestors) had experienced. Using this technology also gives insight into how the brains of those who have experienced intergenerational trauma may develop. This knowledge has been found to be healing to survivors (O'Neill et al., 2018). It is not feasible or even necessary to use MRI and PET scans on all Māori clients who may display symptoms of intergenerational trauma. Nevertheless, this knowledge is vital to be able to identify that there are brain changes in those survivors.

Healing from intergenerational trauma is an arduous journey. It often involves addressing deep-rooted collective wounds passed down through the generations of one's whānau, community or even culture (Kiyimba & Reona, 2022). The larger context in which a whānau is rooted can increase support or stress for an individual. Whānau who still experience racism, oppression, poverty, and lack of opportunity can often increase the effects of stress and trauma (Fishbane, 2019). McDowell et al., (2018) identify that sociocultural-attuned health services have the potential to highlight the larger context of historical trauma and the injustices colonisation has effected; additionally, it can aid in an individual's ability to recognise and validate their experience. Falicov (2015) found that mentally resilient individuals tend to hold onto traditional beliefs of cultural faith during difficult times. Thus, whānau who hold onto and embrace cultural strengths have the ability to be a source of mental health and well-being support to those who are alienated from traditional cultural practices (Mooney et al., 2020).

The Waitangi Tribunal acknowledges that the inequitable health outcomes for Māori are an ongoing source of shame for the New Zealand government (Waitangi Tribunal, 2019). In the past and present, colonisation has had an immense impact on Māori health and well-being (Barnes & McCreanor, 2019). Māori have suffered historical and intergenerational trauma at the hands of colonists, and their suffering continues to plague the healthcare system today (Thom, 2022). The inequities in health between Māori and non-Māori are an ongoing crisis that plagues Aotearoa, New Zealand's healthcare system. Although efforts have been made to balance the scales on health outcomes, there is persistent failure to achieve health equity for Māori (Wilson et al., 2020).

Current Mental Health Statistics in Bream Bay

Obtaining mental health statistics for a small community such as Bream Bay is challenging. While most statistical data generalise the population nationally, there are government statistics on Te Tai Tokerau, the region within which Bream Bay lies. Te Tai Tokerau Māori comprise approximately 36% of the region's population (Ministry of Health, 2023). Māori within this region have worse overall health outcomes than those of other communities (Northland District Health Board, 2019). Life expectancy for Northland Māori is lower than for non-Māori: males live 9.3 years less than their counterparts and females 8.6 years less. The most common causes of mortality for Northland Māori are cancer, circulatory and respiratory disease, external causes including accidents, self-harm and suicide, and endocrine and metabolic diseases. Diabetes rates are all negatively disproportionate for Māori versus non-Māori. Approximately 6.6% of people in Northland have diabetes, 42% of which are Māori. Obesity is also disproportionate for Māori, with 81.1% of Northland Māori adults being overweight or obese (Northland District Health Board, 2019).

Mental health statistics are harder to source than general health statistics for Tai Tokerau. However, there are national statistics that must be acknowledged. Approximately 38% of all Māori living in Aotearoa, New Zealand, will experience or have experienced mental distress or illness in their lifetime and Māori are more likely than non-Māori to be hospitalized for intentional self-harm ("*Aotearoa Key Statistics*," 2022; Buchwald-Mackintosh et al., 2019). According to Te Whatu Ora (2023), Te Tai Tokerau has over 500 daily mental health community visits and five mental health hospital admissions. Māori are less likely to seek help from mental health services than other New Zealanders. Furthermore, they often go undiagnosed or misdiagnosed by service providers due to a misunderstanding

of the client's health perspectives or due to the use of Western frameworks that do not identify their Indigenous clients' health needs (González et al., 2022).

Structural Barriers for Māori Mental Health and Well-Being

Social determinants of health are the systems of a society that include health systems, economic policies, government agendas and political systems (World Health Organization, 2010). Social determinants of health can influence an individual's or group's health status. These are non-medical factors such as the conditions and environment in which a person is born, lives or works (World Health Organization, 2018). Inequalities arise within health systems when the system fails to address and acknowledge different life exposures and unequal vulnerabilities that can compromise health conditions (World Health Organization, 2010). In Aotearoa, New Zealand, specific health structures and governmental policies determine how a person can access care, which services they can access, who can provide those services and how they can be delivered (Haitana et al., 2023). Structural health barriers can limit the health system's ability to provide alternative care pathways, which can impact the effectiveness and quality of care available for Indigenous groups (Durie, 2011).

Aotearoa, New Zealand's healthcare system is predominantly based on Western health systems that focus on Western medicine practices underpinned by scientific research (González et al., 2022). Western healthcare tends to focus on the body and the mind and does not consider holistic health practices. This then creates a systemic barrier for Māori because in te ao Māori health is holistic and considers the whole person and the social elements in which they live (Russell, 2019; Mooney et al., 2020). Furthermore, Western health systems are rooted in neoliberal healthcare structures. These structures privatise and commercialise healthcare and focus on people who can afford the services or provide public funding for services equally without considering any unequal vulnerabilities within groups (Signal et al., 2015). Neoliberal healthcare largely ignores the long-lasting impacts of colonisation and historical trauma, which creates systemic barriers for Māori to receive equitable healthcare treatment. Notably, a neoliberal healthcare system is primarily run by a government with centralised power structures and management. Non-Māori run the majority of health management at the centralised level; therefore, there is a lack of true co-governance and an unequal power dynamic, which disadvantages the administration of Māori health perspectives (Kaphle et al., 2022). Furthermore, due to the inequality of power, the healthcare system in

Aotearoa, New Zealand does not align with the spirit of Te Tiriti o Waitangi (Eggleton, 2020).

Increased Efforts for Māori Mental Health and Well-being

Historically, the New Zealand health system was run under one umbrella nationally through the Ministry of Health, distributed over twenty District Health Boards, including a Māori health directorate ("*Te Whatu Ora*," 2022).

Currently in Aotearoa, New Zealand, there are strategies that aim to decolonise the health system structure. These strategies include increased use of the Māori well-being models which will be discussed below, more Kaupapa Māori research being conducted, and more support for Māori to be trained and working in health and mental health sectors. One of the most significant strategies is the health system reform that began in 2022 through the Labour government. According to Manatū Hauora (Ministry of Health New Zealand), the Pae Ora Healthy Futures Act 2022 was established by the New Zealand government aiming to ensure that every New Zealand resident can access quality healthcare. The Act's purpose is to:

1. protect, promote, and improve the health of all New Zealanders
2. achieve equity by reducing health disparities among New Zealand's population groups, in particular for Māori
3. build towards pae ora (healthy futures) for all New Zealanders.

Through this new Act, Health New Zealand changed its name to Te Whatu Ora and added a new partner agency to help decolonise the health system, Te Aka Whai Ora (Māori Health Authority). Te Whatu Ora replaces the District Health Boards and oversees the health system of the nation. It will ultimately be a centralised agency to design, provide and deliver health services across Aotearoa, New Zealand. Te Aka Whai Ora was originally designed to be an independent agency specifically accountable to Māori and the government, and to plan and provide Kaupapa Māori appropriate services specifically for Māori. This system was being implemented through the Labour government however, since the change of government to the National Party in 2023, Te Aka Whai Ora is now repealed. The expectation is that it will merge back into the previous Māori Health Directorate. Its functionality and aims should

remain comparable at this stage. However, during the development of this thesis there is yet to be a clear directive from the government.

There is also an increasing amount of research that points to strategies for decolonising health where institutions aim to rebuild the knowledge systems and training that reduce the unequal power relationships that sit within the Western health systems globally (Forsberg & Sundewall, 2023). Much of the global health cooperation and research is funded by what is deemed the Global North or high-income countries, which impacts how research is designed and structures are developed to provide healthcare assistance (Green, 2022). Many health structures that are dominant globally were formed in the era of colonialism and still hold colonial mindsets around how they deliver care to Indigenous groups (Khan et al., 2021). The purpose of decolonising healthcare is to balance the power dynamic and promote equity and justice for Indigenous groups where there is not a giver and a receiver but rather a shared and informed knowledge created that benefits both parties (Kwete et al., 2022).

Section Two

Mental Health and Well-being in Aotearoa, New Zealand

Strong evidence suggests that the mainstream medical health systems in Aotearoa, New Zealand, continue to systemically reiterate the belief that Western medicine is superior to traditional medicine (Eggleton, 2020). Western medicine, when used in a mental health and well-being setting, is founded on the philosophy of bio-reductionism (McKee, 1988). This reduces a client's behaviour to physics that are explained through the effects of biology that impacts the brain structures, neurons and hormones. This concept adheres to the mind-body dualism and is grounded in the positivist view of science (Health Quality & Safety Commission, 2019). Western health perspectives view mental health as separate to physical health whereas Māori perspective's view both as part of a person's holistic well-being (Mooney et al., 2020). Within Aotearoa, New Zealand, Western practices are generally taught in higher learning institutions, and these are established as the general practice conducted by medical professionals nationwide. This type of medicine has achieved dramatic advancements and identified in-depth knowledge of the body and mind (Silvano, 2021).

Western medical research (including psychological research) is readily based on participant groups that are accessible to researchers (Pihama, 2015). Because published

research is predominantly conducted in Western-colonised cultures, participant groups for psychological research that include mental health and well-being studies are often conducted with white, educated, and middle-class individuals (Kukutai & Taylor, 2016). Although Western medicine research is known to be effective in some realms, its success should be called into question; because this type of research is limited to other populations of the same demographic and worldview as the participant group (Reid et al., 2014). Like numerous Western cultures, Aotearoa, New Zealand's national health system and practices (including psychology) are founded on Western biomedical models of health- despite their unacceptability for the whole population (Wilson et al., 2020). For example, the psychological field in Aotearoa, New Zealand, is built on Western Academic Scientific Psychology (WASP), which has historically viewed Western values as superior to other types of knowledge systems (Levy & Waitoki, 2016).

Western Frameworks for Māori

Western models and frameworks for mental health and well-being are not universally applicable to all groups of people (Simonds & Christopher, 2013). Many Indigenous groups have different health perspectives and belief systems that do not align with the Western health perspectives (Pitama et al., 2007). Frameworks must align with the client's health perspectives, in order to effectively improve their health outcomes (Smith, 2015). Western mental health and well-being frameworks can cause mistrust, misdiagnosis and inadequate treatment for Indigenous groups (including Māori), because their health perspectives differ (Berryhill et al., 2019). The cultural, historical and social contexts of Māori differ significantly from Western societal perspectives (McLachlan et al., 2017). For example, through colonisation, Māori experienced extreme loss of cultural identity and traditional practices resulting in historical and intergenerational trauma (Simonds & Christopher, 2013). Western mental health frameworks could perpetuate the ramifications of colonisation unintentionally (Wilson et al., 2020). This is achieved by normalising the Western worldviews within certain health frameworks, which can diminish other group perspectives (Bush et al., 2019). Dominant Western health perspectives also tend to focus on the deficit of an individual’s perceived poor health; on the contrary, Māori health perspectives are strengths-based and focus on areas where change can be beneficial (Eggleton, 2020). When Western-based health philosophies are used in bias, there are increased risk factors for Māori and other Indigenous groups (Pitama et al., 2007). As a result, these practices are less

beneficial and altogether unacceptable, because they have the potential to establish detrimental health outcomes for groups of people, such as Māori, who do not uphold the same philosophies and belief systems rooted in the foundation of Western health-based philosophies.

Currently, frameworks of mental health and well-being are challenged by their acceptability for different population demographics (Sekhon et al., 2017). Within health psychology, acceptability is theorised as 'a multi-faceted construct that reflects the extent to which people delivering or receiving healthcare interventions consider it appropriate, based on anticipated or experimental cognitive and emotional responses to the interventions' (Sekhon et al., 2017, p.5). Diepeveen and associates conducted a systematic review of government health interventions combined with the success of altered health behaviours, as they have the potential to improve overall health and well-being (Diepeveen et al., 2013). This research team discovered that successful services had two components to the interventions: the acceptability to the client and the ability of the service provider. Their results also reveal that the client's acceptability is based on the specific content of the design, the context and the quality of care received during the intervention. The overall analysis unveils that if the interventions are considered acceptable to the client, they are more likely to adhere to the recommendations and see beneficial health outcomes.

Arundell and associates also identified that unacceptable interventions are primarily due to a lack of information for the client; resulting in the need for appropriate services to be made available, so that clients can access them for their health and well-being (Arundell et al., 2021). Similarly, unacceptable healthcare options can lead to sub-optimal mental health outcomes for Indigenous and minority groups (Barnett et al., 2019).

Different Perspectives

As stated, many Indigenous groups do not identify with the Western mental health and well-being constructs (Simonds & Christopher, 2013). Nonetheless, these healthcare services continue to be offered to Indigenous groups (Choate, 2019). In conjunction, Western mental health assessment tools and methods used to diagnose mental health conditions for Indigenous people (including Māori) are based on Western health perspectives that often do not align with their worldview. For example, in the Māori culture, it is acceptable for an individual to be guided by their tūpuna through dreams or visions through their wairua

(Mooney et al., 2020). This connection to the afterlife is considered an ordinary part of te Ao Māori to the point that Māori uniformly acknowledge their ancestors during the *pōwhiri* (welcoming ceremony) at the beginning of all important hui. In comparison, talking to the deceased may be considered a delusion and is categorised as a symptom of psychosis according to the *Diagnostic and Statistical Manual of Mental Disorders (5th ed.)* (DSM-5) (American Psychiatric Association, 2013). The disparity between health understandings can cause misdiagnosis, which can decrease the effectiveness of the treatment and negatively affect the client's mental health and well-being due to the service provider's lack of cultural relevance and alignment to their client's values (Al-Busaidi et al., 2018; Simonds & Christopher, 2013).

There are notable exceptions where Western medicine has been less dismissive of Indigenous and traditional health practices that include spiritual and supernatural belief systems (Mark & Lyons, 2010). Craik and colleagues (2023) explored Māori mental health staff perspectives pertaining to the care delivered to specialist mental health and addiction service users getting qualitative and quantitative data from 319 staff. Within the study, only 60% of the participants reported the service delivered to Māori was "good" or "excellent", and 41% considered it to be "fair" or "poor". The data was analysed using a multi-disciplinary research team, which included Māori and non-Māori public health researchers. Participants perceived people-centred/relational models of care as positive and improved care quality. Importantly, some participants acknowledged they needed to use specific Māori care models in their workplace and were aware of the possible limitations of Western models for Māori clients. Other participants who considered Māori to obtain "good" service care acknowledged utilising Te Whare Tapa Whā and aimed to adhere to tikanga guidelines within their clinical practice. From this study Craik et al. (2023) came up with a set of recommendations and opportunities to improve the quality of care for Māori, which in turn can improve the quality of health outcomes for Māori. These changes include improving care integration by using Western mental health and well-being methods in conjunction with Māori, improving cultural safety training for staff and increasing the utilisation of Māori health models and practical frameworks that align with their client's health perspectives (Craik et al., 2023).

The Importance of Kaupapa Māori Research

Another way to improve mental health outcomes is to have knowledge based on Kaupapa Māori research. This is an essential area of study for Māori because it uses scientific methods, while normalising Māori culture, worldview, ethics and knowledge (Tiakiwai, 2015). It also legitimises te ao Māori and validates Māori health perspectives, without a need to compare them against Western health perspectives (Hansen, 2012). While Western research methods allow the researcher to dominate the research through power and control, Kaupapa Māori research partners with the participants (Smith, 2015). This repositions the power by placing it back in the hands of those being investigated (Tiakiwai, 2015). Kaupapa Māori research aims to maintain Te Tiriti o Waitangi, by equalising the power dynamic and decolonising Māori knowledge (Haitana et al., 2020). Decolonisation happens through the means of giving Māori ownership of Māori knowledge and how such knowledge is known. Furthermore, Kaupapa Māori research enables Māori researchers to collate written, informative information that solely aims to benefit Māori. The more Kaupapa Māori research is conducted, the more understanding the scientific community will have in improving Māori health outcomes.

Māori Health Models

Since the 1980's, mental health services have changed in Aotearoa, New Zealand. A significant increase in the prominence and awareness of Māori cultural values and health perspectives has occurred (Durie, 2011). During this time, the Ministry of Health Services accepted the initial introduction of Māori health models. The 1980s also brought many changes to health promotion for Māori (Kiyimba & Anderson, 2022). The first bicultural mental health unit was opened in Waikato at the Tokanui Hospital; it was dedicated to working with Māori struggling with mental health and supporting their whānau (Bush et al., 2019). Within a decade, multiple Kaupapa Māori mental-health services were established throughout Aotearoa, New Zealand, alongside Māori models of health, including Te Whare Tapa Whā, Te Pae Māhutonga, He Pikinga Waiora and the Meihana model (Durie, 1999 & 2001; Pitama et al., 2007). Māori models of health were created to support health service providers and government health agencies, in order to understand Māori health perspectives better. Furthermore, these models validated Indigenous studies within Aotearoa, New Zealand. They encouraged more Kaupapa Māori research and the acceptance of new Māori health models (such as the Meihana model) to be used in mainstream health services (Pitama

et al., 2014). Two of the most influential Māori models of health are Te Whare Tapa Whā and the Meihana model (Durie, 1999; Pitama et al., 2007).

Te Whare Tapa Whā

The most influential Māori model of health is Te Whare Tapa Whā, which is embedded in Māori health policy in Aotearoa, New Zealand (Durie, 1994; Pitama et al., 2007). Developed by Sir Mason Durie in 1984, Te Whare Tapa Whā is a holistic health and well-being model that provides a framework for health service providers to understand health and well-being from a Māori cultural perspective through the symbolism of a four sided house (Durie, 1994). Each wall must be balanced for the house to remain strong upon its foundations (Durie, 2001). There are four dimensions of Te Whare Tapa Whā: the *taha tinana* (physical health and well-being), *taha hinengaro* (mental and emotional health), *taha whānau* (family health and well-being), and *taha wairua* (spiritual health and well-being). What made Te Whare Tapa Whā unique compared to other health models is that this framework acknowledges the need for social connection and spiritual health (Durie, 1994). While many Western health models consider biomedical physical and mental health connections adequate for well-being, Te Whare Tapa Whā considers the entirety of the holistic being, alongside their connections from a mātauranga Māori perspective.

Te Whare Tapa Whā is the most extensively used Māori health model to date; and it is widely used by health organisations and service providers throughout Aotearoa, New Zealand - ranging from small community health services to Te Whatu Ora. Health service providers use the model to help identify clients' health perspectives, and they provide a platform for clients to gain health support for their well-being through a Māori holistic view. Te Whare Tapa Whā is also used academically as a building block for creating other Indigenous models specific to regional communities (Samuels & Watene, 2023). For example, researchers for the Department of Ophthalmology are developing a Kaupapa Māori model of engagement to improve their practitioners' and service providers' cultural training, by increasing their competency and safety. The model enhances Te Whare Tapa Whā, by embedding *pūrākau* (mythical story or ancient legends) into the framework (Pitama et al., 2014; Samuels & Watene, 2023).

Te Whare Tapa Whā is well received by the medical scientific community, and is now being used in studies for non-Māori groups as a holistic well-being model. Suzanne Purdy

conducted a health psychology study in 2020 using Te Whare Tapa Whā as a health model to study vital essential elements for people living with neurological disease or auditory processing disorders, which relate to their ability to communicate with their whānau and support service providers. The study found that the framework contributed to equalising the power dynamics between clients, their whānau and the service provider through strengthening relationships. This was achieved by acknowledging all aspects of Te Whare Tapa Whā which provides space for the client to express their feelings and needs through a holistic lens. The study acknowledged that the model could challenge the practical use within a clinical model. Te Whare Tapa Whā requires a strong level of partnership from all parties involved including whānau, communities, clients and service providers, to understand and provide effective physical, mental and spiritual support (Purdy, 2020). This level of partnership may not always be practically available for all clients, potentially limiting the model's success and the quality of care for Māori.

Te Whare Tapa Whā was trajectory-changing for Māori health understanding as it provides a greater understanding of Māori holistic health (Pitama, 2007). There are, however, limitations to the Te Whare Tapa Whā model. Firstly, it places all Māori in the same category, by assuming all Māori have the same values, beliefs, and experiences. This occurrence takes place because it does not embody a flexible explanation for the four pillars that hold up the framework. Through colonisation and urbanisation, Māori have unique cultural contexts which can change a person's experiences and understandings of health (Durie, 2011). Māori are also iwi-minded, and the culture is not one-size-fits-all (Mead, 2016). Diversity within different communities can get lost with an oversimplified framework, which causes many Māori to feel misunderstood. A second limitation of the framework is its simplicity of complex modes of being. The simplicity limits consideration for underlying factors within their social context such as economic, political or environmental factors. The health psychology study conducted by Suzanne Purdy (2022) agrees with these limitations and adds a third, notably identifying the level of cultural knowledge of the service provider (Purdy, 2020). The model does not consider the service providers' personal biases or cultural knowledge so when a provider has excellent Māori cultural knowledge, it is deemed beneficial to use Te Whare Tapa Whā as a base in clinical settings. There is a risk of the model being too simplistic on its own and that it could be used as a cultural checklist for Māori clients. This can lead to default assumptions and cultural expectations with minimal consideration of the client's specific cultural values and needs (Pitama et al., 2007).

The Meihana Model

Te Whare Tapa Whā is foundational for many other Māori models within psychological practice (Pitama et al., 2014). Many models build on the framework's simplicity and have included more in-depth details about a person's health and well-being from a mātauranga Māori perspective (Matenga & Westenra, 2022). The Meihana model is a newer Māori mental health model developed over five years by Suzanne Pitama and research associates (Pitama et al., 2007). The Meihana model is a framework designed to help clinically measure mental health assessments and interventions for Māori and their whānau (Cram, 2014). A literature review informed the initial research, followed by interviews with twenty-five psychology clinicians who provided vital information on how effectively they were able to implement the Māori health model Te Whare Tapa Whā into their clinical practice. Clinicians were both Māori and non-Māori, and they were based in Tamaki Makaurau (Auckland). The participants were asked to describe how they were implementing Te Whare Tapa Whā within their practice. (Pitama et al., 2007, p. 119). These interviews helped the research team recognise the struggles within the current model and identify potential areas of improvement.

The Meihana model integrates the impact of colonisation, marginalisation, and potential racism for the individual client, by conducting questions within a clinical interview, that encourages the client to share their values and life experiences (Lacey et al., 2011). By providing time and space for clients to share their values, the service provider gains a greater understanding of their health perspectives and identifies what is important to them. It also enables the provider to incorporate their cultural competencies through conducting medical interviews, which can provide a more accurate and comprehensive assessment of a Māori client that aligns with the individual's worldview (Matenga & Westenra, 2022).

The Meihana model consists of six dimensions and overlays them with a core concept called Māori Beliefs, Values and Experiences (MBVE) (Pitama et al., 2007, p. 120). The purpose of including the MBVE is to ensure that there is no defining constraint for service providers to merely tick a ‘cultural box’; but rather, to investigate a client's self-identity as a Māori. The MBVE enables the provider to identify specific beliefs, values and experiences that clients potentially have within their cultural context. The original six dimensions of the Meihana model were Whānau, Tinana, Hinengaro, Wairua, Taio and Ratonga Hauora (previously Iwi-Katoa) (Pitama et al., 2014). However, the model has continued to develop

into a clinical guide for psychologists and other health service providers. In more recently proposed clinical guides for using the Meihana model, the six dimensions have been altered to four specific elements - including the previous ones. The four elements have introduced visual aids (Figure 1), as storytelling is integral to Māori culture. The four elements of the Meihana model are (Pitama et al., 2017):

1. The *Waka Hourua* (the double-hulled deep-water canoe identifies the value of the client and whānau relationship; it acknowledges the impact one has upon the other. Both hulls flow together and help the service provider identify the relevance of the relationship to the presenting issues and identify the need for whānau in future treatment plans. The Waka Hourua reminds providers to work in conjunction with whānau and client together and identify the individual and communal dimensions of the tinana (physical body), hinengaro (mental and emotional), ratonga hauora (access to health services), taiao (connection to physical environments) and their wairua (spiritual connectedness both individually and to each other).

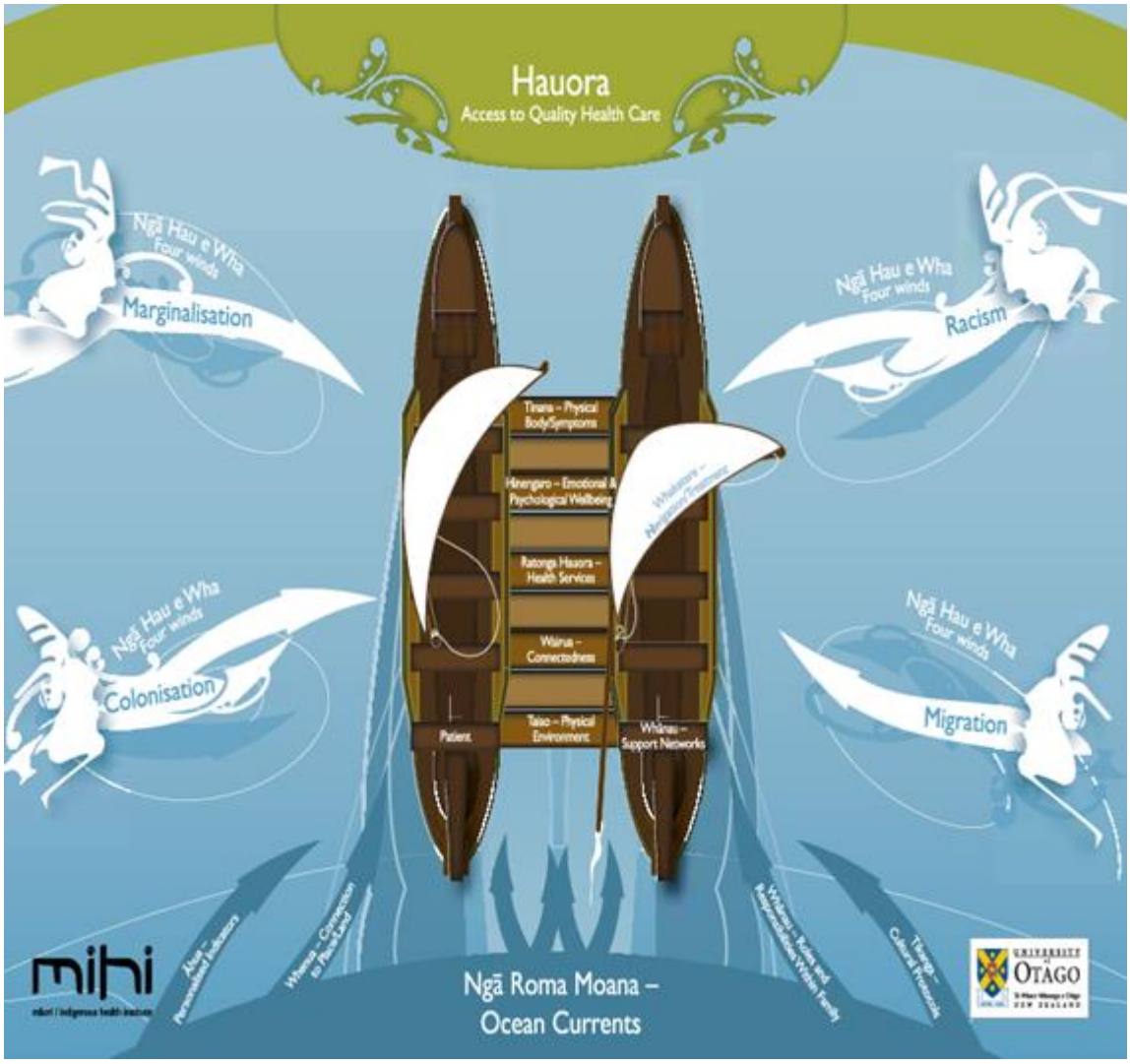
2. *Ngā Hau e Whā* (the four winds) acknowledges the components of society and the historical influences and impact on Māori. The four winds are colonisation, migration, marginalisation and racism. Ngā Hau e Whā considers historical trauma and its effect on the client personally.

3. *Ngā Roma Moana* (ocean currents) represents four factors of te ao Māori: tikanga (the right and ethical way of being), āhua (individual indicators), whānau (family, relationships of iwi and hapū, or close community, responsibilities and commitments) and whenua (spiritual connection to the land, whānau or other).

4. *Whakatere* (navigation) is the fourth element and combines the other three elements. The service provider must integrate the information obtained from waka hourua, ngā hau e whā, and ngā roma moana to formulate an informed treatment plan that personalises the assessment and treatment process.

Figure 3

The Meihana Model



The Meihana model in a visual representation (Pitama et al., 2017, p. 8)

The Meihana model is often used in conjunction with other Māori health models (such as the hui process) for medical and mental health service assessments (Lacey et al., 2011; O'Hagan & Eggleton, 2023). The Meihana model is also part of the Indigenous Health Framework (IHF) used in medical and mental health clinical interactions to optimise communication with Māori clients and their whānau (Al-Busaidi et al., 2019). The Meihana model enables service providers to ask multiple questions to help them engage with their Māori clients (Cram, 2014). Furthermore, active listening is a key aspect of the model that further aligns with Māori health values (Parry et al., 2014). The questions cover various topics, such as the client's whānau, values and personal circumstances. Each question aligns with core mātauranga Māori beliefs. Unlike the Te Whare Tapa Whā, the Meihana model

does not risk oversimplifying Māori health perspectives (Pitama et al., 2007). It also considers the different cultural identities and the historical and past experiences of Māori clients (O'Hagan & Eggleton, 2023). The model's strength and value derive from its practical integration of Māori health understanding into Western-based clinical settings and the Meihana model acknowledges the complexities of a Māori client's value system. The elements within the model help service providers break down their questioning to gain a deeper understanding of the client's personal value system, enabling them to provide more appropriate care (Mooney et al., 2020).

The Indigenous Health Framework (IHF) is an example of how the Meihana model can be used in conjunction with other health frameworks. The values of the system are mostly centred on using health frameworks that will enable health professionals to improve their range of clinical assessments in order to effectively communicate with their Māori clients and their whānau (Al-Busaidi et al., 2018). Three Māori health models comprise the IHF, the Meihana model, the Hui process and the Calgary-Cambridge model (Pitama et al., 2014; Matenga & Westenra, 2022). A case study conducted by Ibrahim Al-Busaidi and associates (2018) found that the IHF was a practical framework for providing appropriate assessment questions, which fostered an effective patient-provider relationship in health settings. The specific use of the Meihana model allowed the communication to obtain a clear structure and direction while implementing efficient cultural competency. The model allowed the provider to engage with the patient and his whānau in a way that made them feel comfortable sharing their values and experiences with the provider. The Meihana model provided a way for sharing personal information that built whakawhanaungatanga with the client, whānau and provider, which positively influenced the health outcomes for the client (Al-Busaidi et al., 2019).

The Meihana model is a beneficial framework for more than just clinical mental health contexts. Grace Matenga and Belinda Westenra (2022) propose using the Meihana model for paramedics when providing emergency services to Māori. Drake and Wilson (2021) also held that paramedics who can understand Māori values, tikanga, and some te reo Māori, can strengthen the relationship between the service provider and the patient. Matenga and Westenra (2022) believe that greater mātauranga Māori and understanding of the Māori health inequalities can positively impact overall health outcomes for Māori. For paramedics in Aotearoa, New Zealand, training is strongly influenced by health models which prioritise

patients' illness and physical symptoms (Barton & Wilson, 2008). Matenga and Westenra (2022) propose that by educating paramedics in mātauranga Māori and tikanga Māori, the level of cultural safety will improve. The pair proposes that using the Meihana model can positively influence the ability of a paramedic to establish a strong connection to the patient quickly, by building whakawhanaungatanga and asking the correct questions at the initial encounter.

The Meihana model is a positive addition to the Indigenous models available for health and well-being providers in Aotearoa, New Zealand for Māori. There is some data on the range of services and ways the Meihana model can be utilised; however, more data on the efficacy of the application to quantify the potential health and well-being improvements for Māori would be beneficial. Although each model has similar themes, they are explained differently between each application. Each theme plays an essential role in the holistic and interpersonal ontology of Māori that impacts health and well-being. Furthermore, these underpinning core concepts are themes that link the Māori models of care together. They are wairua, whānau, hinegaro and tinana (Durie, 1994). Even though they are presented differently between the models, these concepts have been identified as fundamental to the well-being of a person who holds a Māori worldview.

Conclusion

In conclusion, the health disparities between Māori and other New Zealanders are well documented (Durie, 1999; Signal & Ratima, 2015; Kingi, 2017; Eggleton, 2020). The causes for these disparities are vast because colonisation has played a significant role in the inequities (through land loss, racism, language loss and urbanisation) among many other impacts (Signal et al., 2015). Māori mental health and well-being perspectives have been historically disregarded since colonisation by mainstream medical practitioners in Aotearoa, New Zealand (HQSC, 2019). However, since the 1980s, researchers have begun to identify Māori health perspectives and provide models such as Te Whare Tapa Whā to aid in advocating Māori health understanding for health service providers (Durie, 1994). The impact of Indigenous models has enabled mental health service providers to increase their cultural competency, improving the cultural safety of their Māori clients. Te Whare Tapa Whā has been foundational for building other more in-depth Māori models of health, such as the Meihana model. Although these models are proving to impact the health outcomes for Māori positively, there is still space for new Māori health models.

The Māori health models explained above are chosen by the researcher, as a way to identify the decades of research and development that have been placed into the Māori health model designs. It is important to disclose that there is still room for future advancements. Each model is unique; however, they all hold and acknowledge important tikanga values. This study differs from the above-stated models because the Kaupapa Māori Research is conducted according to local tikanga. This research project aims to ensure that Māori (urbanised and mana whenua) of Bream Bay are acknowledged within the study framework, even though there is some crossover with national standards of Māori tikanga. It is imperative that Māori are allotted space to feel connected to the framework, by being understood in a localised way.

Chapter 3: Methodology

This chapter provides the description and purpose of the methodology used to address the above aims. It begins with the research design and an overview of *Kaupapa Māori theory* (KMT), which is the theoretical and methodological foundation for this research. Next, it shifts to explain how KMT has been implemented throughout the research process. This chapter will also acknowledge the ethical considerations taken, the research design method, the participant recruitment process, and the methods used to collect the data are explained. Furthermore, this chapter discusses *Thematic Analysis (*TA*)* and how this method was used to analyse the data set. This chapter also highlights and explains how the research study obtains the validity and trustworthiness of the findings. Finally, as the researcher I will discuss the researcher's positionality through the practice of reflexivity.

The aim of this study is twofold:

1. To identify tikanga-informed values for improving mental health and well-being for Māori specific to Bream Bay.

2. To develop a localised tikanga-informed framework for improving Māori mental health and well-being, that the Bream Bay Community Support Trust (BBCST) can use to provide culturally safe support for their clients.

Kaupapa Māori Research

"He aha te mea nui o te ao? He tangata, he tangata, he tangata."
What is the most important thing in this world? It is the people, it is the people, it is the people (Pihama et al., pg. 32, 2002).

This research study is embedded in KMT. It has positioned rangatira and other Māori experts as advisors from the beginning to the end of the research project. Kaupapa Māori research (KMR) assumes the research involves Māori and includes Māori in the way the research is conducted and throughout the process (Hansen, 2012). KMR ensures the involvement of mentorship of Māori elders such as mana whenua *kaumātua* (male elder) and *kuia* (female elder) within the area of the research that are experienced in mātauranga Māori, in order to maintain that the study is culturally relevant and appropriate to that area and for Māori (McLachlan et al., 2017). Furthermore, involvement with elders ensures that the

application of the research process is undertaken in a way that is scientifically accurate and beneficial for Māori. The research findings were refined from discussions with the cultural advisor group, and the framework has been designed through extensive collaboration.

Kaupapa Māori research challenges the dominance of the Western worldview in research (Bishop, 1999). It inherently derails decolonisation practices by prioritising and privileging te ao Māori, tikanga Māori and mātauranga Māori (Haitana et al., 2020). This allows the Māori worldview to be normalised and removed from the Western lens that has historically marginalised aspects of the culture. The stated principles of Kaupapa Māori theory identify that decolonisation must be central in research to reclaim ownership of Māori knowledge (Hansen, 2012). Decolonisation has informed this research by positioning tikanga Māori through te ao Māori as normative rather than an additive to the research study. This positioning allowed the participants to take ownership of the knowledge that is formed as a taonga for the community. The Māori way of being was centralised throughout the research process, by adhering to mana whenua tikanga, which as a result, aligns with the equal power relationships within Te Tiriti o Waitangi.

Kaupapa Māori theory (KMT) supports Kaupapa Māori research (Pihama et al., 2002). It is a specific framework with an ontology, epistemology and methodology grounded in mātauranga Māori (Kiyimba & Anderson, 2022). Through the lens of mātauranga Māori, KMT is best understood as a knowledge philosophy that has the potential to help scientists research and understand phenomena from a Māori worldview (Mead, 2016; Stewart, 2020). Unlike Western research frameworks, KMT validates Māori knowledge, te reo Māori and culture and simultaneously centralises te ao Māori as the norm rather than as the comparison against a Western way of thinking (Hansen, 2012). In 2010 the Pūtaiora writing group developed Te Ara Tika, which are guidelines for Māori research and ethics. The purpose of the document was to enable health researchers and ethics committees to have a tikanga-informed framework that supports KMR (Hudson et al., 2010). KMT-based research methodology aims to implement culturally safe practices conducted by Māori researchers who ensure that the research protocols are grounded in mātauranga Māori and guided by tikanga Māori (Pihama, 2015). The kete of mātauranga knowledge is continuously evolving and expanding to encompass new learnings within te ao Māori (Mead, 2016). KMT and KMR are instrumental in mātauranga Māori knowledge in various fields, including science, healthcare, education and politics (Hudson et al., 2010).

Before colonisation, Māori had robust frameworks that grounded their ability to theorise about the world around them (Pihama, 2015). Māori are known as strong astrologers and have traditional theories that allow them to understand planting seasons based on the stars (Mead, 2022). Māori are also avid learners, to whom the use of theory is familiar. In te ao Māori, many areas of expertise have been passed down through rangatira from centuries past. These skills include navigation of the sea and tides and the ability to build waka, fish and craft nets (Macfarlane, 2016). By using KMT in research, Māori are continuing their ability to gain knowledge and theorise about the world.

Kaupapa Māori theory has key foundational principles that support Kaupapa Māori research, which align with mātauranga Māori and te ao Māori. These principles include but are not limited to *Rangatiratanga, Tikanga, Taonga Tuku Iho, Te reo Māori, Whanaungatanga, Whakapapa, Manaakitanga, and Aroha*.

Rangatiratanga

Rangatiratanga is the principle of self-determination (Smith, 2015). It emphasises the importance of ensuring that Māori have control and authority over their knowledge and how such knowledge is known (Smith, 2015). It centralises mātauranga Māori as the norm and challenges the dominance of the Western worldview when researching Māori or Māori-influenced phenomena (Mead, 2016). Western science focuses on the norms of Western knowledge and does not focus or give preference to Indigenous knowledge forms (Macfarlane, 2016). By ensuring self-determination, Māori are part of the initiation of the research process, implementation and organisation. Furthermore, by the inclusion of Māori perspectives throughout the research process, Māori maintain ownership over how they are known in the world (Moewaka-Barnes, 2015).

This research study was conducted with a strong understanding of the importance of rangatiratanga, which adheres to the guidelines regarding Māori research and ethics documented in Te Ara Tika (Hudson et al., 2010). It also abides by the Te Tiriti principles of partnership, by simultaneously protecting Māori participants through their voluntary involvement that includes the process of identifying any and all ethical issues. These issues include, but were not limited to, their rights, responsibilities and roles within the research practice. Throughout the research process, a constructive partnership developed between the research team, cultural advisory group, the BBCST and representatives from Patuharakeke.

This group had full authority to question any methods, ethics or frameworks used within the study process.

Tikanga

Tikanga is the principle of confirming that cultural ethics are adhered to within the tribal affiliations and any community affiliations within which the research is conducted (Mahuika, 2015). In this research, tikanga verifies the cultural validity of the study by making sure Māori values, cultural norms and practices are adhered to. An example of tikanga used in Kaupapa Māori research is *kanohi kitea kanohi* (face-to-face), which ensures the research is conducted face-to-face with participants rather than online and demonstrates honour of the other person and respect for the relationship (Smith, 2015).

The principle of tikanga is the cornerstone of this research project. Hui with mana whenua from the outset of the study ensured the research was conducted in a way that adheres to their hapū (Patuharakeke) tikanga and kawa. The Patuharakeke representatives' support and input allowed the research to flow confidently, aligning with the ethics and cultural validity of mana whenua.

Taonga Tuku Iho

Taonga tuku iho is the cultural aspiration principle that aims to validate and legitimise the normalising of the use of mātauranga Māori, te reo Māori and tikanga within a research study (Pihama et al., 2002). Its purpose is to conceptualise Māori knowledge through a Māori worldview rather than taking general Western scientific knowledge and translating it into te reo Māori. Taonga tuku iho adheres to the expression of Māori knowledge being correctly expressed through scientific research. Furthermore, taonga tuku iho aims for all Māori research to be transformative by providing the space for Māori to reclaim the truth of who they are, their history and their lives as they experience it (Haitana et al., 2020).

This research study approached the principle of taonga tuku iho by embracing and celebrating mātauranga Māori by adhering to pre-colonial traditions, such as an initial pōwhiri onto the mana whenua marae by Patuharakeke rangatira and the inclusion of karakia and waiata in every interview and hui. By upholding such te ao Māori traditions, space was created that provided the ability to legitimise and normalise traditional Māori ways of being.

Te Reo Māori

Te reo Māori is one of the foundations of KMT, as much of mātauranga Māori epistemology and ways of knowing are based on oral forms of expression (Pihama, 2015). Te reo Māori use within Kaupapa Māori research is imperative to upholding and honouring culturally valued Māori knowledge (Pihama et al., 2002). There is an enormous danger in researching and synthesising mātauranga Māori and theoretical constructs through a different language (Hohepa, 2015). This is due to multiple layers of meaning within each word in te reo Māori and the risk of meaning being reassigned or lost in translation when words are translated into English (Pitama et al., 2011). There is also a risk of the loss of te reo Māori altogether. This potential is dire to the Māori culture, because te reo Māori legitimises mātauranga Māori and tikanga Māori (Pihama et al., 2015). By upholding the use of te reo Māori within research, it gives accurate meaning to the context of the research. It is important to note that the research does not have to be conducted in te reo Māori. If Kaupapa Māori research required researchers to be fluent in te reo Māori, then there is a potential risk to subjugate Māori and non-Māori researchers who do not speak the language (Eggleton, 2020). The use of te reo Māori and the opportunity for participants to speak the language must be upheld.

This research study approaches the principle of te reo Māori by inviting participants to speak te reo Māori in the interviews and hui, and in circumstances where the researcher did not fully understand the statement, there was space provided to gain clarification on their interpretation. The interviews and hui were recorded and transcribed professionally, ensuring the correct terms of te reo Māori were noted before analysis. This allowed the participants to engage and communicate freely and collaboratively within the meetings.

Whakawhanaungatanga

Whakawhanaungatanga is the fostering of and maintenance of relationships (Bishop, 1996). It is based on establishing relationships that have shared power and control throughout the research process and cultivates the type of interactions that should take place between researcher and participant (Tiakiwai, 2015). It holds a fundamental relational requirement to establish relationships that are beneficial to the research and the whānau of the participant. Whaka is an adjective of action, which is the physical action of building a relationship.

Whakapapa

Whakapapa is used to determine a person's heritage and as a framework to understand one's identity (Smith, 2015). It is more than identifying race and location. It is about identifying an individual's values and beliefs (Mead, 2016). If a person knows their whakapapa, they can extend from this authentic positioning of whakawhanaungatanga through building relationships based on the knowledge and understanding of one's values (Lewis et al., 2023). From a Western psychology perspective, whakapapa can often be taken solely to mean genealogy, which can box participants in for research purposes by trying to classify the individuals (Wilson et al., 2020). Many Māori identify with more than one iwi and can often identify more strongly with the whenua they live in than the one they whakapapa back from (Smith, 2015). It is crucial to identify whakapapa within whakawhanaungatanga when conducting Kaupapa Māori research, because it establishes a base of relationship and identity (Mahuika, 2015). Furthermore, it recognises connections and values within a relationship.

This research project fostered whakawhanaungatanga through pepeha at the beginning of each interview. Each pepeha allowed the participant and researcher to acknowledge their whakapapa in order to build whakawhanaungatanga. Further relationship was established in the interviews and hui, by making time and space for kōrero after the formal kaupapa was conducted. Kai was also provided after every hui, and participants were welcome to stay connected. Through this process, the researcher was able to identify that one person in the advisory group was from the same iwi (Ngāti Tūwharetoa) as the researcher. Also, one of the wives of a local rangatira was from the same hapū (Ngāti Tūrangitukua) as the researcher. The whakawhanaungatanga created a sense of ease and profound connection with the participants. The group was able to share more openly and honestly through building this relationship.

Manaakitanga

Manaakitanga is the principle that emphasises cultural safety for Māori within Kaupapa Māori research by acknowledging the importance of the safety and protection of the Māori people and their culture, including the whenua (Kukutai & Taylor, 2016). Kaupapa Māori research is inherently culturally safe, because it positions itself to collaborate and respect individuals and communities. This allows them to express their cultural identities and

acknowledge their values and opinions without discrimination (Mahuika, 2015). Kaupapa Māori research must seek a positive research outcome for the individual participants and the community it aims to serve.

This thesis process ensured manaakitanga was present throughout the research study. From the initial hui, local rangatira were invited to participate and help guide the cultural safety of the project. All participants, including those from the advisory group, were provided with informed consent documents detailing the data collection's purpose and use. All participants and advisors were invited to provide their preferred time and location for the individual interviews. One participant requested that their interview be conducted on the participant's marae. Another requested the interview take place at their place of employment. Both requests were granted without hesitation to ensure manaakitanga was adhered to, by meeting the participants where they felt most comfortable and safe.

Aroha

Aroha is a principle of love and respect (Pipi et al., 2004). Supporting people through respect allows Māori to have control over their own experiences of how they want to participate in the research and on what terms (Bishop, 1999). Aroha must be considered when obtaining information as it ensures that participants receive full autonomy over what information is held confidential and what is made public. This research study provided individual and hui informed consent forms, which enabled each participant to obtain full autonomy over the information they shared. The form also clearly stipulated that if a participant wanted to withdraw from the study, they could do so at any time. Furthermore, in each interview, the information was stated orally, and space was given for any questions regarding their involvement. All participant recordings were anonymous, and no names are identified in the data analysis.

Research Procedures

This project utilised a qualitative approach to explore and develop a tikanga-informed framework that could potentially improve the mental health and well-being of Māori in Bream Bay, Northland. The data was collected in multiple ways and this section highlights the process. The design of this project was complex because it builds on work I did for a practicum placement for Massey University where initially, I was a research assistant. My role was to conduct and facilitate the data collection for a research project that aimed to

develop a framework based on outcomes from interviews and hui specific to Bream Bay Māori for improving mental health and well-being, under the supervision of Dr Eggleton at the BBCST.

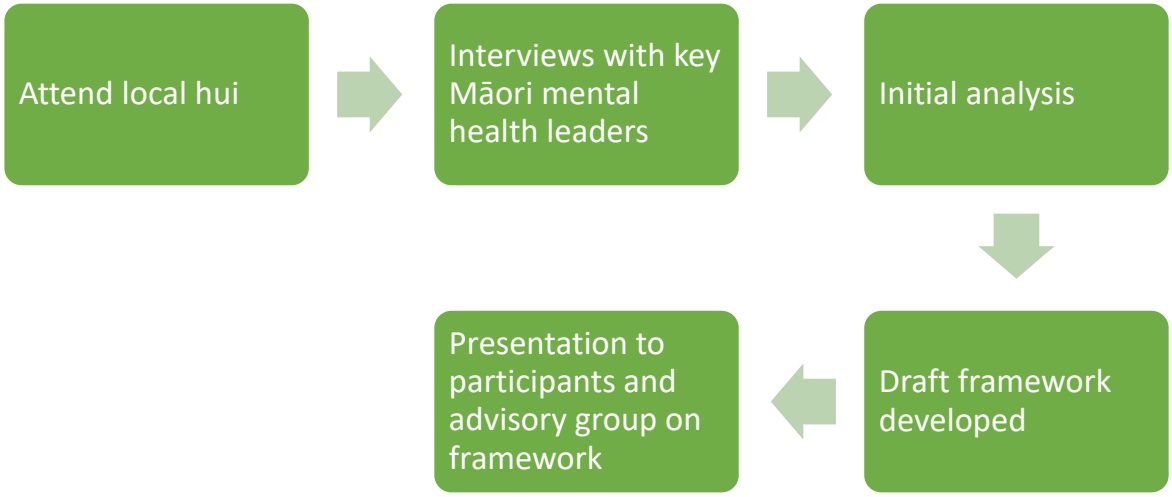
I began my practicum by attending a rōpū hui with key Māori mental health and education leaders living in the Bream Bay area. The hui aimed to initiate discussions on the strategies required to help Māori in the local community improve their mental health. Firstly, at the initial rōpū, the kōrero was conducted casually with me and Dr Eggleton, who took notes. No conversations were recorded because the study was at a conceptual stage. My role was to actively record concepts and ideas discussed. Kai and refreshments were served during the kōrero, which displayed manaakitanga through equalising the power dynamics and providing a sense of connection and community. Afterward, I reflected and noted pertinent points from the discussions.

It was because of the extended involvement with BBCST that this project could occur within Kaupapa Māori research design. I could build connections and work with the community to address a project that was identified by them as being important. I was involved at all stages but the participants, especially the cultural advisory group, were the experts on the topic and held the answers to the aims of the study. The participants were the knowledge producers, and my role was to facilitate and direct the conversations in relevant areas. During the initial rōpū, the research plan was shared with local key Māori experts, and they were invited to participate as individual participants and as members of the cultural advisory group. Eight kaumātua and kuia attended the rōpū; everyone had space to kōrero and shared their views on the study. After the initial hui presentation, the cultural advisory group shared their *whakaaro* (idea, plan) to revise the themes and subthemes to ensure they were grounded in mātauranga Māori. The notion of using Tāne-mahuta came from a consultation with a kuia from the cultural advisory group, who discussed the importance of using pūrākau to share concepts. All the attendees of the rōpū agreed to participate in the study and put forward names of other potential contacts who fitted the participation criteria.

Next, I began conducting semi-structured individual interviews with the attendees of the rōpū and other key Māori mental health leaders in our community. These interviews were then analysed, and the data was submitted to the rōpū for feedback. This was all part of addressing Aim 1: To identify tikanga-informed values for improving mental health and well-being for Māori specific to Bream Bay. The initial part of the process is outlined in Figure 4

Figure 4

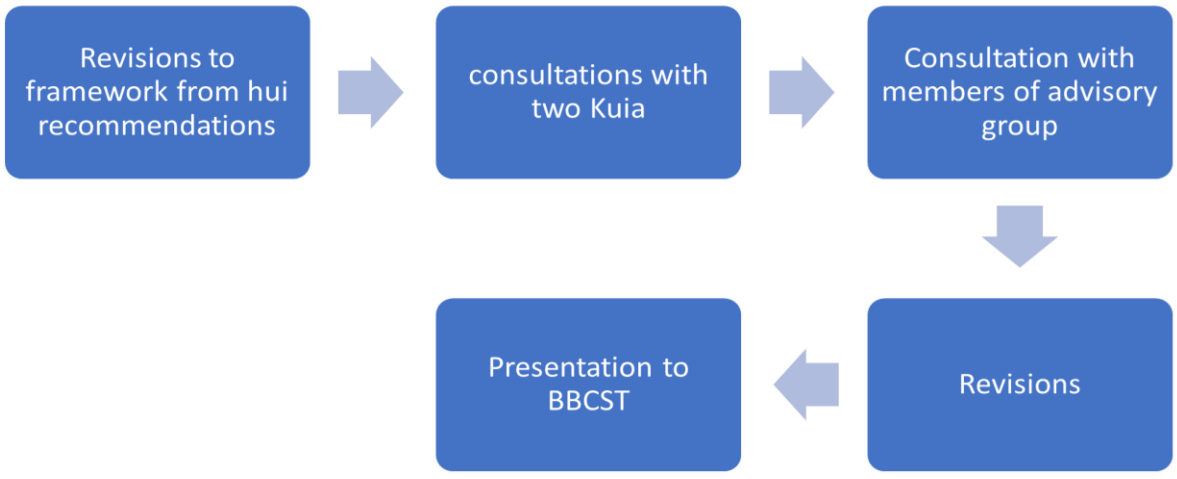
Research Design Part One



To further develop a tikanga-informed framework that the BBCST could use, the process continued as outlined in Figure 5. The conceptual framework was created based on the information obtained from the interviews, hui and the input and guidance from the cultural advisory group. Once complete, the framework was presented to the advisory group and then to the board members of the BBCST Board. The two diagrams depict the collaboration, ongoing consultation, and community-led process.

Figure 5

Research Design Part Two



The advisory group members were found using convenience sampling and through contacts associated with the BBCST. The method also ensured that key kuia and kaumātua were included in participation due to the sampling strategy. This allowed me, as the researcher, to build upon the *whanaungatanga* (strong relationships) already established through the BBCST.

The inclusion criteria participants were as follows: participants had to be Māori and have an affiliation with the Bream Bay area through employment or as mana whenua or *rāwaho* (someone living in an area they do not whakapapa back to) residing in the area. First and foremost, the participants had to have a strong knowledge of mātauranga Māori and tikanga Māori and work within mental health, medical health, or education to some degree. The study recruited twelve participants who met the criteria. There was one extra participant that that did not meet the employment criteria, however, they were included in the study because they are mana whenua and a representative for Patuharakeke (the local hapū). Eight participants were mana whenua from Patuharakeke while the other five participants were urbanised Māori (who either lived or worked) in Bream Bay. All participants, apart from one, resided in the Bream Bay area. There were ten females and three males interviewed. Since Bream Bay is a small community only twelve participants fulfilled the required criteria before population saturation was reached.

Once all interviews and transcripts were analysed, all participants were invited to a hui where I presented the findings and discussed an initial concept of the framework design. Each participant was emailed a Participant Information Sheet (PIS), an individual Participation Sheet and Hui Participation Sheet prior to the hui highlighting the benefits and risks (if any) in participation (see Appendix A, B and C). The hui was not recorded; however, a medical student from Auckland University attended the hui as part of her research assignment under Dr Eggleton. She was assigned to take notes during the kōrero, which was subsequently presented to the researcher. This hui allowed me as the researcher to collaborate with the participants' ideas, make changes, and adapt the concept framework as required by new information. Kai and refreshments were served after the hui to include appropriate manaakitanga. This time of casual kōrero also created a space for whakawhanaungatanga, where the participants had a less formal opportunity to share their thoughts and perspectives.

Interviews

Data was collected via semi-structured interviews that were recorded using a Sony N50 voice recorder as the primary device and a Samsung Galaxy S7 as the secondary backup device. The recordings were professionally transcribed and returned to Dr Eggleton, who gave them to me after his initial approval. Each interview was conducted at the location requested by the participant in order to give agency of comfort to the participant. They were also invited to bring a support person if required. Only one participant chose to do so. All interviews were conducted in-person to facilitate the importance of kanohi ki te kanohi in KMT. An interview schedule was emailed to each participant before the scheduled interview (see Appendix D). The interview schedule highlighted the study's main aims, the seven questions or themes that may be covered, the expected timeframe and the notification that it would be recorded.

The semi-structured interview questions were:

1. What are some of the issues that you see with current mental health programmes e.g. counselling, general practice-led interventions, drug and alcohol programmes?
2. What are some things that the current programmes do not address?
3. What are some ways to improve mental health programmes?
4. What would a tikanga-led process look like for addressing mental health issues?
5. How would this be implemented?
6. How would this address the issues previously discussed?
7. Would there be another approach?

The interviews ranged from 25 minutes to 1 hour and 18 minutes, while most were between 45 and 55 minutes. Since Kaupapa Māori research is non-prescriptive, substantial flexibility was required by the researcher. Karakia was offered at the beginning and end of each interview; however, it was guided by each participant. Although formal interview times were short, more time was spent after the interview to kōrero further and build whanaungatanga.

Participants were offered the opportunity to receive a copy of their interview transcript. The response options were:

I wish to be sent a copy of my transcript so I can review it for accuracy

I wish to receive a copy of my audio-recording

I wish to receive a summary of the results

The responses varied, with some participants wanting to receive both the transcript and the audio recording (n = 2), transcripts only (n = 2), summary only (n = 3), and audio and summary (n = 3). One participant requested all three options of transcript, audio recording and summary of results, while two opted to receive no copies.

Ethics

Ethics for this project was somewhat complicated due to my initial work as a research assistant for Dr Kyle Eggleton of the University of Auckland. Dr Eggleton had gone through a full ethics procedure for a wider research project based at the BBCST thus, in discussions with the supervision team, it was decided to apply for Massey University's Human Ethics Committee low-risk application. Peer review discussions were completed with academic research supervisors Dr Kathryn McGuigan and Dr Matthew Shepherd. These discussions considered the ethical requirement for KMR to evolve through critical reflection and subsequent amendments (Smith, 2015). To practically ensure that adjustments were made, an ethics hui was organised with onsite supervisor Dr Eggleton and the cultural advisory group through the BBCST. The six issues identified and peer-reviewed throughout the ethics process along with the academic and onsite research supervisors: autonomy, avoidance of harm, benefit, whakapapa, tika and manaakitanga.

Participants, including the advisory group, were given autonomy over their ability to participate in the research. They were emailed comprehensive information about the project and were later provided with a Participation Information Sheet (Appendix A). Consent was confirmed before any interactions. The participants were given the ability to clarify any questions regarding the process, intent, or outcomes of the project prior to the interviews. Semi-structured interviews were conducted to collect the data. No identifiable information was used in the recordings of the individual interviews, to ensure privacy and confidentiality. Each interview recording was saved and analysed under a specific code, e.g. Interview One and Interview Two, rather than using identifiable names or content. Furthermore, no information was used against participants' wishes. This method of anonymity ensures the avoidance of harm to a participant by protecting their identity. Participants were also

provided with a list of broad topic questions prior to the interviews and hui, so they were fully informed of the content of the meetings. They were also invited to discuss only what they felt comfortable sharing.

Whakapapa was upheld throughout this research study by building new and strengthening existing professional relationships with mana whenua Māori and urbanised Māori experts in the local community. Building these relationships has the ability to strengthen the ties the local Māori community has to this study, and it also has the potential benefit of the framework for their wider whānau and friends. Dr Eggleton and the BBCST team hold a solid whakapapa to local hapū, and the research took place in conjunction with their support and under their supervision.

This research study protects the rights and upholds the interests of Māori at its core. Its contribution to build and improve Māori mental health and well-being was developed through Kaupapa Māori theory as the methodological underpinning. Significant measures were made to create a cultural advisory group and to ensure every step of the process was culturally appropriate, culturally safe and Māori-centred. Throughout the interviews and hui, tika was upheld by adhering to local hapū kawa through karakia, waiata and pepeha introductions.

Cultural and social responsibility was conducted, as participants were treated in a culturally sensitive way to maintain their dignity and respect for their identity. Manaakitanga was upheld through alignment with Te Tiriti o Waitangi obligations. By maintaining dignity and respect for each participant, the research extends to improve the collective welfare of local Māori communities. All participant interviews and hui were conducted face-to-face. At the end of each interview, manaaki was demonstrated by offering each participant a *koha* (gift) of a $20 Fresh Choice gift card. The koha acknowledged gratitude for the participant's time and contribution to the research.

Funding

Funding for the project was through a grant from the Research and Education Charitable Trust of the Royal New Zealand College of General Practitioners. Grant number LH19-369

Data Analysis Approach

The analytical approach employed to analyse the data of this research study is Thematic Analysis (TA). This method is often used in Kaupapa Māori qualitative research to identify and examine themes and patterns within a dataset and is frequently used as a foundational method of qualitative analysis (Campbell et al., 2021; Haitana et al., 2020). Braun and Clarke designed TA to analyse qualitative data with an interpretive paradigm that gives voice to the participant and provides theme structures for the researcher (Braun & Clarke, 2019). TA is an interpretive method where the researcher deeply familiarises themselves with the data and identifies themes and overall patterns (Braun & Clarke, 2006).

TA is considered a fitting qualitative research method for Kaupapa Māori research because it is a flexible approach that aligns with the diversity that often comes with Kaupapa Māori research. It allows researchers to explore, document and communicate the experiences and values of the participants (Braun & Clarke, 2006). This is especially important in Kaupapa Māori research as it aligns with the goals of equal power and shared knowledge (Tiakiwai, 2015). Furthermore, it honours cultural responsiveness and allows Māori voices to be heard through their own lived experience. Within this KMR approach TA is used as an analytical tool as a way of sorting the data. Although it is a Western method, it is appropriate because it enables the researcher to draw meaning from within the data itself, rather than from set scientific theories. This allows for Māori perspectives and voices to be interpreted as the norm.

TA differs from other analytic theories that seek to identify patterns in a qualitative dataset (Braun & Clarke, 2019). Although TA is theoretically flexible, it does have its limitations and boundaries, such as subjectivity and dependence on the researcher's reflexivity and skill (Campbell et al., 2021). However, these boundaries can be seen as assets in Kaupapa Māori research. The researcher's positionality and subjectivity are a resource that honours the researcher's whakapapa and increases the whakawhanaungatanga between the researcher and the participant. Valuing subjectivity induces reflexivity. As the researcher I am a subjective part of the research. As an urbanised Māori living in Bream Bay, I have group insight and a personal desire to see the improvement of Māori mental health.

Themes within Reflexive TA can be identified through inductive or deductive analysis. Inductive analysis links the themes to the data itself and may bear little relation to

the specific questions asked in the interviews (Campbell et al., 2021). In contrast, deductive themes are chosen inferentially and are based on specific questions. Furthermore, deductive analysis requires the researcher to theoretically understand the topic (Braun & Clarke, 2006). In this research study, the inductive analysis approach was decided upon for the analysis to reflect the data. However, after consideration, some deductive analysis was used to confirm the coding and theme construction related to Kaupapa Māori theory and aligned with the research questions.

Braun and Clarke (2006) created six guidelines for Reflexive TA that include (1) data familiarisation, (2) initial code generation, (3) generation themes, (4) theme review, (5) theme refining, and (6) report production. These phases are not linear, and I did loop back to previous phases as the analysis developed. However, I did adhere to the TA guidelines and spend a lot of time familiarising myself with the dataset (Braun & Clarke, 2006). Familiarisation was achieved by repeated listening to the interview recordings, reading through and refining the transcripts, and reviewing my notes. Reviewing the transcripts was extremely important to ensure that the correct te reo Māori words were transcribed or understood.

Following familiarisation, initial codes were generated to help organise the data, and initial labels were created in Excel to organise the data into meaningful groups. All data transcribed from the interviews and data from notes that answered or provided insight into the thesis aims, were coded through latent and semantic approaches. From there, the focus was to sort the individual codes into meaningful themes across the dataset. Codes and themes were reviewed to assess their relationship, and sub-themes were created to collaborate on topics of shared meaning. The analysis process was not linear, and a reflexivity process of returning to each step (particularly from initial coding to themes) allowed for deeper engagement with the dataset. Reflexivity required moving codes from one theme to another and creating new relationship categories. Because the codes are actively constructed by the researcher in TA, Dr Eggleton reviewed my TA, and we discussed any potential areas of schemas, similarities, or coding errors. To further improve validity, a medical student from Auckland University provided research assistance and conducted TA on three interview transcripts. My findings and the student's were compared and discussed again with Dr Eggleton to identify schemas, similarities, or errors. Through this iterative process, the final themes were constructed. The themes highlight unique aspects of the dataset and provide coherent overarching topics of

importance that enable the research to provide value to the diverse range of local Māori knowledge in relation to health and well-being.

Reflexivity

Within KMT and thematic analysis it is important to be clear on positionality (Cram & Adcock, 2022). As mentioned in the introduction, I am an urbanised Māori living in Bream Bay. I am of Māori, Scandinavian and Scottish descent, born and raised in Whangārei, Te Tai Tokerau. My father is Māori Scandinavian and was legally adopted by a Māori couple, Awhi and Hariata Te Rangi, whom I knew as my Papa and Nanny. My mother was from Dargaville and is of Scandinavian and Scottish heritage. My Papa is my rangatira and lived in many mātauranga Māori ways. He spoke fluent te reo Māori, kept tikanga, and attended hapū hui often. My Papa would teach us old waiata and some basic te reo Māori when visiting.

Although my grandparents were proud of their Māori heritage, they raised their son with a colonised mindset. He was the only Māori boy in his school and grew a sense of whakamā about the colour of his skin. Like many Māori from my father's generation, he carries the burden of internal racism that disallowed him to embrace te ao Māori and the culture of his ancestors. Growing up, my mother and Papa introduced me to some mātauranga concepts on occasion. He was so proud when one of his mokopuna pronounced te reo Māori correctly or remembered a karakia by heart. Once my Papa passed away, my connection to the Māori culture felt like a piece of me had slowly become lost.

Growing up, I was the only dark-skinned sibling out of four. But I knew nothing about the culture I physically represented. I was called a "coconut" or a "bounty bar," brown on the outside and white on the inside. I began to feel too Māori to be Pākehā but too Pākehā to be Māori. During my adolescence, I felt an internal divide between the cultures. I had preconceptions about my values and assumed my upbringing was far from te ao Māori.

Through studying psychology, from the beginning of my undergraduate degree until now, I have taken every paper and opportunity to learn about Māori psychological perspectives and worldviews. As a result, my beliefs and attitudes changed gradually. As the semesters progressed, I began to realise how much I resonate with te ao Māori, and how much I was brought up with a Māori worldview despite not being taught much by my parents. I began to believe not all mātauranga Māori is learned; but instead, is passed down through my DNA from my ancestors. Mātauranga Māori values are so deeply ingrained in us

Māori that no matter how much my childhood hid me from my culture, it was within me, and I carry it into this research.

As the years progressed, I could feel the internal divide within me begin to close, and an acceptance of who I am as a conglomerate of cultures began to settle in my wairua. Through this research study (and with the support of the cultural advisory group), I am now on my journey of self-discovery, where I find my place of belonging within the two worlds. I am standing on solid ground where the divide is no longer inside me. I am one of the many kaitiaki of this whenua and of this knowledge, and I am responsible for embracing and passing on mātauranga Māori.

I acknowledge the importance of my journey as it impacts my subjectivity and potential biases within the study. Because of my social and cultural upbringing, reflexivity highlights the importance of having a cultural advisory group to guide the tikanga process and uphold Kaupapa Māori theory throughout the research. By acknowledging my journey, I demonstrate transparency, which builds whanaungatanga and creates a culturally safe environment for participants. I position myself as the researcher and the participants as the knowledge holders. At points within the research process, I was able to reach out to individuals within the cultural advisory group with any questions or concerns about how to ensure the authenticity of the research as a Kaupapa Māori research study and how to go about adhering to tikanga by using correct mātauranga Māori. The cultural advisory group was fundamental in the methodology of this research study.

Chapter 4: Findings

This chapter presents the findings from the interviews, hui and kōrero with the thirteen participants of this study, including the six individuals on the cultural advisory group. Through the application of TA, alongside consultations with the academic and onsite research supervisors, analysis of the research aims was addressed. This chapter will present these findings in two parts: Section One addresses the first aim, Section Two addresses the second.

Section One

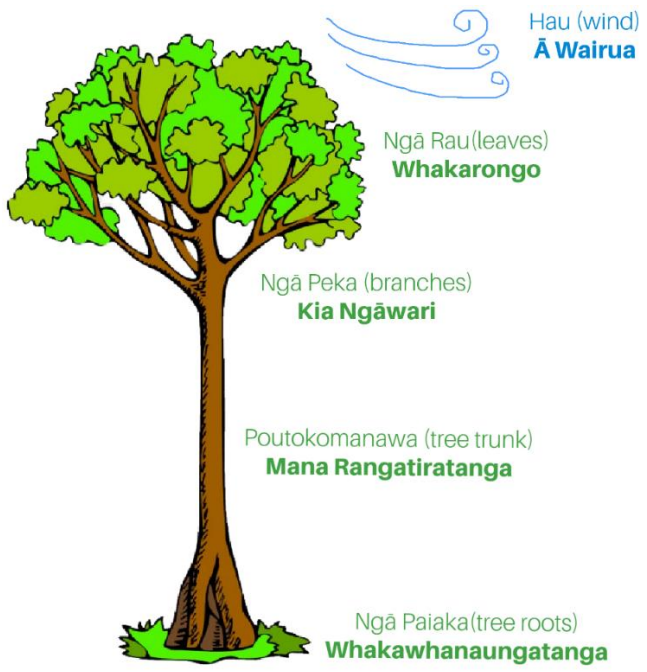
This section addresses the study's first aim.

> To identify tikanga-informed values for improving mental health and well-being for Māori specific to Bream Bay.

Section One utilises portions of the semi-structured interviews to explain and identify the themes, patterns and insights that construct the findings within the TA process that inform Aim One of the research study. To maintain the essence of mātauranga Māori, five tikanga-informed values are identified (Figure 6) through the creation story of Tāne-mahuta and how the atua depicted as a tree holds value within the confines of its elements.

Figure 6

Five Tikanga-informed Values Grounded in Tāne-mahuta



Within the tikanga values multiple subthemes were formulated in order to bring clarification to what participants regard as the foundations that represent the main themes identified by the data. Each tikanga value is linked to a specific element of Tāne-mahuta, the atua of the forest (Table 1). Descriptions of how the elements of Tāne-mahuta support the findings are described throughout.

Table 1

Tikanga-informed Values / Themes and Subthemes

Themes	Subthemes
Ā Wairua	Create A Sense of Belonging
	Collaborate With Local Iwi
	Holistic Care
Whakarongo	Identify Greatest Need
	Authentic Individual Care
	Intuitive Active Listening
Kia Ngāwari	Resources
	Safe Environment
	Programmes
Mana Rangatiratanga	No Stigma, No Judgement
	Normalise Help Behaviours
	Future Focused
	Active Participation
	Client Led Services
Whakawhanaungatanga	Partnership Of Health
	Role Models
	Connection

Ā Wairua

Ā Wairua is a tikanga value that represents the participant's understanding of the importance of a person's wairua (spirit) and their ability to connect and communicate with it as part of tikanga Māori. The wairua is the connection of the physical to the unseen. Wairua in mātauranga Māori is understood as *wai* (waters) and *rua* (two). It represents the intertwining of the spiritual and the physical (the two waters) parts of a person's being. It also identifies the essential understanding through te ao Māori that everything is connected through the physical and the spiritual. Ā Wairua also identifies how, in te ao Māori, being connected to one’s wairua is imperative to a person's well-being and health. Moreover, this connection has the ability to impact a person's sense of belonging and identity. Many participants discussed a lack of connection and understanding of wairua for many local Māori and how this could contribute to the mental health and well-being struggles of Māori.

Ā Wairua also represents *hau* (wind). The wind that blows the leaves, branches and trunk of Tāne-mahuta, blows unseen through all the elements of one's entire *au* (self). It acknowledges the need for a sense of belonging and connection between all elements of Tāne-mahuta by connecting him to other *pou* (pillars). The same wind blows through the forest, connecting the spiritual and the physical.

Belonging

For a mental health framework to be suitable and tika for Māori, it must include an element of enabling and teaching clients how to connect with their wairua to obtain a sense of belonging. Many participants identified that in te ao Māori a connection and understanding of one's wairua is essential for health and well-being. Furthermore, many participants acknowledged the importance of Ā Wairua connection as the beginning of a person's sense of belonging to their culture, whenua and tūpuna.

One participant shared in their interview how learning through tamariki (children) in their workplace helped them see the importance of connecting the physical with the spiritual:

> I learnt my pepeha through the tamariki because they would say it. And then I realised hey these tamariki are, first they connect to Io-matua-kore, to God and then they awaken their spirit by singing a beautiful waiata. And then the next thing they do is remind them of where they come from. The maunga, that's me, that river that's, that water belongs to me. This whenua, that's me, you know? Like and then that's when I started to, my piki tapu wairua, my spirit started to get lifted… So I started doing that every day and that's what started to ground me.

Another participant described how a disconnection from the Māori culture can result in a disconnection from a person's wairua, which has the ability to impact their mental health and well-being along with those around them. When people lose a sense of belonging, they look for connections elsewhere. The participant explained how they believe a connection to their wairua is a shield of protection for their mental health. They shared that there have been struggles with disconnection from wairua in their whānau and how it has affected their community's well-being.

> I'm quite a spiritual person, anyway, so I know when things aren't right for me. 'Cause they, you know, or I've made a silly decision and I've done something that's

> been detrimental to my wairua, because I get māuiui, I get sick. I get, my dad visits me in dreams, you know? I have whānau that are involved in gangs that live locally. They do supply. A lot of our drug problem is at the hands of that particular gang. And he, I'm just reflecting on him as a person and he is a… beautiful man, but is disconnected from who he is... I don't know how that happened 'cause he grew up here. But I just think when you're e rotu te ao Māori and you're fully invested in that Māori world view…it's like a big shield… And unfortunately, those who aren't connected don't have the same safeguards.

Some participants describe the importance of Ā Wairua as a way of not only connecting to their culture but connecting to their tūpuna (ancestors) and obtaining guidance from the wisdom of the past to improve their mental health and well-being:

> You know, and I often think why can't we speak openly about, oh I felt my nanny. She was here with me today, you know? Why can't we say that out loud? And why can't we talk with our…mental health thing and be like, you know, I can feel my tūpuna and it's, you know, they're telling me what to do.

One participant explained how they experience connecting to their wairua through a feeling and how they trust that feeling to determine if they connect with others. That feeling is how they gauge a client's mental health and well-being. The participants explain how they have learned through their mahi (work) that it is crucial to be aware of the heightened wairua for whānau and clients when they are in a trauma state:

> We're talking about Kaupapa Māori we're talking about our Māori people. We feel it before we see it if that makes… You know if you've got a connection with someone or if you don't, I'll walk out the door. From my own experience, when we're talking about mental health, and they're [patients] heightened. A Whānau in that mental health and they're going through… Traumas, the state that they're going through, it's almost heightened as well so that spiritual aspect that wairua aspect is a part of what that is.

A participant shared an example through his mahi of how young men have apathy from low self-esteem. They have yet to have someone come alongside them and show them how to do things that build their confidence. The participant demonstrated how regular

connection with a client can help create a sense of belonging and how service providers need to engage and encourage their clients in a way that builds belonging.

> I see... just downright apathy… I had six of them [youth clients] peeling potatoes, helping me out on Tuesday. And I looked over there and I thought oh man, what are they doing, you know. And they're chopping up and they're like chop, chop [slowly], you know… I don't wanna come and go hey, what are you doing... I just kept going back, oh man, how are you guys going, are you doing a good job there?... trying to put some humour into it… I get that some of them have never done it before… So next time I'm gonna sit down with them. I need to sit down with them, talk to them and peel flat out so they get a sense of wanting to compete with me. You know, the male thing.

Collaborate With Local Iwi

Collaborating with local iwi is identifiably essential to obtaining ā wairua, ensuring that local tikanga is adhered to through collaboration. One participant is an expert in mātauranga Māori and explained how every iwi has its own protocols and way of doing things. To honour the mana whenua and the wairua of the kaupapa, the protocol of local iwi or hapū must be followed. The participant further explained that for a framework to be beneficial to Māori and to have local community buy-in, it needs to adhere to localised tikanga, which can only be conducted through building relationships and collaborating with local iwi:

> And when we're talking about tikanga, ko wai te mana whenua, the tikanga. So the iwi here, Patuharakeke has the mandate on what the tikanga is that we use in schools. The tikanga in what we use in everywhere basically.

One participant shared the importance of collaborating with iwi as a means to gain a sense of belonging. Finding kuia and kaumātua along with other te ao Māori experts willing to connect with clients regularly, allows for a relationship and wairua connection to build, which underpins tikanga. Regular input into a person's identity helps create a sense of belonging and, in doing so, improves one's mental health and well-being:

> A sense of belonging and being connected is not just who you are as a Māori. No it's, I believe you get that from the people around you, okay, that are regular in your life. That are there week in, week out.

Connecting with elders and other strong individuals within the client's community can create a sense of belonging within a Māori client's wairua. The most critical point needed to ensure the connection is, indeed, tikanga is the consistent building of positive relationships that could aid and improve the mental health and well-being of clients.

Holistic Care

Holistic care is identified as a subtheme within Ā Wairua, because in te ao Māori, health is impacted by all parts of the human being. Māori health understanding does not compartmentalise parts of a person's being but sees all aspects, wairua (spirit), tinana (body), hinengaro (mind), whānau (family) and whenua (land), as playing a role in the health and well-being of an individual. Multiple participants considered holistic care essential to a tikanga mental health and well-being framework. Like other Māori mental health frameworks, such as the Meihana model and Te Whare Tapa Whā (Durie, 1994; Pitama et al., 2007), the participants identified that Western mental health frameworks are often biomedical and have a tendency to focus on the hinengaro (mind) and the tinana (body) only.

One participant explains that in te ao Māori, there is no compartmentalisation when it comes to mental health:

> Wairua - I don't know, I'm guessing the, I'm thinking about saying this, but the wairua aspect is like the greatest, like, we're talking about mental health… We, you know, like it's, in the frameworks and all of the models that are out there, we don't look at ourselves as these compartmental parts.

A participant shared that they use the Meihana model in their mahi because it is easy for clients to understand. However, they do not believe the framework aligns with te ao Māori understanding of mental health. The participant identified that for a true tikanga-informed framework, holistic care must begin from the central state of an individual and move out into identifying the support networks that surround the client:

> I use that framework when I'm in my mahi because it's just easy to like it's these pou and it's really easy to understand. But, when we're talking about real Māori, Kaupapa Māori that doesn't even exist… if we're asking about a real Māori model. It starts with the au which is the person who is in the state. And then around them is their whānau… The au goes into the whānau, and then what does that look like and what supports?

Another element of holistic care that is attached to Ā Wairua is whānau. When considering a tikanga approach to mental health and well-being, whānau is an integral part of a person's understanding of themselves, their sense of belonging and their support system. Participants shared the importance of connecting with whānau and identifying if whānau is a support structure for an individual's mental health or a hindrance.

One participant identified that whānau hui can encourage whānau members to support the individual through their journey and how they are often unaware of the person's struggles and needs:

> Whānau hui, I think, can be really invaluable. If they're willing. 'Cause that's a big step to be willing to participate in something like that. 'Cause a lot of the time the clients' families or whoever they're living with, their support people… can be totally unsupportive 'cause they have no idea. So if they've got a drug and alcohol condition, not to consume, purchase or possess, but everyone else is on the piss or smoking weed at home. And they're sitting there going but I can't, but they're gonna do it anyway.

The participant also identified much whakamā for clients when sharing their mental health struggles. Nevertheless, they believe it is essential to identify their supportive stance of people so that in spite of their shame, they have the strength of those around them to help them through:

> So whānau hui is really good if it's relevant and if they're open to it. But definitely find out who their contacts are and support people are, and let them know that hey, we're just gonna touch base with them every now and then just to see how you're going. And you'd be surprised how many people don't want that too. Again whether they're ashamed or they just don't want their family to know what they've been doing…

Another part of holistic care is connecting a person's being to the whenua. One participant shares their journey as a mana whenua and kaitiaki of Bream Bay, their connection to the whenua, and how this impacts their mental health. They gave an example of a comparison between urbanised views and mana whenua views of the area. Their example highlights the ongoing impact of colonisation and urbanisation on Māori mental health:

> So we've got a whole lot of aiding houses. Only two of the people that live in them are manawhenua hau kāinga… The rest of them are urban Māori. So when that came about to us, to the two people that live there, this is our whenua and this is our, you know, we're kaitiaki here. To them, they don't have that same sense of connection and belonging.

Another participant shared how urbanised Māori and mana whenua continue to struggle with connecting to the whenua in a multitude of ways. This participant emphasized the strong need for the tikanga framework to be able to cater to the detrimental impact urbanisation has historically had on the mental health of Māori:

> In Bream Bay, you've got two different types of Māori. You've got urban and then you've got mana whenua hau kāinga. So, we view things very differently… They're [urbanised Māori] disconnected… from their own whānau, and their whenua… they're scrambling for a sense of belonging... They're really searching for that belonging, and I think a part of that is their own mental health and their responsibility.

Multiple participants identified that part of belonging to a place is by connecting their wairua to their whānau whenua. They recognize that urbanised Māori have a tendency to struggle connecting (compared to mana whenua) more frequently, due to the displacement that occur through colonisation and the rippling effects it continues to have on present day circumstances of Māori.

Summary

The importance of wairua to a person's health and well-being aligns with other Māori models of health, such as Te Whare Tapa Whā and the Meihana model. The theme Ā Wairua is also an essential aspect of mātauranga Māori, and was a strong theme identified throughout the research. The subthemes of belonging, holistic care and collaborating with local iwi all highlight how it is tika for Māori to see themselves through a holistic lens. As discussed by

participants, mental health and well-being comes from the au (centre of an individual), links to their wairua, and expands through their whole being to connect with those around them and the elements of creation such as the whenua. When all aspects of a person's being are healthy, their well-being can flourish.

Whakarongo

Whakarongo is a strong tikanga theme identified through TA of the interviews. Whakarongo is a theme that represents the need for Māori to be truly heard, clearly understood and intuitively listened to. This theme honours the need for authentic individual care rather than ticking cultural boxes. The English translation of whakarongo is limited; it means to listen. However, when understood through te ao Māori, whakarongo can be understood as the vibrations of a person being understood through deep intuitive listening (explanation cultural advisor).

Whakarongo represents Ngā Whā (leaves) of Tāne-mahuta. The leaves represent how small things can significantly affect one's mental health. The leaves create a shelter from other outside elements. Ngā Whā shows authentic growth through the correct care. They represent the ability to provide individual care to someone in a way that will help shelter his/her mental health from negativity.

One participant shared their experience of attending counselling with a close whānau member who was struggling with their mental health. The counsellor was able to whakarongo in the truest form by giving space for the client to speak until they were ready to begin processing their pain:

> When you whakarongo you, rongo is to feel, comes from you're ā rongo… So whakarongo is the act of actually feeling, not just listening... We have all our senses, listening, touch, smell, sight. But, te whakarongo is also to feel. So that's a huge thing for our people, is to have that connection in terms of feeling. So what she did [counsellor] was whakarongo in au's true form…She did it for a couple of days until we… were kind of ready to be moved on... Over that period of time that I could see a difference and … was … really starting to kōrero. And that was huge because there were others that he'd been to in the past that couldn't…. I also felt that as the support person, that I was being listened to as well.

Intuitive Active Listening

Whakarongo is another theme for this study's tikanga mental health and well-being framework. Participants identified that clients are not always understood by their service providers in a way that they feel heard or understood in mental health settings. A participant shared their experience of watching a counsellor who had the ability to effectively whakarongo intuitively while also actively listening to her client. This method was notably healing the client:

> But it was an intuitive ability to listen. So she was intuitively watching his body language which gave her signs. She was picking up on where to place her energy as well in the room… That's that mana enhancing... I just saw it in play.

Another participant shared their professional struggle with red tape and contracts prohibiting service providers from offering services that enabled them to spend enough time listening to clients' mental health struggles, which limits their ability to whakarongo:

> I'll give you an example. Our building where I've been working is… across the road from the DBH mental health services, community services. People would come in there wanting help and they would be told they couldn't be helped that day, but they would redirect (to us)… where we had no contracts to help anybody. And these people would turn up and with real deep needs and yet there was nobody to see them… So we would take them in and a lot of what we found that they weren't getting was the opportunity to be heard... We would bring people in and have there be no set time frames. In fact we'd give them as long as they needed… and actually look at them as an individual. Not as they have to fit into this model or this plan. But, actually look at them as an individual with how they've got to where they are now and how can you make the plan real for them?

Greatest Need

A consistent overall subtheme within whakarongo from participants was the need for a framework to be able to identify the greatest need of their clients. It can be challenging for clients to focus on their mental health and well-being when there are more pressing stresses in life. Participants confirmed that it is tikanga to meet the initial need to first demonstrate support by building a relationship before working on the client's mental health.

Another participant shared a moment of revelation in their health career when they realised their clients had immediate needs that prohibited them from working on their mental health and well-being:

> I had a dear old lady in a ward where I just knew… This is fixable. Why are we not seeing changes with her? Because actually she was more worried about the fact that her cats were at home and no one was feeding them…. So her level of anxiety was through the roof and she was just not even listening. All she wanted to do was leave and all it took was a person, to say to her… what is the most important thing that you would like to fix today? And she said I just need to know that someone's feeding my cats… If we get the cats looked after now she can… actually engage, because she's not worrying about her babies... Because you can provide them with the best level of care and you miss the boat every time… But, you can't help them until you find… what they need the support with first.

Another participant explained how, in their vocation, they work alongside many teens who have suffered immense trauma. They shared how avoidance behaviours (such as addictions) often cover these traumas. They spoke about the frustration of services that focus on the addiction but do not look for the underlying causes of the addiction; and as a result are not meeting the most significant needs that have the potential to aid in long-term recovery:

> We've got youth that have been raped. We've got youth that… because of being raped… they've turned to drugs, alcohol to really lower that burden. And that's, you know, and then having to wake up the next morning, go through that same cycle where they're still using weed, alcohol just to cover up the actual situation that's happened.

One participant identified the struggle of working with clients in mental health when other pressing problems accumulate. They consider how mental health becomes less of a priority for financially struggling people:

> The problem in the community I would say at the moment, Illness, crowded (housing)… people have struggled with losing their jobs in this area because of the refinery. Contractors have been laid off so that means families are without incomes, or minimised incomes. Women are working a bit more than some of the men if the contractors have lost their jobs. Families… who are struggling financially, who are

> struggling emotionally because they've had kids at home, not going to school…and if they are asking for help it's more, mental health seems to be, yeah, it doesn't seem to be the biggest priority at the moment. It's more just like food on the table, petrol in the car, getting to town to do groceries. 'Cause everything is so expensive around here.

Authentic Individual Care

Authentic individual care is a subtheme connected to whakarongo. When a service provider acts in true whakarongo, they can offer authentic care for each client. Participants determined that when a client is genuinely listened to, their trust is built, and they can become more open to sharing their struggles.

One participant shared a difficult memory of visiting a counsellor when they were fifteen years old for a trauma they had experienced. They discussed how the inability to provide whakarongo caused them to feel negatively towards seeking help. The counsellor recommended breathing techniques and meditation for the teen. There was no authentic individual care, and the experience left the participant worse off than before the visit:

> I've done a bit of counselling before… some of the counsellors… were just there to tick boxes. Realistically I just needed someone to talk to, and they were giving me exercises of how to breathe... non-Māori practitioners, mainstream practitioners… were just giving me this meditation, I should do this, I should be doing that…. And to be quite honest it never helped. It never helped because really you were talking and next minute it was like oh, I'll get you to do these breathing techniques.... But I really never got to answer the nitty-gritty of why I was going through what I was going through… I've never gone back to counselling.

Another participant described their experience as a teacher looking for authentic mental health support for their female students. Finding a provider was one thing. The other was finding a trustworthy provider to provide authentic whakarongo for their students:

> I didn't always trust them and I knew the girls didn't trust them [mental health service providers] otherwise they [students] would have gone to them in the first place… having somebody that you can trust, that you can kōrero with and know that whatever they're dealing with in terms of their mental health... you're just listening to them

> with understanding and empathy… Being able to refer the student… to somebody that… I trusted and… probably more important that they trusted.

Summary

All participants identified, in some way, the importance of whakarongo while maintaining tikanga and working with Māori clients. The subthemes of identifying the greatest need, authentic care and active listening all relate back to treating the client as an individual and providing services in a way that allows clients to feel heard and understood.

Kia Ngāwari

The theme *Kia Ngāwari* is the third tikanga value and it represents flexibility. This term reflects a participant's desire for a tikanga mental health and well-being framework that aligns with mātauranga Māori. It is ever-expanding, developing and flexible to accommodate multiple needs and different types of people. Kia Ngāwari are the Kō Ngā Peka (branches) that reach out from the trunk of Tāne-mahuta and hold the leaves in place. They are flexible and able to move as the elements require. They also grow at the pace the trunk and roots allow in due season. They shelter the roots and trunk from outside elements that can damage the root system. They represent the need for collaboration that can reach out from within the person to the community, healthcare services, and role models and improve their mental health and well-being.

One participant explained that Kia Ngāwari is tikanga. There must be flexibility in tikanga. It is individual and starts with one's au and then extends out to whānau. What is right for one individual may not be for another. By having flexibility within a framework, service providers can gain a deeper understanding of an individual's tika (values) and create a safer environment for them:

> Tikanga is like the tika, the right ways of doing things. And so that's only dependent on the people and if they follow those tikanga… who's tika are we following…? What are their whānau tikanga? What are their hapū tikanga? Does the hapū have these ways of being that help support their mental health and well-being? And outside of that is their iwi… It can't be hardlined that it's this, this and this. Because that will change from this person to that person to this person because their tikanga for them would differ, so yeah (laughter).

Another participant communicated the importance of flexibility when working in mental health. Providers must be able to adapt and make changes to the type of help they offer to provide quality care.

> …what you do with Mrs Brown is never going to be the same as what you did with Mrs Williamson down the road, you know what I mean? You had to be able to adapt to the person as an individual and find out how they tick and their whānau tick and how's the best way to make it work for them?

Resources

Within Kia Ngāwari is the subtheme *Resources*. Findings suggest that for a framework to be tikanga, it must use the resources that are available and accessible within the community. Resources such as the awa, moana, maunga and whenua are essential for building mental health and well-being. Other resources include taking what Western resources are available and using them in a te ao Māori way or integrating Māori and Western resources to collaborate and provide better client care.

Many participants at the hui agreed that there are great resources in our community that can improve mental health. One participant found in their practice that using natural environmental resources did improve the mental health and well-being of local youth:

> Using our coastal resources, our bush, our, you know, our environment and getting kids out and about is where you… get a lot of traction.

During the hui, a cultural advisor shared how some resources are already available in their practice. Some have Western frameworks, but these can be a benefit for those who are struggling with mental health and well-being. The advisor suggested that identifying the resources available in the community would allow clients to obtain more immediate care, equating to better health outcomes.

A participant identified in their interview how the power of storytelling is a resource for Māori. The participant recalled hearing *whakatauki* (stories) and *pūrākau* (historic myths and legends) through their rangatira on how to work through life's challenges:

> And that's exactly what our nanny and our kuia and our kaumātua do. They tell the story. They talk about the issue through story or pūrākau… whatever framework will be used… to portray stories.

Another advisor commented that for any programme to be a beneficial resource it must be timely and easily accessible:

> To have any sort of meaningful programme it has to be timely. It has to be timely and then it has to be really easily accessible.

Safe Environment

Clinical environments can be daunting for any client, especially for Māori clients. Participants communicated the need for service providers to create a tikanga space where clients feel safe enough to open up. Safe Environments is a subtheme of Kia Ngāwari because they must be flexible. Service providers may need to consider moving away from clinical environments to help work with their clients in places where they feel most comfortable or safe, such as meeting them at the client's whare or their mahi. Alternatively, other participants suggested connecting with environmental resources, such as the beach:

> How can you make that environment a little… meaningful for them to come to be able to kōrero… unpacking generational traumas and all of that? How can you make that environment more like… a marae environment… A whare.

One participant acknowledged that accessing mental health services in the Bream Bay community can be challenging. Moreover, finding appropriate help where Māori clients feel comfortable is even more difficult. Many service providers are taught through Western frameworks, and they often neglect cultural norms that could increase their clients' comfort and ability to share their experiences:

> Access to anything as far as mental health services is really poor. You know, even if somebody wants to be seen and wants to get some help, it's really difficult to get them connected with a person. And then when they do get connected with a person are they going to be met with someone who actually meets them in a space that's okay and makes sense to them? Things like… they might need to bring their support whānau with them. You know, how are you actually going to frame the whole interaction that

you have with them to make them feel safe?... Make them feel like they're comfortable…

Follow Up Care

One subtheme that occurred multiple times throughout the research process is the need for follow up care. There was no specific way in which it should be conducted but the important point was made time and time again that it should be conducted. By service providers following up with clients, they give them the opportunity to share their experiences. It is of the utmost importance to determine whether the services allocated to Māori clients have a measurable positive impact.

A participant shared their personal journey of going to a counsellor who missed the mark. This participant believed that if there had been a follow-up call or service available, they would have potentially wanted to return to this counsellor:

> … after that counselling session a follow up call, even if it's by the same counsellor or by another colleague. Just to say hey, you caught up with Sue yesterday, just wanna see how you're feeling about that, you know. Because I think if I had a follow up call and was able to give my opinion and how I felt it could've been in time for me to, (obtain) another solution.

Another participant acknowledged the importance of follow-up care as a social worker, because it allows clients to feel regularly supported. It also enables clients to continue with their healing process:

> Having those follow-ups… as a social worker, we're always following up on our clients. Like, you know, oh how's everything going? Like meeting up with them on a weekly or fortnightly basis just so they know that we're there to support them and they're not on their own, so they don't give up on the process as well.

Programme Design

Flexibility within programme design was specified as an essential subtheme of Kia Ngāwari within the participant cohort. There was a unanimous discussion at the participant hui, that for a framework or programme to be tikanga, multiple and flexible services must be available to aid individual mental health needs that incorporate te ao Māori. Suggestions

ranged from personal counselling to gender-specific courses to whānau and parenting support programmes.

One participant shared the success of a female wellness programme offered through BBCST. It was a six-week course based on Te Whare Tapa Whā principles run by the client connectors at the Trust. The connectors received great feedback from participants and wanted to increase the programme's flexibility by extending it to build stronger relationships within the group:

> Like we had the female, the wellness programme which our two… connectors… were running it and it was amazing… I was sending my clients there… And they gained so much out of it because they learned about Te Whare Tapa Whā that's how they worked on that one. But, because it was only a six-week programme, that it was short. And they loved it, but then they felt that it, like our actual clients felt that it should of went longer.

One participant identified that Bream Bay needs more parenting resources. They found through their mahi that providing support for teen clients is only half the battle. If the client's whānau is also offered support, making a positive long-term change is possible. This participant disclosed a working experience in Whangārei where a parenting programme, called Positive Lifestyle, was met with successful outcomes. The participant attributed the success to the relationships that the providers built with the client's whānau, as opposed to the programme itself:

> I suppose for parents… you do like a two pronged, you know, the tamariki and the parents... You don't have to necessarily combine them… what we find here, when we work with whānau here, they can come in here, do PL Parents which is positive lifestyle programme which is a really quite not too heavy programme on anger, you know, all these things… And, you know, it depends on how good your relationship with that person is on how much benefit or wellness they're gonna get out of it.

Another participant acknowledged that parenting programmes need to be presented differently for Māori. The participant discussed how parents need to share their feelings without worrying if their honesty will get them into trouble with Oranga Tamariki CYF (Child Youth Family Services). There must be enough flexibility within a programme that parents feel comfortable sharing their struggles with their children without judgement:

> Parenting courses… they just want to give their kids a hiding… But, obviously they don't do that… they may sound bad, but they don't act on it… they need to be able to share that… Cause, you know, that's how they feel. So when they're coming to those programmes they're thinking that it's a waste of time 'cause they can't be honest, you know? They can't be honest about how they're feeling because they're scared that they're going to get reported, you know… why come to a programme where they're not going to learn anything of it because they're not going to say really how they feel. Yeah they're only going to say what people want to hear, yeah.

Participants agreed individual counselling is essential in building mental health and well-being for Māori in the community. One participant expounded upon their experiences in counselling by expressing that having someone to confidentially speak to (who is also a trained listener) has the ability to make an impactful difference. An important distinction the participant made was that the listener does not necessarily need to be a counsellor. Similarly, flexibility in who can provide help should be considered:

> Definitely and one of them would've been, really one would've been someone that was just there to listen. Someone there to hear the maemae. And I guess what I mean by that was someone to actually sit down and not say anything… someone I could offload to. And I thought that's what this counsellor was… But as well as good role models and, you know, now these days, and that's probably why I'm in the work I do, because like I said you've gone through it, you've overcome it, what can you do for the next generation?

Summary

The participants contributed to the concept of Kia Ngāwari concerning tikanga. There was unanimous agreement at the hui that flexibility is vital to tikanga and providing respect and appropriate care for every individual. Many participants identified their frustration at Bream Bay's lack of resources and programmes for mental health and well-being. They believe that more resources are essential in improving mental health for Māori, along with ensuring such resources are designed flexibly to allow for safe environments where healing can occur.

Mana Rangatiratanga

Mana rangatiratanga is a protective measure ensuring Māori have sovereignty over their health and healing experience. Rangatiratanga can be understood in English as the right to self-authority, to be chief over one's own autonomy, ownership and sovereignty (Mead, 2016). Mana does not only relate to individuals but can also be used to describe the power, influence and strength of a whānau, groups, events, hapū or iwi. As a tikanga value identified within the research project, Mana rangatiratanga can be best understood as the importance of upholding clients' personal strength, autonomy and ownership throughout their healing and health process.

Mana rangatiratanga is the Poutokomanawa (tree trunk), representing clients' ability to stand strong individually. Their tika and value system must be honoured and cared for to improve mental health and wellness. Poutokomanawa acknowledges all the connections a person may have with outside elements such as their community and support structures. However, it also acknowledges the strength of au, the trunk that holds their sense of belonging.

One participant in the cultural advisory group explained that for a framework to ensure Mana rangatiratanga it should be led by rangatira. This is because they should know what their people need in order to improve their mental health and well-being. The participant goes on to say that this expectation is reasonable in theory. However, unfortunately, it is a burden that has not been passed down to current leaders due to colonisation:

> Tikanga led Māori health programme would be based on rangatiratanga. So it would be the families of the rangatira who would lead. Remember this is theory... And they should know what to do when their people are sick… So, you've got the theory, rangatiratanga hierarchical, birthright. But the reality is no hierarchy, no right…No tradition, no change … to create… An ethical framework to improve the mental health of Māori... It would be about the rangatiratanga who the owner of the land on behalf of all the others is… And then your tohunga who have the knowledge about health and the body and cultivation and 'cause it's all mixed together… So that's a Tika based, all theory... What we have instead is a mongrelised Māori society and leadership, hence no change.

The participant disclosed there are tikanga-led health workers who can step up to guide Māori people into obtaining better health and well-being. However, they pointed out that the workers are overworked due to the immense need in the community:

> But, if you want a tikanga-based and ethical Māori system of health, then you're going to struggle because where are you going to find these ethical Māori health workers? They're burnt out… it would be good to come up with a theory of an ethical, an ethical way to I don't know, is the word retrieve? To restore? To improve? To transform Māori, mate (sick or ill) Māori, mate (sick or ill) wareware (the forgotten). I just know it's difficult. But, it doesn't mean it can't be achieved.

During the interview, the researcher observed the participants' anguish and passion for Māori culture, the people and their communities. Although the conversation had a heavy sense of urgent need for the Māori in Bream Bay, the participants hoped to see Māori thrive again.

No Stigma, No Judgement

A strong subtheme identified under Mana rangatiratanga is ensuring that the service providers hold no stigma or judgement toward Māori or the individual. For a service to be beneficial and tikanga for Māori, whoever is running the programme must be approachable and have te ao Māori knowledge.

One participant shared their view on how to maintain tikanga through being open-minded and knowledgeable in te ao Māori:

> Whoever's running it needs to be approachable and have tikanga knowledge. I don't think they need to be fluent or know everything but they also need to be prepared to have questions asked and be able to answer those. And… having that empathy, being openminded… But it's just being open and inclusive, no judgment and it being a safe place.

Another participant specified their struggle to find culturally safe employees without unintentional bias or judgment towards their clients. They spoke strongly about being cautious about who is trained to run the tikanga framework. In their previous mahi, they

observed that the risk of the wrong staff can be potentially detrimental to the client's mental health and well-being:

> I'm just going to plainly say it… we need to be careful who we hire because some of those people that are vulnerable walk in, and if they feel judged in any way all of a sudden they're closed. And they're walking out and they're not coming back. And if they're not going to end their lives, they're going to self-sabotage which is through alcohol addictions.

Normalise Help Behaviours

Normalising Help Behaviours was identified as a subtheme under Mana rangatiratanga. Not only is Normalising Help Behaviours tikanga, but it produces self-confidence for individuals to share their experiences. By normalising talking about emotions and personal experiences, participants believe the stigma of asking for help will be removed.

One participant shared their struggle with clients who feel uncomfortable sharing their feelings. The participant spoke of one whānau who they were unable to get the parents of their teen client to express their feelings to their tamariki:

> "Why can't we make I love you normalised, you know? Why can't we make crying normalised, aye? Where kids can cry and it's all good, you're safe."

Another participant shared the importance of men learning to communicate and sharing how they feel towards their sons. The participant shared their experience with older Māori clients and observed that being open with their emotions and feelings was not common practice for previous generations:

> "Even for boys, I love you my boy or I love you son. It's hard for our men because yeah, I think about my Dad and my Mum's generation, it was unheard of."

One participant openly shared their experience as a counsellor specialising in working with teens. They identified the need for normalised help behaviours instead of abusive behaviours through positive gendered programmes:

> "We've still got girls who think that it's okay that their boyfriend busted their eye, you know? So that would help mental health. Programmes with, you know, women, young girls learning how to be their own woman, yeah."

Future Focused

Being *Future Focused* is part of Mana rangatiratanga because it provides a means of self-sovereignty over the client's health journey and autonomy and control over their future. Being future-focused is also essential in tikanga Māori because it aims to see Māori thriving and builds hope for the next generation.

One participant discussed the immense need to provide hope for the future of tamariki in the Bream Bay community. They shared the need for practical opportunities to build mental health and well-being. By providing opportunities to learn new skills, clients have new hope for their future:

> If you give kids opportunities around work and they've got a future ahead of them… you're instilling hope and you take away shame, you know?... It, I can do this, I am capable. I have got a future. I can go somewhere. I'm not just stuck in Ruakākā for the rest of my life, sitting in a garage getting wasted or stoned out of my brain. I will be okay.

A participant expressed that the reward of being future-focused on the youth work associated with this type of role takes time. The participant had to learn that the youth will remember what has been imparted to them over time, and that is what can change their future:

> What I've been taught is that it's not about the now, it's about what happens with him for the next 5, 10 years that you've imparted into them. And that's what I've had to learn is you can't change someone overnight. And overnight could be a year, overnight could be two years. You've gotta start thinking it's their future. When they become men, when they become parents. When they become a husband… or a wife.

Active Participation

Active Participation is a subtheme within the overarching tikanga value of Mana rangatiratanga. This concept derives from the observation that for any health service

framework to be beneficial, it must be client-led and have active participation. Active participation aligns with Mana rangatiratanga because it allows clients to control their healing experience.

A participant shared an example of a successful well-being programme that was run specifically for Māori. The participant believed the success of the programme was not the programme itself but rather the buy-in from the participants who chose to engage and participate actively:

> We did a programme which was called Fight Fitness which was an exercise-based programme… highly used by Māori. Okay it was… physical… but exercise as you know is tied so much into your mental well-being… people really owned that programme. They were so excited, they turned up every morning, they had a Facebook page group. They were really supporting each other. We had copious amounts of evidence to show the success of the programme.

Unfortunately, the participant disclosed that even though there was proof of the programme's success, the financial funding was cut off; and the programme is no longer provided in the Bream Bay community due to lack of finances.

One participant shared a personal experience when working with Māori clients who assume they are not Māori and can often have an attitude when attending such services:

> I've had it many a time, Māori clients come in and look at me and go what do you know about tikanga Māori, you're not even bloody Māori. And as soon as I start speaking te reo Māori, break those barriers down and they go oh, okay. Because that's those assumptions... Some people just open up and want help, but some can come in with an attitude.

This interview extraction demonstrates the need for culturally safe service providers who understand te ao Māori and can adhere to tikanga Māori through kawa. Furthermore, the interview identifies the power in being understood and how this newfound sense of empowerment could create opportunities where a person is comfortable to have the desire and confidence to act on this proclivity. In turn, this action equips the client with the ability to actively participate.

Another participant shared a frustrating experience where a willing client asked for help but did not receive any, due to funding. When the participant was asked the question, "Do you feel like Māori would use services like counselling more if it was available or once they knew it was here (referring to BBCST)?" the participant responded as follows:

> I do absolutely. If it was delivered, if it was available to them and it was something that they knew, that when they really had the moment and they could do with the help, I know they would. Half the problem is that you finally put up enough courage to say I need some help, but if it's not met with a solution.

This answer demonstrates the willingness of Māori to participate actively in their healing journey. Nevertheless, they do not commonly know what is available when it comes to resources and services that are available to them in the local community.

Summary

By personally experiencing the need for mana rangatiratanga first-hand, participants were able to articulate what is needed for a tikanga-informed framework to function well. Most participants discussed the struggle to connect clients who want help and who are actively willing to participate in their healing journey to find the appropriate support. Deep passion for wanting Māori to obtain help in a way that will enable them to have hope for their future stood out in the interviews amongst the frustration of the lack of understanding and availability for what support Māori need in mental health. Although many participants have had to mahi within limited available resources, it has provided great insight into what can be changed to improve Māori mental health and well-being.

Whakawhanaungatanga

Whakawhanaungatanga is the fifth tikanga value and theme identified as essential to obtaining the study's aims. Whakawhanaungatanga is the opportunity to build and support positive relationships and connections with individuals, whānau and communities (Duncan & Rewi, 2018). Whakawhanaungatanga is tikanga because 'relationship' is foundational to te ao Māori. For mental health and well-being services to be tikanga, they must be based on building strong relationships and connectedness. Whakawhanaungatanga aims to build rapport and mutual understanding that have the potential to increase client engagement and

service provider competency (Wilson et al., 2020). The participants associated whakawhanaungatanga as the foundation and root system of all health interactions for Māori.

Whakawhanaungatanga is ko ngā paiaka (tree roots). It is the deep foundational roots that an individual builds that connects their au to others through relationship. Ko ngā paiaka is a person's hidden parts that run below the surface, keeping them grounded and strong, the base of their mental health and overall well-being. Ko ngā paiaka is their tikanga, culture, and understanding of the world.

One participant shared a personal positive experience with a counsellor who built relationship and whakawhanaungatanga through physical connection:

> "The linking of hands is really important because they linked their hands and then they linked. And it was just through that process, that initial process that, which helped, that formed that whakawhanaungatanga."

Another participant identified the power of building trust through whakawhanaungatanga that allowed them to share in their mental health journey:

> "With counselling appointments, you want to talk to someone that you have a level of trust with. And part of building trust is building a relationship. Yeah, otherwise it's very clinical, it's very cold. You're in and out."

Partnership of Health

The term Partnership of Health came through the cultural advisory group during the hui presentation. Initially, the subtheme, Partnership of Healing, was put forward from the findings of the analysis. However, one advisor shared the need to ensure that each term used in the findings is strength-based and that it does not infer that Māori are "broken." Whakawhanaungatanga connects to building a partnership of health because the relationship is required between the service provider and the client. There was much whakaaro about the term, and it was agreed that 'health' induces strength because anyone can get healthier, while 'healing' induces weakness and conveys that the client is sick.

Most participants were vulnerable and honest about their mental health and well-being journeys and shared openly about what care they needed during their struggles. One participant shared a need for ongoing support with a trusted person:

> My mental health, which I know is not good. It would be some external support to talk with someone who I can have a trusting relationship with on a professional level. Who I could trust that their advice and support was going to be worthwhile, yeah.

Another participant shared a personal experience regarding mahi, which incorporated the essentialness of building trust between students, teachers and counsellors. The participant identified the power dynamic of students trusting authority. Congruently, the participant acknowledged that trust is earned and must be met with a combination of stability and reliability, which is due to the instability experienced in many students' lives:

> Because a lot of the students, especially our Māori, they trust you… One of the gaps is that trust and being able to one, rely on stability. Because I think that they had such trauma in their lives like oh I'm saying like massive trauma for a whole lot of reasons. Both generational and what was happening to them in their lives, that they had no stability. So having somebody that was willing to be there and to support them through that, even if it was just an ear to listen.

One participant describes how their clients jump from service to service without obtaining any mental health improvements because there was no genuine connection made between the provider and the client:

> But then you can get caught up in the service, you just go from referral to referral to service to service, you know? There's no real actual connection made with anybody.

Role Models

Role models is an important subtheme that is connected to whakawhanaungatanga. It is not always those with credentials who have the potential to influence and improve mental health and well-being. Rather, individuals with character and understanding can build hope and provide long-term support for those in need. The concept of role models is pinpointed as tikanga because Māori are collectivist and community-focused. Similarly, the concept of relationship is foundational to well-being for Māori through whakawhanaungatanga.

One participant identified the importance of connecting with role models and kōrero with people with more life experience for mental health. This participant spoke openly about the influence that conventions at the marae have on their mental health and well-being:

> But, on the marae there are so many opportunities to kōrero with people that have so much life experience that those moments have been more beneficial for me in my life, and my kids too. Than actual paying this person who's got this… degree or whatever. Yeah, life experience for some of our kaumātua and kuia trump that. I'm not saying that they replace… those counsellors.

Another participant recognised the impact and importance of working with tamariki through building a solid relationship and choosing to be a role model for those they have influence over:

> That's what I love about youth work is that you can impact. It doesn't matter if you impacted 1, 10, 20, 1,000 people, you're impacting someone's life by the fact that you're there to listen, you're there to care for them, love them like they're your own children.

One participant highlighted an experience of seeing *rangatahi* (teens) in need of role models who support and encourage them. This participant spoke about how young people need relationships that emotionally build them up and normalise communicating their feelings:

> And just be a part of their life because that's all they're yearning for is someone just to listen. Someone just to hug them and say I love you; you know. Even for males. It's hard for males to say I love you.

Several participants established that having a role model builds strength through resilience for Māori. One participant deduced that building resilience is a driver for those who want to be role models for others in their whānau:

> But, in a Māori world view it's a lot bigger than that. It's about wanting to give back to your whānau. It's about wanting to be a role model for other people. Your drivers to be resilient aren't an individual, it's not an individual driver. It's being resilient for the whole of your whānau I guess really.

Another participant shared the importance of role models to build resilience in mental health:

> And so I think having role models is so important. And they might be in your whānau, they might be outside of your whānau. But, identifying role models and why they are a role model for you. That's also part of resilience because you have something that you aspire to.

A cultural advisor spoke about the importance of tikanga through obtaining role models that provide authentic care. The advisor shared that it could be most beneficial for role models to be endorsed by kaumātua or respected whānau leaders. They identified the need for a programme to be run by people who have established relationships and whakawhanaungatanga rather than by strangers for Māori to feel comfortable to attend:

> It has to be authentic and it has to be relevant and it almost has to be endorsed by either kaumātua, respected leaders or families, because they have the connections to the right people. If it's run by an organisation that are strangers or run by people that they don't know very well, they're quite hesitant to take it up I think. Yeah, its relationship based like everything.

Connection

Connection is a subtheme within whakawhanaungatanga. To have whakawhanaungatanga, an authentic connection must be built on a positive relationship. Throughout the interview, participants pinpointed the need for authentic care through connection as imperative to a tikanga-informed health and well-being framework.

One participant learned throughout their career that people are aching for connection, the ability to offload and have someone to talk and share. When working with rangatahi, the participants identified that clients need a friend to share with, so they do not feel so alone in their experiences:

> Nobody else knows what's happened to us. We know the pain. Nobody else knows the pain. So we need to, we must, not need, we should, we should talk more. We have to talk to each other because this is a pretty friendless world. And, you know, I've taught teenagers for many years, I don't any longer, but you know, from those kids I know the one thing that they want is a friend. They want a friend.

During one interview, a participant acknowledged that by me adhering to tikanga through sharing my pepeha at the beginning of the kaupapa, they were able to establish a connection with interviewer that allowed them to be more open in the discussion:

> You did your pepeha and you said it and then that made that connection to me. And so I was instantly connecting in my mind and in my ways connecting my ancestors, which was through my grandmother. And I was connecting, I went straight to the mountain, and I went straight to the rōpū. And, you know, so I was making those connections already which goes back to what I was talking about, oh I was forming that trust. Because that whakawhanaungatanga, whether we like it or not in our professional fields is the most important. And how we make that connection, it's not just the, a process… It continues and it moulds itself.

Another participant confirmed that connecting does not have to be one-on-one between the service provider and the client. Connections can go deeper than that into a community or a person's own culture:

> But it's even just connecting with a community, you know. Having a place to belong. And I think in Māori culture, you know, when you're on the marae you've got a place to belong. You've got your tūrangawaewae and back in the day communities and you all worked and lived together.

One participant was frustrated with how many service providers do not understand tikanga or what is important for Māori. Without this imperative knowledge, it is impossible to provide beneficial care for mental health and well-being, because building a connection is difficult when there is no understanding:

> So let's talk about Māori, what culturally is important to them, you know? Knowing how important the tikanga is for them to actually bring that into your assessment, your intervention, you know? It grounds the whole premise of what you're providing them. And if you've got somebody that doesn't even understand the slightest bit about that you're like a ship in the night passing each other without actually connecting.

Summary

All participants identified ways in which whakawhanaungatanga is an essential tikanga element that must inform a framework for mental health and well-being. There were passionate discussions within the hui about ensuring a partnership of health is built on positive relationships between the service provider and the client. Throughout the interviews, the participants delved into their own needs for role models and the need to be role models for the local Māori community. An evident longing for connectedness was conveyed as a strong determiner of mental health and positive well-being.

Conclusion Section One

Ā Wairua, Whakarongo, Kia Ngāwari, Mana Rangatiratanga and Whakawhanaungatanga are determined as the five tikanga-informed. These values inform the first aim of this study by identifying tikanga-informed values that will aid in improving mental health and well-being for Māori specific to Bream Bay. The values have been established by following a Kaupapa Māori research process that allows Māori voices to be heard and authentically represented. The research process ensured that mātauranga Māori, tikanga Māori and te ao Māori were maintained throughout the process.

Section Two

This section addresses the study's second aim and the next phase of the research to establish a mental health and well-being framework built upon the tikanga-informed values identified in Section One. The purpose of the framework is to improve the quality of care for BBCST clients through whakawhanaungatanga, by improving the service providers' understanding of their clients' health perspectives. By obtaining greater understanding of their Māori clients, service providers will be able to deliver and facilitate more appropriate and quality care that aligns with te Ao Māori health perspectives.

> **Aim 2:** To develop a localised tikanga-informed framework for improving Māori mental health and well-being, that the Bream Bay Community Support Trust (BBCST) can use to provide culturally safe support for their clients.

For a framework to be tikanga-informed, it must be strengths-based. Building on the values identified in Section One, seven themes were recognised to develop a tikanga-informed framework for improving mental health for Māori clients at the BBCST (Table 2).

Table 2

Framework Themes and Subthemes

Themes	Subthemes
Māramatanga Waiora / Health Understanding	• View on mental health • Trust in the health system • Holistic / biomedical perspectives • Knowledge of available services • Knowledge of self-care needs
Tuakiri / Self Identity	• How they identify / daughter, mother, son • Resilience / self determination • Strengths and weaknesses • Self-awareness / ability to articulate feelings
Ngā Poupou / Support Structures	• Services available to them • Whānau and community connections • Employment • Opportunities
Ā Wairua / Spiritual Connection	• Awareness of the physical / spiritual connection • Understanding of spiritual experience • Identify spiritual gifts
Tōku Tūrangawaewae / Cultural Connections	• Connection to culture • Urbanized or Mana whenua • Impact of colonisation • Impact of intergenerational trauma
Tātai Hononga / Strength of Relationships	• Relationship stability • Whānau connections • Friends and community connections
Tōku Tikanga / What is right for you	• Personal tika • Whānau tika • Identify personal values • Identify greatest need

Through collaboration with the participants of this research study, the above themes and subthemes- named the Seven Strengths- have been identified as being important to the well-being of Māori in Bream Bay. These are discussed below.

Māramatanga Waiora / Health Understanding

Throughout the interviews and in the hui, a theme continued to arise regarding clients' distrust of the current health system and limited understanding of what options are available

to them. Many participants acknowledged that some clients, especially older Māori, would only go to the doctor or obtain healthcare if their ailments were chronic.

> … They never used to go to the doctor because that means there's really something wrong with you.

Participants identified that younger Māori were more likely to obtain health services if they knew they were available or had the funds to do so.

> And it's really, really hard for our clients to get counselling first and foremost without having to go through a GP which again can be a barrier to most people. 'Cause one, they don't even have a doctor. They can't afford to go to the doctor. So putting up barriers like that to even contemplate going is, it's just too hard. It's too hard basket.

Multiple participants acknowledged that clients still struggle to understand how to access available services.

> They just usually go into a doctor's office and then they get referred and then waiting for that referral as well. And then even when you ask the doctor, oh when, you know, what's going to happen now? And they're like oh we'll refer you; they'll give you a call. Like they can't even say a timeframe… it's like you could be waiting months and then you'll get a letter in the mailbox which says you're not eligible… People just want answers.

Participants recognised that service providers need to identify if their client has a holistic or biomedical health perspective and provide services that support that perspective. One participant shared the struggle of not understanding how to access the right services based on their needs.

> I couldn't imagine being in the darkest, you know, being in my darkest hour walking into that doctor's and asking for help. Having a, you know, or even sitting there, 'cause the doctor's sitting there, he's only got 15 minutes. And saying in 15 minutes I think I'm going to commit suicide today; you know?

The finds of this study show that when a service provider is assessing a client in their first interview, they should aim to obtain insight into the client's health understanding, by asking questions about the clients view on mental health, their trust in the health system, and

their knowledge of available services. By obtaining information on the client's health perspective the service provider can develop an understanding of the client's values within the healthcare system. A greater understanding can provide an improved ability to identifying the most beneficial approach for the client's mental health and well-being.

Tuakiri / Self Identity

Participants agreed that the lens through which a client views themselves is critical to understanding the client. Identifying how the client views themselves in connection to their relationships, their strengths, and their ability to articulate their feelings in a positive or negative light, can allow service providers to recognise areas that need support within the client's self-belief system.

In an interview a cultural advisor shared their perspective on the importance of tuakiri.

> To have resilience you must have identity a deep and strong knowing of who you are, where you come from. Identity is essential to resilience because resilience interacts with resistance. You must be strong and resilient to resist against racism, against prejudice and judgement.

One participant shared their experience of being unsure of their identity which was causing mental distress.

> Even myself, I have not fully found myself, you know? Like I'm still searching, you know, doing whakapapa and that type of stuff. And it's not a, yeah, it's just knowing who you represent yeah.

Participants determined that tuakiri is linked to all facets of well-being for Māori. By gaining more awareness of clients' self-identity, the provider is gaining an understanding of their individual tikanga. A participant shared the importance of tuakiri in tikanga.

> 'cause everyone's got a whakapapa, like you know? And it's about you come, you learn, it's all about learning about yourself, just in a Tikanga, Tikanga way.

Another participant discussed the importance of tuakiri when it comes to well-being and resilience.

> Don’t let anyone tell you that being Māori is not good. Yeah, be proud and be strong in that, you know? And yeah, knowing who you are, where you come from. Having your aspirations, your goals. Knowing the values that you live by. Those are all keys to resilience for us.

The subthemes allow the service provider to gauge how clients view themselves and their ability to articulate their feelings. By gaining more awareness of a client’s self-identity, the provider is gaining an understanding of their individual tikanga.

Ngā Poupou / Support Structures

Ngā Poupou are the support structures that are outside of the au. The participants identified that everyone has a set of pou (pillars) that enable them to maintain their mental health and well-being. Some of the specific pou that have been identified through TA in this study are services available to clients, whānau and community connections, and employment opportunities.

Participants determined that the strength of a person's well-being is connected to their positive connection with their whānau and community.

> The au goes into the whānau, and then what does that look like and what supports are there outside of that is the whanaunga, like all those connections… matter.

It was also pinpointed that service providers are pou that help maintain mental health and well-being.

> So, it’s been difficult to access somebody that is like… our kids that… look like them, sound like them. Similar background… it’s difficult to find appointments now with the counsellors that are available that meet that criteria.

A participant identified that they had seen their clients’ mental health improve from support and connection.

> When they were struggling it was definitely because they were disconnected from who they were and where they came from. And as soon as someone reached out and supported them on that journey of self-discovery, they, yeah, everything else takes care of itself.

Employment opportunities is a pou that was identified by a participant as important for the mental health and well-being of their Māori clients.

> Like if you think about wellness, mental wellbeing, it's not just okay we'll fix them mentally… Like down at the Trust, we have people losing their jobs. They don't know how to be unemployed. So, these people that are feeling vulnerable, some have anxiety, they're locking themselves away.

In a hui participants determined that the strength of a person's well-being directly relates to the positive connection with their whānau and community. It was also pinpointed that employment and support services were also pou that help maintain mental health and well-being. Some participants described their experience of needing help to improve their mental health. They described seeking help from various pou such as whānau, rangatira, kaumātua, and even their vocations. By identifying the pou in a client's life, a service provider can see where the strengths lie in their connections and can help the client lean into those connections for support.

Ā Wairua / Spiritual Connection

Ā wairua identifies the values of a person being connected to their wairua (spirit). Ā wairua is identified as one of the seven strength structures of the māwhaiwhai because of its ability to connect all elements (including the seen and the unseen). Participants shared their experiences of connecting to their wairua to get them through mental health struggles.

A cultural advisor at the hui explained connecting to their wairua by stating:

> Māori don't meet people, they feel people.

This statement has been understood in the context of someone who can sense if they can build trust with someone through tuning into their wairua.

One participant shared how their mental health improves when they receive direction from their tūpuna through engaging their wairua.

> I'm Māori, and I have my tūpuna… I feel them, I know they're there. Like they brought us here to the marae today because they wanted the kaupapa started here. And it's beautiful, it's a beautiful thing.

A participant shared that karakia and waiata improves mental health because it helps build *honu* (deep) connection to things they identify with.

> If someone gave me a karakia, or someone gave me a waiata to listen to… I could resonate with, and I could see myself benefiting from, you know?... Having that honu, having that connection to someone and they could identify things that they thought could help you to improve your mental health.

The participants suggested that service providers should learn more about the client's understanding and connection to their wairua. This knowledge would improve providers' awareness of the client's spiritual understanding, help providers offer services that align with an individual's tikanga, thereby avoid crossing boundaries where a client may feel unsafe.

Tōku Tūrangawaewae / Cultural Connections

A theme that arose repeatedly in the interviews is the lack of *tōku tūrangawaewae* (cultural connections) with clients suffering from poor mental health. Some participants believed the disconnection may be linked back to colonisation and the urbanisation of Māori.

> Because of colonisation… Māori people get confused or have a sense of loss about their identity and who they are as Māori. Especially if you can't speak te reo, you know? People say well I'm Māori, but I can't speak my language. I'm Māori, but I don't know where my marae is. I'm Māori, but I don't know what the tikanga are.

One cultural advisor shared the importance of service providers understanding their Māori client's view education in connection to their culture.

> Mental health, needs to start to get to grips with how Māori people stand, understand the schooling system. Which is way different to my schooling system. I mean my schooling system all the way through, totally Pākehā.

Multiple participants shared their experiences of how learning about and connecting to their culture and whakapapa positively changed their mental health. One specific participant shared how whakapapa creates connection.

> I remember when I, 'cause I grew up in an English environment and when I learnt where I'm from and being okay with being on a marae I'd hear my marae or my

> whare or one of my tūpuna names, and I'd sit up straight and go I've gotta go talk to them afterwards. Wanting to make that connection. Because instantly you, it's just that one word or that one person, that one thing that you feel connected. But that's just me because I had a deep longing to connect.

Another participant openly discussed their desire to strengthen their identity through whakapapa.

> Even myself, I have not fully found myself, you know? Like I'm still searching, you know, doing whakapapa and that type of stuff. And it's not a, yeah it's just knowing who you represent yeah.

A participant pointed out that it is important for a service provider to identify what connection their client wants to have with their culture.

> I know a lot of Māori clients for example don't know their whakapapa, don't know where they're from. And some of them don't really give a shit, don't' care. And then some are ashamed because they don't know.

One participant discussed how some Māori, including urbanised Māori, lack a sense of belonging because they are disconnected from their culture.

> They're disconnected from their own whānau, and their whenua. And they're trying to, they're scrambling for a sense of belonging. I see that with the Nova Scotians in Waipū too. They're really searching for that belonging, and I think a part of that is their own mental health and their responsibility.

A service provider can gain insight into the tikanga of their clients, their belief systems, and their connection to their culture by gaining knowledge on the impacts of colonisation, urbanisation or other historical or intergenerational traumas. It should be noted that the participants did not endorse the idea that all people would have the same level of connectedness to their culture. By asking questions about these topics, service providers can understand their clients' values and improve their services to positively impact the clients' tōku tūrangawaewae.

Tātai Hononga / Strength of Relationships

Participants and cultural advisors unanimously believe strong relationships tikanga Māori and are essential to building mental health and well-being. Numerous participants shared their experiences of needing whānau relationships to help get them through hard mental health struggles. In contrast, others recalled the desperation of wishing they had more relational support throughout their struggles.

One cultural advisor spoke plainly about Māori who move away from their whānau and the impact on losing those connections.

> But, another thing that has happened is that people have had to move away from their homes into another smaller community, but… they… don't have that same connection as being able to fall onto Aunty and Uncle.

One participant identified their experience of isolation and the impact it had on their well-being.

> When you're in a state of really bad mental health, you isolate yourself, you know? And so, one thing to get yourself out of that isolation is to connect. But if you're isolated you don't know who you're connecting to.

The importance of supportive relationships for mental health was identified by a participant who works with youth.

> I think a lot of our youth now these days are committing suicide, because they haven't got a safe support. A lot of that mamae that they're holding onto, when there's stuff that's happening in their life which is hard.

Participants recognised that having strong relationships is essential for their well-being. The importance of relationships ran deeply through this research process, from interviews to hui and cultural advisory group consultations. Some participants relayed their experiences building relationships with Māori clients and found that the stronger their relationship was with the client, the more the client trusted them and allowed them to partner in their health journey. The findings of this study suggest that a framework should include considerations of the client's relationship stability, their whānau connections, and their community connections. When a service provider identifies a client's relationships, they gain

insight into the stability and strength of those relationships and can help the client identify their strong connections.

Tōku Tikanga / What is right for you

Tōku tikanga identifies the individual's values, goals and, most importantly, what is ethical and right for that person. Participants throughout the interviews and hui expressed their belief that Māori cannot be boxed into one type of ethical framework and that each person, hapū, iwi and area has different tika that are right and relevant to them.

A participant shared their experience with clients who come for help regarding one area but from further investigation, there was another area they need immediate help with, before they could deal with the reason they asked for help.

> If you don't meet them with what the real issue is then they're not even going to want to engage with us. So even if that's not even to you, doesn't even look important, it is to them. So you fix that first, then they're going to have the energy, the clarity of mind, the ability to then say okay now let's tackle this.

The participant continued by sharing that it is important to identify how the client wants to be helped, before offering help.

> So to me it comes back to that hearing, listening and realising that no matter how much you want to help a person, you can't' help nobody if you don't help them where they want to be met… 'Cause they'll walk out of here and go, but my issue is. That still hasn't helped me.

Participants identified that tōku tikanga is the foundation for what is missing in many mainstream mental health services and that consideration of a client's individual values and needs must be addressed to provide beneficial care.

A cultural advisor discussed the need for a framework or model to be flexible and work with client's individual needs.

> So the model needs to be flexible enough to, we look at each individual in their own tika. And then their whānau tika and their whanaungatanga. There's their whanaungatanga tikanga that they have to, you have to take into consideration.

It was suggested that tōku tikanga should be identified in the early stages of care. By doing this, the service provider can work in conjunction with the client's values without wasting time finding solutions that do not align. The client may feel more heard, understood and supported because the services meet their personal needs. Tōku tikanga has the potential to speed up the healing journey by eliminating the use of services that are ineffective for a specific client, which in turn will free space in those services for clients who will benefit.

Initial Framework

An initial framework based on the themes of the research findings was developed and presented to the participants and the advisory group at a hui.

A member of the cultural advisory group described what a tikanga-informed mental health and well-being framework would look like: everything begins with the au (individual) and expands out like a māwhaiwhai.

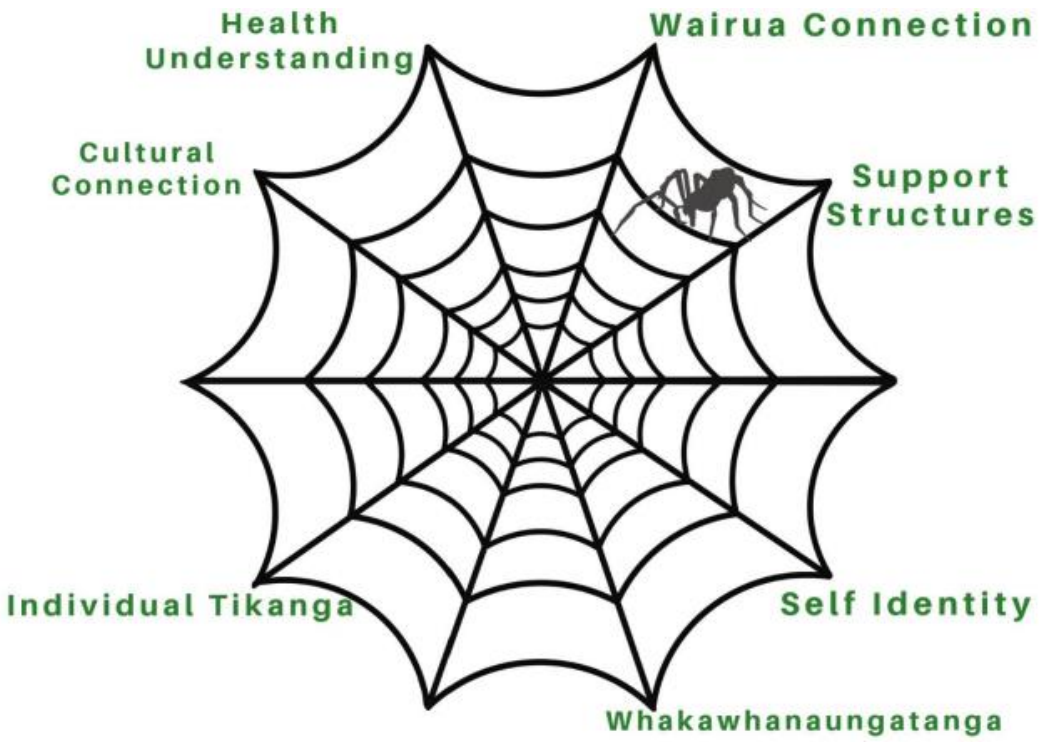
> A real Māori model… starts with the au which is the person who is in the state. And then around them is their whānau. So ‘cause the au goes into the whānau, and there outside of that is the whanaunga… Look at it like a tukutuku pūngawerewere [or māwhaiwhai, spider web] ... It’s like a spider web that links out… So, the model needs to be flexible enough to… look at each individual in their own tika. And then their whānau tika and their whanaungatanga.

From this kōrero, the seven strengths were put into a framework I named *Māwhaiwhai Kaupapa* (spider web). The māwhaiwhai symbolises the mental health and well-being of a Māori client, while honouring mātauranga Māori through te ao Māori creation story. The symbolism of the māwhaiwhai is that it can nestle within the tikanga-informed values of Tāne-mahuta identified in Aim One (Figure 6).

The initial framework was presented to the participants and the cultural advisory group in a hui. The framework comprised of two illustrations: Figure 7 and Figure 8. Figure 7 illustrates the *pūngawerewere* (spider) symbolising the individual's au and the māwhaiwhai (spider web) symbolising the strengths and weaknesses of their whole well-being. Figure 8 illustrates that a person’s māwhaiwhai can be damaged.

Figure 7

Initial Hui Presentation of Framework Concept

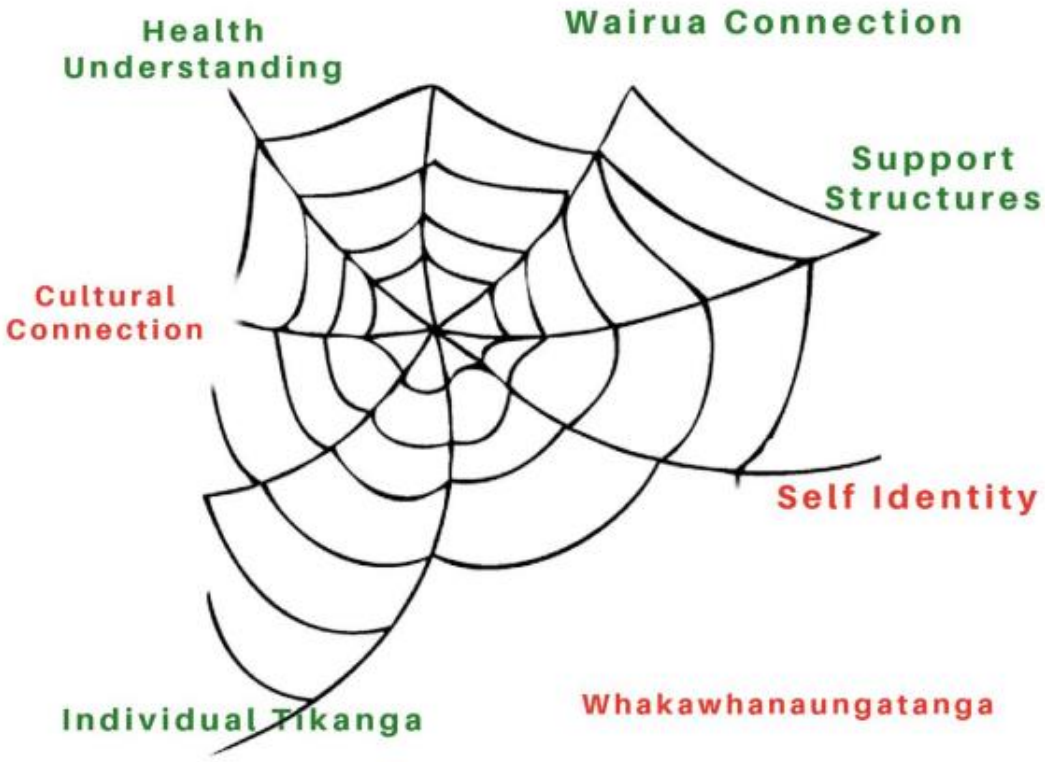


The purpose of the pūngawerewere was meant to represent the idea that a person struggling with mental health can be hard to identify. Their struggles can lack distinguishing features like a pūngawerewere hidden in the ngahere. Incorporating the pūngawerewere also acknowledged that while someone might be struggling with their mental health, they can still be building strengths within different areas of their web of well-being.

The purpose of using a māwhaiwhai was to depict that not all webs are created equal. There can be gaps and holes in areas where a māwhaiwhai has been knocked or a client lacks the knowledge, opportunity or support system that can enable them to build a strong web of well-being in that area. The weak spots in the web are areas where people may struggle with their mental health.

Figure 8

Initial Hui Presentation of Framework Concept of Broken Māwhaiwhai



By identifying which of the seven strength structures within the māwhaiwhai are strong and which ones need help and support, service providers can offer appropriate care and support in the areas of weakness. The benefit of this type of framework is that while a client can acknowledge the areas of weakness in their well-being, they can also identify their current areas of strength.

Māwhaiwhai Kaupapa Framework Development

After presenting the initial framework, there was an ongoing process of collaboration and consultation with the cultural advisory group. During the hui kōrero, there were multiple suggestions, whakaaro and recommendations from participants and cultural advisors to revise the framework to fit a more te ao Māori perspective. The hui and following kōrero were not recorded; notes were taken to ensure that the main discussion points and suggested changes were identified. Many changes were made to the initial framework; the main ones are summarised below:

1. The spider should not be part of the framework. The kōrero was that being compared to a spider feels *paru* (dirty).

2. Spiders represent fear, or the initial reaction when seeing a spider is to "squish it."

3. Several attendees of the hui requested the removal of the spider but were unanimously in favour of the spider web as a symbol of mental health and well-being.

4. Change the seven strengths to have te reo Māori titles. One cultural advisor felt that using English titles takes away from mātauranga Māori. It was advised that culture and language are intrinsically linked, so much so that the titles must honour te ao Māori.

5. Another recommendation was to continue to contact the cultural advisory group members individually with any questions I had, to ensure I continued adhering to Kaupapa Māori theory.

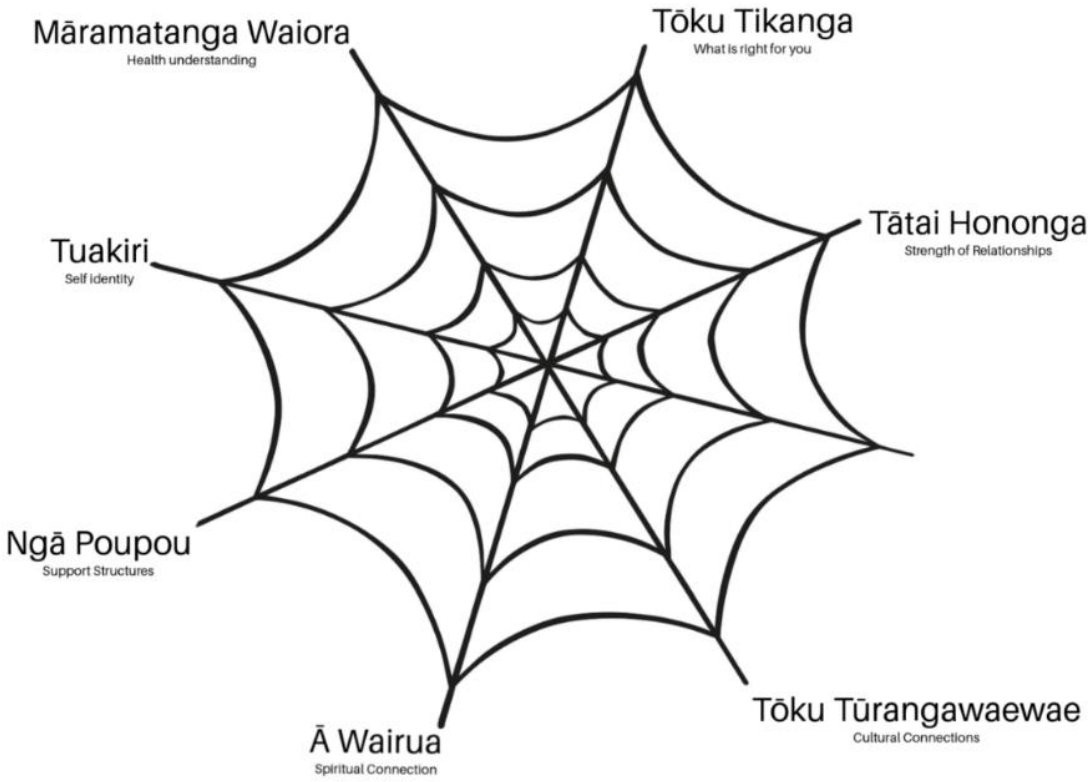
After the hui, revisions to the initial framework were made based on the recommendations. During this time, I consulted members of the cultural advisory group to collaborate, discuss the changes, and better understand the recommendations. From these consultations, a final framework was created. The pūngawerewere (spider) was removed entirely. The titles were translated into te reo Māori, and the descriptive language around the framework was modified to align with te ao Māori perspectives. The research design plan was adhered to by consulting kuia and other members of the cultural advisory group to collaborate and ensure that the research stayed community-led.

Final Framework

In te ao Māori, people are not separate from nature or identity; and whakapapa is not just who one's ancestors are. They are part of a larger structure connected to all elements. Everyone and everything are connected in some capacity. Through this lens, mental health and well-being can be understood by observing the māwhaiwhai. The web represents the strengths that a client has built within their own lives to protect their mental health and well-being. Each strength is interconnected and woven to fashion a robust yet delicate structure that creates a protective barrier against negative forces to maintain mental health and well-being (see Figure 9).

Figure 9

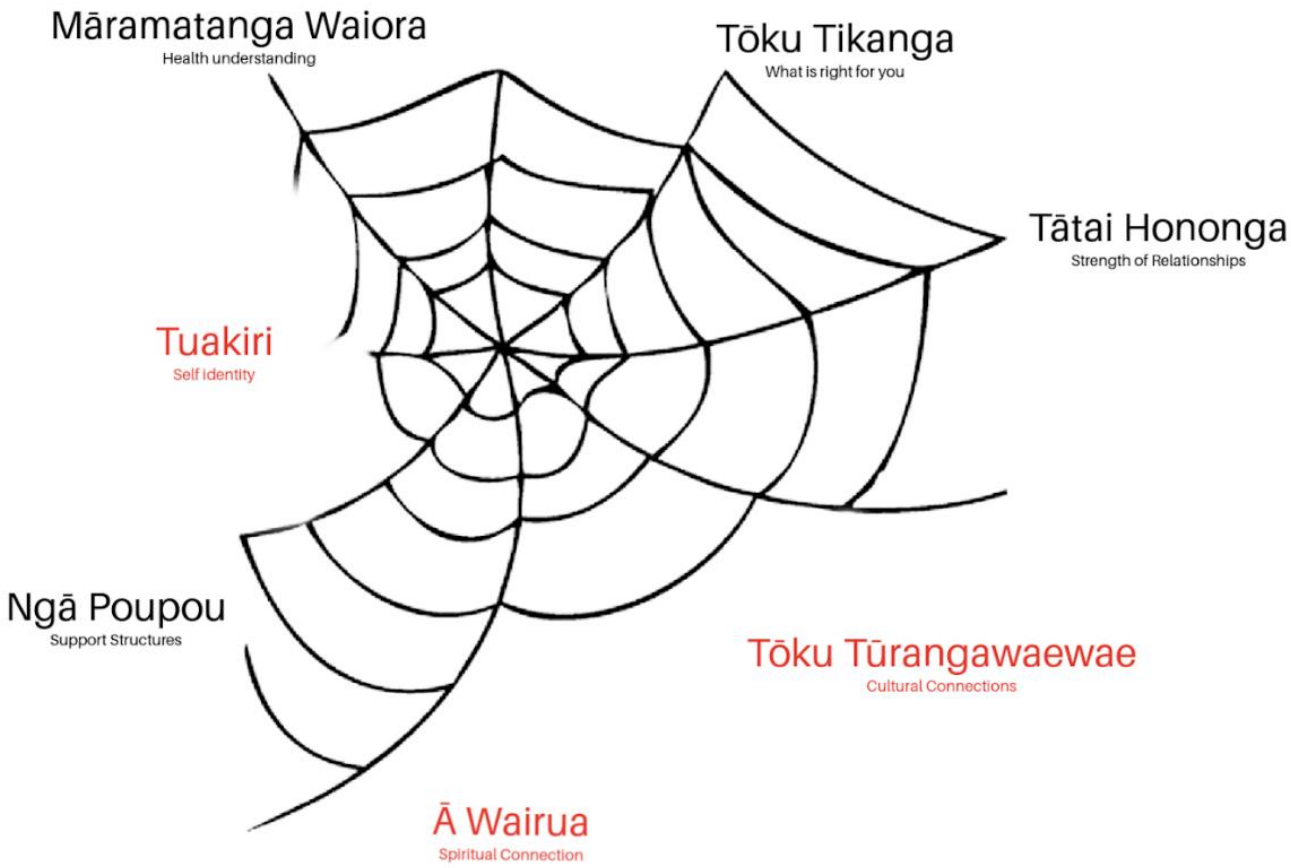
Final Māwhaiwhai Framework



Not all māwhaiwhai are equal. It is possible for gaps and holes in a client's māwhaiwhai, where knowledge, opportunity or support is lacking that would otherwise enable the client to build strength in these deprived areas. When clients need help, it does not necessarily mean their entire māwhaiwhai is broken. Often it means some areas need strengthening. Figure 10 demonstrates the imagery of the broken māwhaiwhai representing areas of mental health where a client might be suffering (Figure 10).

Figure 10

Final Māwhaiwhai Framework Broken Web



Māwhaiwhai Kaupapa Assessment Tool Creation

The Māwhaiwhai Kaupapa framework was developed based on five initial tikanga values and changed in response to ongoing collaboration to seven strengths. The purpose of the assessment tool is for service providers to have a framework to follow as a means to gain relevant tikanga-informed client information. The framework allows the provider to ask questions and to ensure they are covering all areas within the framework of the māwhaiwhai to gain a greater understanding of their Māori clients (see Figure 11).

Figure 11

Māwhaiwhai Kaupapa Assessment Tool

Māwhaiwhai Kaupapa		
Māramatanga Waiora / Health Understanding	• View on mental health • Trust in the health system • Holistic / biomedical perspectives • Knowledge of available services • Knowledge of self-care needs	
Tuakiri / Self Identity	• How they identify / daughter, mother, son • Resilience / Self determination • Strengths and weaknesses • Self-awareness / ability to articulate feelings	
Ngā Poupou / Support Structures	• Services available to them • Whanau and community connections • Employment • Opportunities	
Ā Wairua / Spiritual Connection	• Awareness of the physical / spiritual connection • Understanding of spiritual experience • Identify spiritual gifts	
Tōku Tūrangawaewae / Cultural Connections	• Connection to culture • Urbanized or Mana whenua • Impact of Colonisation • Impact of intergenerational Trauma	
Tātai Hononga / Strength of Relationships	• Relationship stability • Whānau connections • Friends and community connections	
Tōku Tikanga / What is right for you	• Personal tika • Whānau Tika • Identify personal values • **Identify greatest need**	
Date:	**Initial Consult** **Follow Up** *(Circle One)*	

Conclusion Section Two

In conclusion, this section has identified and described the development of a tikanga-informed framework for improving Māori mental health and well-being- māwhaiwhai kaupapa- for Māori in Bream Bay. This framework enables clients to see areas of strength in their lives, while also identifying areas of weakness. Notably, it also enables providers to understand clients better. The seven strengths and the māwhaiwhai kaupapa were a collaboration of knowledge from Kaupapa Māori theory, qualitative science research, and mātauranga Māori joined together to form a *taonga* (gift) that the BBCST can use. It is a strengths-based framework that builds on tikanga Māori values, aligns with localised tikanga, and aims to improve cultural safety for service providers and their clients.

Chapter 5: Discussion

This chapter discusses the research findings in relation to Kaupapa Māori theory and Māori models of well-being, pertaining to psychology. It also identifies the strengths, limitations, future recommendations, and opportunities of this study. Lastly, the clinical psychology implications of this research are considered, and a reflection of my role as the researcher is outlined.

The primary focus of this study was to develop a tikanga-informed, culturally safe framework for mental health from a localised perspective. There were two research aims. The first aim was to identify tikanga-informed values for improving mental health and well-being for Māori specific to Bream Bay. The second aim was to develop a localised tikanga-informed framework for improving Māori mental health and well-being, that can be used by the BBCST to provide culturally safe support for their clients. The research design is a Kaupapa Māori study that utilised a qualitative approach via semi-structured interviews and hui. Their unique perspectives were analysed through reflexive TA.

The framework was further developed in ongoing partnership and collaboration with the participants and cultural advisory group and was designed around the concept of the māwhaiwhai. The māwhaiwhai represents the tikanga-informed themes that were identified throughout the research process that signify the strengths required to maintain well-being from a te ao Māori perspective. Visually the framework displays a whole web and a web with missing strands, indicating areas that may be weak and could potentially cause mental health challenges.

This Study as it Relates to Western Health Perspectives

Western mental health frameworks struggle to obtain cultural relevance when there is a misalignment with a client's worldview (Al-Busaidi, 2018). The study's findings agree with Al-Busaidi and associates' previous literature along with Reid and associates (2014) that Western mental health and well-being models can be limited to their participant populations. Furthermore, participants unanimously agree that Māori have a holistic health perspective through a te ao Māori lens and can struggle to relate to Western health frameworks due to their biomedical nature. As Smith (2015) identified, models of health must align with the individual client’s view on health for improved outcomes. However, Māori are often not

being offered healthcare from frameworks that align with their value systems. Levy and Waitoki (2015) suggest that Western frameworks are highly valued and used by most mental health service providers in Aotearoa, New Zealand. All participants substantiate this finding but also support the existing literature by Durie (1994) and Russell (2018) that the te ao Māori health perspective is more comprehensive in nature through being inclusive of an individual's tinana, wairua, whānau, hinengaro, community and environmental elements. Therefore, a gap exists between Western mental health framework being provided and the Māori mental health perspective that needs addressing at local, community and national levels. This research addressed this gap by working with local communities through a bottom-up approach.

Levy and Waitoki (2015) suggest that Western frameworks are highly valued and are used by most mental health service providers in Aotearoa, New Zealand. However, Western mental health and well-being frameworks can be inadequate for Indigenous groups such as Māori because their perspectives on health may vary (Berryhill et al., 2019). This study's findings identified the value of māramatanga waiora, which aligns with the findings of Diepeveen and associates, who concluded that to be successful, healthcare services need to be acceptable to the client (Diepeveen et al., 2013). Māramatanga waiora is a tikanga-informed strength identified within this research study that encompasses the need for the provider to identify the client's understanding of health and their trust in the health system. Barnett and associates (2019) found that unacceptable health services can lead to inequitable health outcomes for Indigenous people (Barnett et al., 2019). By identifying māramatanga waiora a provider can mitigate the potential risk of providing care that does not align with the client's mental health perspectives.

The tension within psychology is illustrated clearly by the diagnostic tools for mental distress being based on the DSM-5, which are largely determined by Western psychiatrists and psychologists who are influenced by their own socioeconomic and cultural views (Kiyimba & Anderson, 2022). An example of this is, the participants in this study value connection to their wairua, for example being guided by their tūpuna. This finding aligns with Mooney and associates who identified that in the Māori culture connecting to one's tūpuna through dreams and visions is considered normal (Mooney et al., 2020). However, this could be considered a symptom of psychosis if Western diagnostic tools were used to evaluate the client's mental health.

This Study as it Relates to Māori Models of Health

Multiple Māori-focused mental health and well-being frameworks have been created to address the inequitable mental health outcomes for Māori in Aotearoa, New Zealand, such as Te Whare Tapa Wha and the Meihana model (Durie, 2001; Pitama et al., 2014). The frameworks have created space for Māori views on mental health to be more understandable to service providers and for psychology to begin to decolonise and provide care in culturally appropriate ways (Smith, 2015). However, despite greater understanding of Māori health perspectives, health inequalities continue.

Like Te Whare Tapa Whā and the Meihana model, the findings of this study are similar in their perspective that health and well-being must take into consideration not just the biomedical framework of the physical and mental, but that the whole person is connected through their wairua, tinana, hinengaro and taha (Durie, 1994; Pitama et al., 2007). These findings also agree with Mooney et al. (2020), that a person is connected to the elements that surround them, both socially and physically. Finally, the seven strengths within the web also support the previous literature that holistic care is an essential part of a Māori health framework (Russell, 2018).

The findings of this research study differ from the simplicity of Te Whare Tapa Whā in the categorisation of all Māori sharing the same values, beliefs and experiences. This study identified that although groups such as iwi or hapū may have shared values and beliefs, most Māori hold their own individual perspectives. Therefore, the framework design included the need for service providers to identify their clients' tuakiri. By understanding a client's tuakiri better, they can provide more flexible and individual care.

This study's findings concur with the Meihana model because they both identify the need for tikanga, individual needs, and the importance of whānau and community relationships (Pitama et al., 2017). In the Meihana model, they are referred to as the ngā roma moana and in the māwhaiwhai framework, they are referred to throughout the seven strengths but are predominantly found within Ā wairua and tātai hononga. Tōku tūrangawaewae also displays similarities with the Meihana model through the importance of obtaining information on the client's connections to their culture and the negative impacts of colonisation and intergenerational or historical trauma (Cram, 2014).

The findings also align with the leading Māori models that relationship through whakawhanaungatanga is paramount and impactful for one's well-being (Durie, 1994; Pitama et al., 2007). The Meihana model identifies the waka hourua as the value of relationships with the whānau, community, client and service provider. This study supports the argument that relationships and connection are paramount to an individual's mental health and well-being, as well as tikanga. By building a solid relationship, all parties can work together to build a partnership of health, which in turn will create a sense of support and belonging that will increase the client's well-being. Purdy's (2020) study previously noted that Te Whare Tapa Whā requires a substantial commitment to the relationship by whānau, client and service providers to improve a person's mental health and well-being. However, reflecting on the findings considering the Meihana model and Te Whare Tapa Whā, this research implies the importance of whakawhanaungatanga and strong relationships to be tikanga to all Māori health models.

The findings align further with the Meihana model through ngā hau e whā (Pitama et al., 2017). The participants of this study repeatedly discussed the effects of colonisation, marginalisation, migration and racism as historical impacts on the mental health of Māori in Bream Bay. Ngā hau e whā in the Meihana model identifies the four winds of historical trauma: colonisation, migration, marginalisation, and racism (Pitama et al., 2007). The findings align with the Meihana model in the need for service providers to be culturally competent enough to have not only an understanding of the impact of historical trauma for each client but also intergenerational trauma and the impact of individual life experiences (Pitama et al., 2004). The participants acknowledged that service providers' cultural competency needs to increase through whakarongo. This study highlights the importance of intuitive listening and seeing a person as an individual rather than placing them in a cultural box. Each client has different experiences and lineage, and participants believe that by providing whakarongo service, providers can identify a person's greatest need and provide authentic individual care.

The study identified the importance of mana rangatiratanga, which agrees with the Meihana model that space needs to be provided where the client's autonomy is shifted back into their hands, giving them power over their health journey (Pitama et al., 2017). Matenga and Westenra's (2022) research findings also align with this perspective as they discovered that by educating paramedics in mātauranga Māori and tikanga Māori, they were able to

improve cultural safety. This new knowledge increased the first responders' ability to establish whakawhanaungatanga with their clients, which equalising the power dynamic (Matenga & Westenra, 2022). Suzanne Purdy's findings in her study that used Te Whare Tapa Whā as a health model were consistent with the findings of Matenga and Westenra (2022). Purdy found that using Te Whare Tapa Whā strengthened the relationship between the client, whānau and the service provider, which improved the balance of power over the client's health journey (Purdy, 2020). Participants of this study proposed the need for client-led services enabling them to build upon their strength rather than from a place of weakness, which is the basis of the māwhaiwhai framework. Data analysis established that the strengths-based frameworks become tikanga because they align with mātauranga Māori by being future-focused. As one participant in this research said, "It is the Māori way."

This Study as it Relates to Kaupapa Māori

This research study is grounded in mātauranga Māori through the scientific theoretical lens of Kaupapa Māori theory. The findings align with KMT as they provide new knowledge to inform mental health and well-being from a Māori worldview (Stewart, 2020). The study adheres to Te Ara Tika and validates Māori knowledge and culture by centralising and normalising te ao Māori perspectives (Hudson et al., 2010). The study itself further aligns with KMT through conducting tikanga practices of the mana whenua throughout the research process, even from the initial rōpū where Patuharakeke kaumātua conducted the correct proceedings to being welcomed onto the Patuharakeke marae at Takahiwai. Tikanga and kawa were consistently upheld to align with the importance of culturally safe practices within KMT (Pihama, 2015). Tikanga was also found within the study's findings, when participants identified the importance of an individual tikanga. This differs from traditional perspectives of tikanga when tribal and community affiliations were deemed the most important (Mahuika, 2015). While there are speculative reasons for these differences, such as individual needs being more specific to mental health and wellness, or a sign of acculturation from colonisation. In order to come to a more definitive conclusion on this matter, a further investigation would be required.

Fundamental foundational principles of Kaupapa Māori theory were identified within the findings. Firstly, the semi-structured interviews were conducted in a tikanga way through kanohi kitea kanohi, which also adheres to taonga tuku iho by normalising mātauranga Māori proceedings (Pihama et al., 2002). By conducting the interviews in person, the study confirms

Haitana and associates' (2020) explanation of taonga tuku iho in research because it provides space for Māori to reclaim their truth in a way that they feel comfortable sharing their lived experiences. Within these designated spaces, te reo Māori was welcomed and encouraged throughout the process, as it is imperative to uphold and honour Māori knowledge (Pihama et al., 2002). I was concerned that my lack of te reo Māori could impede the analysis process of synthesising the mātauranga Māori into a colonial language. The concern lay in the multiple layers of meaning within each te reo Māori word, which could be lost in translation from my limited knowledge. Pihama and associates (2015) point out the risk of losing the Māori culture through the loss of te reo Māori. After consideration and discussion with the academic advisors and the cultural advisory group, I decided to share my limited knowledge of te reo Māori at the beginning of each interview. I asked each participant if they felt comfortable describing any te reo Māori words I may not understand. This decision built whakawhanaungatanga by being honest and aiming to build relationships through trust. It also adhered to the principle of Manaakitanga, which is imperative to KMT, by discussing any topics of importance that may produce cultural concern. By addressing the language limitation to my understanding, I protected the participants' perspectives and through this acknowledgement, the Māori culture (Kukutai & Taylor, 2016).

Rangatiratanga was another foundational principle of Kaupapa Māori theory adhered to throughout the research. The term was central to the findings of tōku tikanga and the interview process. Like rangatiratanga, tōku tikanga places control and authority of knowledge back to the knowledge giver (Smith, 2015). Overall, the cultural advisory group for this study demonstrated the importance of Māori ownership stemming from Māori knowledge. This awareness supports Moewaka-Barnes's (2015) perspective that Māori must maintain ownership over how they are known throughout the research process. The semi-structured interviews allowed the participants to maintain ownership of their knowledge while also being present in a comfortable way. The hui allowed the participants to hear the findings based on their perspectives presented back to them. The presentation was imperative to adhering to KMT because it maintained a cycle of placing the control of Māori knowledge back into the hands of the knower. The hui allowed the participants to change the analysis and ensure their knowledge was accurately represented.

Strengths and Contributions

One key strength of this study is the opportunity to conduct this kaupapa. Throughout the literature review, it became apparent that there is limited Kaupapa Māori research in health and psychology. Although it is essential to acknowledge the presence of remarkable Indigenous models, it is imperative to highlight that there is significant room for more Kaupapa Māori research to benefit Māori health outcomes. The strong response to a study of this kind in Bream Bay and the ease of recruitment verified this, along with the immense support of the BBCST. Moreover, the research identified a void in the literature of Kaupapa Māori research studies specific to geographical areas and to iwi mana whenua tikanga. Consequently, this research has beneficial implications for Māori health outcomes in the targeted area by providing new understandings of the specific mental health and well-being needs of Māori from or living in Bream Bay. Furthermore, considering the development of the Māwhaiwhai Kaupapa assessment tool, the study provides a practical contribution to the academic field and the Bream Bay community.

A foundational strength of this research is that Kaupapa Māori theory is the underpinning methodology (Hansen, 2012). Kaupapa Māori theory ensured a culturally safe foundation that allowed mātauranga Māori and tikanga Māori to be heard through a te ao Māori perspective, providing a space for Māori voices and perspectives to be heard and acknowledged (Haitana et al., 2020). The implication of anchoring this study in Kaupapa Māori theory is that it allowed Māori perspectives to contribute to the existing body of literature about Māori. This provides a unique opportunity for Māori to have ownership over Māori knowledge and the context in which it is known. The theory also ensures the research is conducted with integrity and respect for the participants and the exclusive knowledge they were willing to share. By conducting Kaupapa Māori research, this study strengthens and upholds mātauranga Māori and provides health and well-being solutions through a te ao Māori lens, by Māori, for Māori.

The study was able to be built upon the strength of the relationship that has been built between the BBCST and the mana whenua of Patuharakeke through efforts led by Dr Eggleton. The team at the Trust and the local hapū have an enduring and resilient relationship built over decades. The implication of this relationship ensured the kaupapa was conducted through hapū specific tikanga which simplified the development and formation of the Māori cultural advisory group. This group was essential to the research study as it provided a base

of expert knowledge in mātauranga Māori and created a foundation of whanaungatanga. In my interactions and interviews with participants, this strong relationship provided confidence in the study and allowed the kōrero to flow easily. Without the relationship, it may have taken much longer for the participants to trust the aims of the research or the research team. This would have been detrimental to the quality of the knowledge that was so generously provided, and much depth to the kōrero may have been lost without it. The cultural advisory group also served as a sounding board and guide as I interpreted the interviews and hui through a critical lens. By the end of the study, I had ascertained that the whanaungatanga was extended to me as the researcher because they could see my sincere desire in wanting better mental health outcomes for Māori in our community.

The TA method provided several strengths for the study. TA provided theoretical flexibility, which sat well within the context of Kaupapa Māori research. The method also allowed for reflexivity and transparency. TA is favourable for new researchers and provides an iterative process that allows the researchers to conduct rounds of analysis and codes (Braun & Clarke, 2019). Therefore, it is a method that permits space to analyse and re-analyse data, developing the researcher's skills and enabling the researcher to delve deep into the data in a reflective and transparent manner (Braun & Clarke, 2006). This method was particularly useful in this Kaupapa Māori study, allowing the researcher to take analysis and codes to the cultural advisory team, which helped address potential biases or misunderstandings. An example of this is a participant's comment on the importance of a partnership between the client and the service provider. During analysis, the comment was coded as Partnership of Healing. When presenting the initial analysis to the cultural advisory group, it was identified that Partnership of Healing is not from a te ao Māori perspective because it is not strengths-based. The term implies that the client is ill. It was recommended by the cultural group that the code be changed to a more appropriate hence the term Partnership of Health was decided upon. The TA model allowed the changes to be made in a timely manner. The academic and onsite supervisors were able to analyse and discuss the findings through ongoing reflexive engagement and kōrero.

Limitations

There were limitations to this study, the first being participant recruitment. The first group of people invited to participate as cultural advisors to the initial rōpū were gathered through an invitation from the BBCST. This meant that some potential community

participants were unaware of the participant opportunity because they did not have a relationship with or connection to the Trust. Although convenience sampling may not affect this specific study much because the community is very small, it is essential to consider the recruitment procedure when assessing the broader relevance of the findings. Therefore, the second limitation of this study is the sample size. Because the community is very small and there are few known or available participants who fulfil the criteria, sample saturation was found quickly with twelve people.

Data collection itself may be a limitation of the study due to the data being collected via semi-structured interviews. There can be limitations to the reliability of such interviews due to interpretation bias. My limited knowledge and individual perspectives may have influenced the data results. Furthermore, my limited understanding of te reo Māori may have further limited the undertaking. The participants were invited to share their perspectives in the language they were most comfortable using. While the interviewer's ability and te reo Māori knowledge were noted at the beginning of each interview, some participants may have felt the need to share their whakaaro in English to benefit the interviewer. However, most participants spoke in both English and te reo Māori. Every effort was made to ensure the highest reliability and validity of the interviews by obtaining professional transcriptions for the data. Outsourcing the transcription allowed for the professional perspective of an additional observer to dictate the interviews thoroughly. Further validity was warranted by obtaining research assistance from the medical student who participated in the TA as the supplementary evaluator of the transcripts and codes.

Another consideration of this study is that the data is population-dependent and area-specific. This, however, is not a negative limitation, as the study was developed specifically for the Bream Bay community. The data may not be generalisable for different iwi, hapū or other urbanised Māori living in other geographical areas because not all hapū have the same protocols. Moreover, not all Māori have had the same lived experience or generational trauma. Colonisation and the urbanisation of Māori have had different impacts in different areas; therefore, values may not be universal for all Māori groups. The coding and analysis of the data focused on ensuring that the correct tikanga for the mana whenua was upheld. Although there is much likeness between different iwi and hapū tikanga, the Bream Bay community's tikanga may not translate to other communities.

A final limitation in this study was the potential time constraints during the interviews and hui. Within KMT ideally there would be no time constraints, as many meetings and discussions would be used. The interviews were initially meant to be conducted within 45 minutes; however, some were over an hour. It was essential to let the participant continue to share their perspectives and opinions for as long as they felt comfortable but there was limited space and time in the hui for all attendees to give input due to the number of people in the group. On reflection, one recommendation would be to offer a second individual interview after the hui, so the participants have space to share their opinions with more time. A second interview may also prove beneficial as the participant may be more comfortable with the researcher through building trust in the relationship.

Reflexivity

This kaupapa was conducted using a Kaupapa Māori research approach, enabling vast exploration and flexible data analysis. The findings produced relied on the researcher's personal perspective and comprehension of the data. To get the most from the flexibility within Kaupapa Māori research, periodic discussions with my supervisors and the cultural advisory group were conducted throughout the research process. For additional scrutiny of any limitations, my subjective positioning was given to offer a comprehensive context of how the findings emerged.

Throughout this research study, I was aware of the impact my background may have on the outcome of the findings. Although I have become well-versed in academic Māori psychological perspectives, I am still learning about my sense of belonging as a Māori researcher. When I was invited to partake in the research, I was partly honoured and excited to have the opportunity to use my skill set to identify areas of need in health and well-being for Māori in my local community. On the other hand, I was nervous, and to be brutally honest, I felt a sense of whakamā about being the one to conduct the study as a Māori researcher. My lack of te reo Māori and understanding of the monstrous impact of colonisation was apparent as I began my journey. However, from the beginning, I was encouraged to be honest about who I was, my personal experiences, subjectivity, and potential biases. Because of that, I was welcomed with immense encouragement and understanding from the academic Māori community. The guidance of the cultural advisory group was not only crucial to the validity and reliability of the study, but also to my ability to grow and learn throughout the process. By positioning myself as the researcher and

honouring the participants as the knowledge holders, I could participate in the study with authenticity and accountability to who I am and to all those involved in the study. My cultural knowledge grew in more ways than I could have imagined. The study impacted me on such a personal level that I began tracing the journey of my tūpuna and whenua: I travelled with my husband to visit whānau whenua and awa and connected with the kaitiaki and other whānau. As a Māori researcher my confidence and passion grew. I was humbled by the cultural advisors' support and encouragement throughout the journey and the participants' willingness to see this study succeed for the benefit of Māori in Bream Bay.

Recommendations for Future Research

Because there is such a small pool of research available for mental health and well-being, this study affords a significant opening for future research opportunities. Once the BBCST has implemented the framework into their mental health programme, further research could be conducted to explore their clients' potential health and well-being benefits. Alternatively, conducting the same study in a different community may also prove insightful into the individual health and well-being perspectives of different iwi and hapū throughout Aotearoa, New Zealand. Further exploratory research could include testing the framework in different geographical regions to evaluate its efficacy and generalisability for different Māori groups, as this sample size was limited. Another avenue for further research could be that other communities could use the research design as a basis for developing their own frameworks. There is a significant opportunity for the final framework design to be tested in different mental health, health and medical settings.

Practical Implications

The findings obtained from the study have provided an excellent opportunity for a beneficial practical health and well-being framework to be developed. This framework may be used by service providers such as psychologists, mental health workers, counsellors and other medical professionals to help identify an individual's tikanga values and their mental health and well-being perspectives. The tool offers a practical strengths-based framework that allows service providers to identify the areas of strength a client has in their life and highlights those areas that may be detrimental to their mental health and well-being. The practical implication of this framework is that it is the first of its kind specific for Māori living in the Bream Bay area. The BBCST will implement this tool in its mental health and

well-being programme. The benefit of its use will not only potentially improve the health outcomes for Māori, but it also presents an occasion for further research and testing of the framework, which may prove its value in other population groups.

Psychological Implications

This study highlights the need for more Kaupapa Māori research studies to improve Māori mental health outcomes. For too long, Māori have experienced heightened psychological and social distress (González et al., 2022). The participants' perspectives align with other research findings that Māori and Western health perspectives differ. Western psychological approaches do not consider as many influential factors on an individual's health as Māori perspectives do. Notably, the study shows that Māori consider multiple elements when reflecting on their well-being. They normalise spiritual connections and understand the impact of those around them, their support structures, and their connection to their culture. The findings confirm previous literature outlining holistic health perspectives that need a foundational connection to their wairua (Durie, 1994; Russell, 2018; Mooney et al., 2020).

This study validates the differences in mental health and well-being perspectives for Māori in the Bream Bay area. The findings align with the Code of Ethics for Psychologists working in Aotearoa, New Zealand, Principle 1 Respect for the Dignity of Persons and People '1.3.2. Both non-Māori and Māori psychologists who work with Māori seek advice and undertake training in the appropriate way to show respect for the dignity and needs of Māori in their practice' (C.O.E, 2002). The findings of this study add to the academic research that identifies the need for improved cultural training and knowledge, along with seeking advice from Māori on how Māori mental health is conceptualised.

Section Two Conclusion

In conclusion, Section One of the findings identified five values that participants believe to be essential in developing a tikanga-informed framework for improving mental health and well-being for Māori specific to Bream Bay. Section Two of the study used the values from Section One to underpin and develop a framework for the use of BBCST to provide culturally safe support for their clients' mental health and well-being. This study adds to limited available te ao Māori-specific resources by providing a usable strengths-based mental health and well-being framework, Māwhaiwhai Kaupapa. While this framework

shares some similarities with Te Whare Tapa Whā and the Meihana models, it adheres to tikanga specific to local mana whenua. This study's findings do not replace the current Māori health models; instead, they add a bottom-up approach to the development of culturally safe and Māori-centred practices that can improve mental health and well-being outcomes for Māori in Bream Bay.

References

Aho, K. L. T. (2014). The healing is in the pain: Revisiting and re-narrating trauma histories as a starting point for healing. *Psychology and Developing Societies*, *26*(2), 181-212.

Al-Busaidi, I. S., Huria, T., Pitama, S., & Lacey, C. (2018). Māori Indigenous Health Framework in action: addressing ethnic disparities in healthcare. *The New Zealand Medical Journal*, *131*(1470), 89–93.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Arundell, L. L., Barnett, P., Buckman, J. E., Saunders, R., & Pilling, S. (2021). The effectiveness of adapted psychological interventions for people from ethnic minority groups: A systematic review and conceptual typology. *Clinical Psychology Review*, *88*, 102063.

Ashiagbor, D. (2021). Race and colonialism in the construction of labour markets and precarity. *Industrial Law Journal*, *50*(4), 506-531.

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (2019). Ethnic variations in compulsory detention under the Mental Health Act: a systematic review and meta-analysis of international data. *The Lancet Psychiatry*, *6*(4), 305-317.

Barton, P., & Wilson, D. (2008). Te Kapunga Putohe (the restless hands): A Maori centred nursing practice model. *Nursing Praxis in New Zealand*, *24*(2).

Berryhill, M. B., Halli-Tierney, A., Culmer, N., Williams, N., Betancourt, A., King, M., & Ruggles., H. (2019). Videoconferencing psychological therapy and anxiety: A systematic review. *Family Practice*, *36*(1), 53-63.

Best, E. (1952). *The Maori as he was* (Vol. 96). Wellington.

Bishop, R. (1999). Kaupapa Maori research: An indigenous approach to creating knowledge. In Robertson, N. (Ed). Maori and psychology: Research and practice. Proceedings of a symposium sponsored by the Maori & Psychology Research Unit, Department of Psychology, University of Waikato, Hamilton, Thursday 26th August 1999 (pp.1-6). Hamilton, New Zealand: Māori and Psychology Research Unit, University of Waikato.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597.

Browning, C. R. (2022). *The woven Treaty—kaitiakitanga as a theory of the guardian relationships and principles of Te Tiriti o Waitangi/the Treaty of Waitangi* [Unpublished doctoral dissertation]. University of Otago.

Buchwald-Mackintosh, K., Gowda, S., Te Tai Mahere, Ngā Tai Ora (2019). *Northland Population Health and Wellbeing Indicators Framework* (Report). Northland District Health Board.

Bush, A., Campbell, W., & Ransfield, M. (2019). Te Ara Waiora a Tāne: a kaupapa Māori mental-health assessment and intervention planning approach. *Australasian Psychiatry*, *27*(4), 337-340.

Came, H., & Tudor, K. (2016). Bicultural praxis: the relevance of Te Tiriti o Waitangi to health promotion internationally. *International Journal of Health Promotion and Education*, *54*(4), 184-192.

Campbell, K. A., Orr, E., Durepos, P., Nguyen, L., Li, L., Whitmore, C., Gehrke, P., Graham, L., & Jack, S. M. (2021). Reflexive thematic analysis for applied qualitative health research. *The Qualitative Report, 26*(6), 2011-2028.

Cashmore, E. (2002). *Dictionary of race and ethnic relations*. Routledge.

Champagne, F. A. (2008). Epigenetic mechanisms and the transgenerational effects of maternal care. *Frontiers in Neuroendocrinology*, *29*(3), 386-397.

Choate, P. W. (2019). The call to decolonise: Social work's challenge for working with indigenous peoples. *The British Journal of Social Work, 49*(4), 1081-1099.

Cormier, P. N. (2017). British colonialism and indigenous peoples: The law of resistance–response–change. *Peace Research*, 39-60.

Craik, B., Derrett, S., Wyeth, E. H., Green, M., & Cox, A. (2023). Staff perceptions of the quality of care delivered in a New Zealand mental health and addiction service: Findings from a qualitative study. *International Journal of Mental Health Nursing*. 32(4):1072-1081. doi: 10.1111/inm.13141.

Cram, F. (2014). Measuring Mäori wellbeing. *MAI Journal*, *3*(1), 18-32.

Cram, F., & Adcock, A. (2022). Kaupapa Māori research. In P. Liamputtong (ed). *Handbook of Qualitative Cross-Cultural Research Methods* (pp. 56-84). Edward Elgar Publishing.

Crengle, S., Davie, G., Whitehead, J., de Graaf, B., Lawrenson, R., & Nixon, G. (2022). Mortality outcomes and inequities experienced by rural Māori in Aotearoa New Zealand. *The Lancet Regional Health–Western Pacific, 28*. doi: https://doi.org/10.1016/j.lanwpc.2022.100570

Curtis, E., Harwood, M., Riddell, T., Robson, B., Harris, R., Mills, C., & Reid, P. (2010). Access and society as determinants of ischaemic heart disease in indigenous populations. *Heart, Lung and Circulation, 19*(5–6), 316–324. http://doi .org/d4xv57

Diepeveen, S., Ling, T., Suhrcke, M., Roland, M., & Marteau, T. M. (2013). Public acceptability of government intervention to change health-related behaviours: a systematic review and narrative synthesis. *BMC Public Health*, *13*(1), 1-11.

Dow, D. (1999). *Maori health & government policy 1840-1940*. Wellington: Victoria University Press.

Drake, H., & Wilson, D. (2021). Māori patients. In B. Williams, & L. Ross (Eds.), *Paramedic principles and practice: A clinical reasoning approach 2E* (pp. 860–874). Elsevier.

Duncan, S., & Rewi, P. (2018). Tikanga: How Not to Get Told Off! In M. Reilly., S. Duncan., G. Leoni., L. Patterson., L. Carter., & P. Rewi (Eds.), *Te Kōparapara: An introduction to the Māori world* (pp. 30-47). Auckland University Press.

Durie, M. (1994). Tirohanga Māori / Māori Health Perspectives. *Whaiora: Maori Health Development* (pp. 67-81). Oxford, Oxford University Press New Zealand.

Durie, M. (1999, October). Te Pae Māhutonga: A model for Māori health promotion. In *Health Promotion Forum of New Zealand Newsletter*, 49(2), 5.

Durie, M (2001). *Mauri Ora: The Dynamics of Māori Health*. Huia Publishers.

Durie, M. (2004). An indigenous model of health promotion. *Health Promotion Journal of Australia*, *15*(3), 181-185.

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

Eaton, T., Hutton, R., Leete, J., Lieb, J., Robeson, A., & Vonk, J. (2018). Bottoms-up! Rejecting top-down human-centered approaches in comparative psychology. *International Journal of Comparative Psychology, 31*. doi 10.46867/ijcp.2018.31.01.11

Eggleton, K. (2020). *Measuring the quality of Māori health providers. A critique of Tauiwi paradigms* [Doctoral dissertation, University of Auckland]. ResearchSpace@ Auckland.

Ertan, A. S., Putterman, L., & Fiszbein, M. (2012). Determinants and economic consequences of colonization: a global analysis. *Available at SSRN 2129786*.

Ertan, A., Fiszbein, M., & Putterman, L. (2016). Who was colonized and when? A cross-country analysis of determinants. *European Economic Review*, *83*, 165-184.

Falicov, C. J. (2013). *Latino families in therapy*. Guilford Publications.

Fishbane, M. D. (2019). Healing intergenerational wounds: An integrative relational–neurobiological approach. *Family Process, 58*(4), 796-818.

Forsberg, B. C., & Sundewall, J. (2023). Decolonizing global health—what does it mean for us? *European Journal of Public Health, 33*(3), 356-356.

González, R., Carvacho, H., & Jiménez-Moya, G. (2022). Psychology and Indigenous people. *Annual Review of Psychology*, *73*, 431-459.

Goodman, A. (2016). God's own silence: An analysis of New Zealand historians' treatment of the evangelical background to the treaty of Waitangi. *Stimulus: The New Zealand Journal of Christian Thought and Practice*, *23*(1), 4-11.

Gracey, M., & King, M. (2009). Indigenous health part 1: Determinants and disease patterns. *Lancet, 374*(9683), 65–75. doi: https://org/10.1016/S0140-6736(09)60914-4.

Green, S. (2022). Colonisation, post-colonialism and decolonisation. In D. Hölscher, R, Hugman, D. McAuliffe (eds). *Social Work Theory and Ethics: Ideas in Practice* (pp. 1-20). Springer Nature Singapore.

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*, 1609406920953752.

Haitana, T., Pitama, S., Cormack, D., Rangimarie Clark, M. T., & Lacey, C. (2023). 'It absolutely needs to move out of that structure': Māori with bipolar disorder identify structural barriers and propose solutions to reform the New Zealand mental health system. *Ethnicity & Health, 28*(2), 234-256.

Hansen, J. (2012). *Linda Tuhiwai Smith and decolonizing methodologies: The significance of 'research' to Indigenous intellectuals and their communities in "Potiki" and "Pears from the Willow Tree"*. Oklahoma State University.

Hay, I. (1989). *The caring commodity.* Oxford University Press.

Health Quality & Safety Commission (HQSC). (2019). *A window on the quality of Aotearoa, New Zealand health care 2019*. HQSC. https:// www.hqsc.govt.nz/our-programmes/health-quality-evaluation/ publications-and-resources/publication/3721/.

Hikuroa, D. (2017). Mātauranga Māori—the ūkaipō of knowledge in New Zealand. *Journal of the Royal Society of New Zealand*, *47*(1), 5-10.

Hohepa, M. (2015). Kia Mau Ki te Aka Matua: Researching Māori development and learning. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A*

reader. A collection of readings from the Kaupapa Rangahau workshops series (2nd ed., pp. 115-124). Te Kotahi Research Institute.

Houkamau, C., Milojev, P., Greaves, L., Dell, K., Sibley, C. G., & Phinney, J. (2021). Indigenous ethnic identity, in-group warmth, and psychological wellbeing: A longitudinal study of Māori. *Current Psychology*, 1-17.

Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te ara tika guidelines for Maori research ethics: a framework for researchers and ethics committee members*. Wellington: Health Research Council.

Isobel, S., Goodyear, M., Furness, T., & Foster, K. (2019). Preventing intergenerational trauma transmission: A critical interpretive synthesis. *Journal of Clinical Nursing*, *28*(7-8), 1100-1113.

Kaphle, S., Hungerford, C., Blanchard, D., Doyle, K., Ryan, C., & Cleary, M. (2022). Cultural Safety or Cultural Competence: How Can We Address Inequities in Culturally Diverse Groups?. *Issues in Mental Health Nursing*, *43*(7), 698-702.

Kepa., M. (2019). Mingling the hau [breath of life] in Aotearoa, New Zealand. *Sámi language and Culture Association, 3*(2), 50-64.

Kepa., M. (2021). Community pest control areas 2018-29: Takahiwai hills and forest, Takahiwai, Te Tai Tokerau. *Scope Contemporary Research Topics, 6*, 2018-2029.

Khan, M., Abimbola, S., Aloudat, T., Capobianco, E., Hawkes, S., & Rahman-Shepherd, A. Decolonising global health in 2021: a roadmap to move from rhetoric to reform. *BMJ Global Health, 6* (3), e005604.

Kingi, T. K. (2005). *Māori mental health: Past trends, current issues, and Māori responsiveness.* Wellington: Massey University.

Kingi, T., Russell, L., & Ashby, W. (2017). Mā te mātau, ka ora: The use of traditional Indigenous knowledge to support contemporary rangatahi Māori who self-injure. *New Zealand Journal of Psychology (Online)*, *46*(3), 137-145.

Kiyimba, N., & Anderson, R. (2022). Reflecting on cultural meanings of spirituality/wairuatanga in post-traumatic growth using the Māori wellbeing model of Te Whare Tapa Whā. *Mental Health, Religion & Culture*, *25*(3), 345-361.

Kukutai, T., & Taylor, J. (2016). *Indigenous data sovereignty: Toward an agenda*. ANU Press.

Kwete, X., Tang, K., Chen, L., Ren, R., Chen, Q., Wu, Z., Cai, Y., & Li, H. (2022). Decolonizing global health: what should be the target of this movement and where does it lead us?. *Global Health Research and Policy, 7*(1), 3.

Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: a framework to enhance the doctor-patient relationship with Maori. *The New Zealand Medical Journal (Online)*, *124*(1347).

Lands, C. N. (1928). Other Grievances. *Royal Commission to Inquire into Confiscations of Native Lands and Other Grievances Alleged by Natives (Report of). Appendix to the Journal of the House of Representatives*.

Lay-Yee, R., Milne, B. J., Wright-St Clair, V. A., Broad, J., Wilkinson, T., Connolly, M., ... & Kerse, N. (2022). Prevalence of loneliness and its association with general and health-related measures of subjective well-being in a longitudinal bicultural cohort of older adults in advanced age living in New Zealand: LiLACS NZ. *The Journals of Gerontology: Series B*, *77*(10), 1904-1915.

Lewis, L., Walker, S., King, P. T., Mackay, H. T. U., Talamaivao, N., Anderson, D., & Kemp, S. (2023). Koi te matapunenga maianga i te matapuuioio–See the unseen, feel the unfelt, believe in the impossible: Courageous practice in a Māta Waka social service provider. *Journal of Indigenous Social Development*, *12*(1), 3-27.

Lima, L. F. S. (2016). Between the New and the Old World: Iberian Prophecies and Imperial Projects in the Colonisation of the Early Modern Spanish and Portuguese Americas. *Prophecy and Eschatology in the Transatlantic World, 1550− 1800*, 33-64.

Macfarlane, A. H. (2016). Research and practice in psychology: Calibrating cultural understandings. *Professional Practice of Psychology in Aotearoa, New Zealand*, *3*, 365-382.

Macfarlane, A., Macfarlane, S., & Curtis, T. (2019). Navigating kaupapa Māori fields of knowledge. *Oxford Research Encyclopaedia of Education.*

Mahuika, R. (2015). Kaupapa Māori theory is critical and anticolonial. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A reader. A collection of readings from the Kaupapa Rangahau workshops series* (2nd ed., pp. 34-46). Te Kotahi Research Institute.

Mark, G. T., & Lyons, A. C. (2010). Maori healers' views on wellbeing: The importance of mind, body, spirit, family and land. *Social Science & Medicine*, *70*(11), 1756-1764.

Marsden, M. (2003). *The woven universe: Selected writings of Rev. Māori Marsden*. Estate of Rev. Māori Marsden.

Matenga, G., & Westenra, B. (2022). How can paramedics integrate the hui process and Meihana model into their practice to provide better healthcare for Maori?. *Whitireia Journal of Nursing, Health and Social Services*, (29), 59-67.

McDowell, T., Knudson-Martin, C., & Bermudez, J. M. (2022). *Socioculturally attuned family therapy: Guidelines for equitable theory and practice*. Taylor & Francis.

McKee, J. (1988). Holistic health and the critique of Western medicine. *Social Science & Medicine*, *26*(8), 775-784.

McLachlan, A. D., Wirihana, R., & Huriwai, T. (2017). Whai tikanga: The application of a culturally relevant value centred approach. *New Zealand Journal of Psychology (Online)*, *46*(3), 46-54.

McLean, F.S. (1964), *Challenge for Health: A history of public health in New Zealand*, Wellington: Government Printer.

McNabb D (2019) Decolonising social work education in Aotearoa, New Zealand. *Advanced Social Work Welfare Education, 21*(1), 35–50.

McNeil, K. The Doctrine of Discovery Reconsidered: Reflecting on Discovering Indigenous Lands: The Doctrine of Discovery in the English Colonies, by Robert J Miller, Jacinta Ruru, Larissa Behrendt, and Tracey Lindberg, and Reconciling Sovereignties: Aboriginal Nations and Canada, by Felix Hoehn (2016) 53. *Osgoode Hall Law Journal*, *2*, 699.

Mead, H. M. (2012). Understanding Mātauranga Māori. *Conversations on mātauranga Māori*, 9-14.

Mead, H. M. (2016). *Tikanga Maori (revised edition): Living by Maori values*. Huia publishers.

Mental health Foundation (2022). *Mental distress prejudice and discrimination in Aotearoa. Key Statistics*. https://mentalhealth.org.nz/resources/resource/mental-distress-prejudice-and-discrimination-in-aotearoa-or-key-statistics-2022.

Milne, M. (2010). He rongoā kei te kōrero: Talking therapies for Māori. *Wise practice guide for mental health and addiction services. Auckland: Te Pou*. Miller, R. J., & Ruru, J. (2008). An indigenous lens into comparative law: The Doctrine of Discovery in the United States and New Zealand. *WVU College of Law at The Research Repository*, *111*, 849.

Miller, R. J. (2010). *Discovering indigenous lands: The doctrine of discovery in the English colonies*. Oxford University Press.

Ministry of Health. (2024). *About Us*. https://www.teakawhaiora.nz/about-us/organisational-structure.

Ministry of Health. (2022). *Annual Data Explorer 2021/22: New Zealand Health Survey* [Data File]. URL: https://minhealthnz.shinyapps.io/nz-health-survey-2021-22-annual-data-explorer/

Ministry of Health. (2023*). Office of the Director of Mental Health and Addiction Services: Regulatory Report 1 July 2021 to 30 June 2022*. Wellington: Ministry of Health

Moewaka-Barnes, H. (2015). Kaupapa Māori: Explaining the ordinary. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A reader. A collection of readings from the Kaupapa Rangahau workshops series* (2nd ed., pp. 29-32). Te Kotahi Research Institute.

Moewaka Barnes, H., & McCreanor, T. (2019). Colonisation, hauora and whenua in Aotearoa. *Journal of the Royal Society of New Zealand*, *49*(sup1), 19-33.

Mooney, H., Watson, A., Ruwhiu, P., & Hollis-English, A. (2020). Māori social work and Māori mental health in Aotearoa, New Zealand. *Mental Health and Social Work*, 259-279.

Mutu, M. (2019). The Treaty claims settlement process in New Zealand and its impact on Māori. *Land*, *8*(152). https://doi.org/10.3390/land8100152.

New Zealand History (1964). *The 1960s key events, Marsden Point Refinery Opened*. New Zealand History Ngā kōrero a ipurangi o Aotearoa. p. 7. https://nzhistory.govt.nz/culture/the-1960s/1964.

New Zealand Psychologists Board. (2002, January 1). *Code of ethics for psychologists working in Aotearoa/New Zealand*. Psychologists Board; New Zealand Psychologists Board. https://psychologistsboard.org.nz/wp-content/uploads/2021/06/CoE-with-te-reo-FINAL-161012.pdf

NZ Topographical Map (2023). [*Untitled Map illustration of Bream Bay*]. (2023). https://www.topomap.co.nz/NZTopoMap?v=2&ll=-35.962168,174.611893&z=11

Northern Advocate (1943, 24 March). *How Bream Bay was named*. P. 5. Accessed in. https://paperspast.natlib.govt.nz/newspapers/NA19430324.2.64.

Northland District Health Board (2019). *Northland Population Health Status.* NDHB-A3-Northland-Health-Strategy-Infographic.pdf (northlanddhb.org.nz).

O'Hagan, L., & Eggleton, K. (2023). How does cultural safety embed into our consultation models? A critical reflection. *Journal of Primary Health Care, 15*(1), 4-5.

O'Malley, V. (2006). Northland Crown Purchases, 1840-1865. *A report commissioned by the Crown.* New Zealand Government.

O'Neill, L., Fraser, T., Kitchenham, A., & McDonald, V. (2018). Hidden burdens: A review of intergenerational, historical and complex trauma, implications for indigenous families. *Journal of Child & Adolescent Trauma*, *11*, 173-186.

O'Sullivan, D., Came, H., McCreanor, T., & Kidd, J. (2021). A critical review of the Cabinet Circular on Te Tiriti o Waitangi and the Treaty of Waitangi advice to ministers. *Ethnicities*, *21*(6), 1093-1112.

Office of the Chief Coroner of New Zealand (2022). *Deputy chief coroner releases annual provisional suicide statistics.* Media-release-Deputy-Chief-Coroner-251022.pdf (pds.govt.nz).

Orange, C. (2015). *The treaty of Waitangi*. Bridget Williams Books.

Orange, C. (2021). *The Treaty of Waitangi| Te Tiriti o Waitangi: An illustrated history*. Bridget Williams Books.

Paradies, Y. (2016). Colonisation, racism and Indigenous health. *Journal of Population Research, 33*(1), 83–96. https://doi. org/10.1007/s12546-016-9159-y.

Parry, R., Jones, B., Gray, B., & Ingham, T. (2014). Applying a Māori-centred consultation approach for engaging with Māori patients: An undergraduate medical student case study. *Journal of Primary Health Care*, 6(3), 254–260. https://doi. org/10.1071/hc14254

Patterson, J. (1991). Utu and punishment. *Victoria University of Wellington Law Review., 21*, 239.

Penehira, M., (2015). Mana Kaitiakitanga: Mouri moko! Mouri wahine! Mouri ora! Protective power. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A reader. A collection of readings from the Kaupapa Rangahau workshops series* (2nd ed., pp. 105-114). Te Kotahi Research Institute.

Phillips, B., Daniels, J., Woodward, A., Blakely, T., Taylor, R., & Morrell, S. (2017). Mortality trends in Australian Aboriginal peoples and New Zealand Māori. *Population Health Metrics*, *15*, 1-12.

Pihama, L., Cram, F., & Walker, S. (2002). Creating methodological space: A literature review of Kaupapa Maori research. *Canadian Journal of Native Education*, *26*(1).

Pihama, L. (2015). Kaupapa Māori theory: Transforming theory in Aotearoa. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A reader. A collection of readings from the Kaupapa Rangahau workshops series* (2nd ed., pp. 5-16). Te Kotahi Research Institute.

Pipi, K., Cram, F., Hawke, R., Hawke, S., Huriwai, T., Mataki, T., Milne, M., Morgan, K., Tuhaka, H., & Tuuta, C. (2004). A research ethic for studying Maori and iwi provider success. *Social Policy Journal of New Zealand*, *23*(3), 141-153.

Pitama, S., Robertson, P., Cram, F., Gillies, M., Huria, T., Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand Journal of Psychology*, *36*(3), 118.

Pitama, S., Huria, T., & Lacey, C. (2014). Improving Maori health through clinical assessment: Waikare o te Waka o Meihana. *The New Zealand Medical Journal, 127*(1393), 107–119.

Pitama, S. G., Bennett, S. T., Waitoki, W., Haitana, T. N., Valentine, H., Pahiina, J., Taylor, J., Tassell-Matamua, N., Rowe, L., Beckert, L., Palmer, L., Suetonia, C., Huria, T., Cameron, L., & 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.

Podsiadlowski, A., & Fox, S. (2011). Collectivist value orientations among four ethnic groups: Collectivism in the New Zealand context. *New Zealand Journal of Psychology*, *40*(1), 5-18.

Pool, I. (2015). Maori demography and the economy to 1840. *Colonization and Development in New Zealand between 1769 and 1900: The Seeds of Rangiatea*, 151-176.

Purdy, S. C. (2020). Communication research in the context of te whare tapa whā model of health. *International Journal of Speech-Language Pathology*, *22*(3), 281-289.

Rangiwai, B. (2022). Towards an understanding of Io through Atuatanga. *AlterNative: An International Journal of Indigenous Peoples*, *18*(4), 529-537.

Ratima, M. M., & Signal, L. (Eds.). (2015). *Promoting health in Aotearoa, New Zealand*. Otago University Press.

Reed, V. H. (1928) *Royal commission to inquire into confiscations of native lands and other grievances alleged by natives* (report of). W. A G. Skinner, Government Printer.

Reid, J. (2010). The doctrine of discover the doctrine of discovery and Canadian law. *The Canadian Journal of Native Studies*, *30*(2), 335-359.

Reid, J., Taylor-Moore, K., & Varona, G. (2014). Towards a social-structural model for understanding current disparities in Maori health and well-being. *Journal of Loss and Trauma*, *19*(6), 514-536.

Reilly, M. (2018). Te tīmatanga mai o te ao: The beginning of the world. In M. Reilly, S. Duncan, G. Leoni, L. Paterson, L. Carter, M. Rātima, & P. Rewi (Eds.), *Te Kōparapara: An introduction to the Māori world* (pp. 12–39). Auckland University Press

Rigby, B. (1998). *The Crown, Maori and Mahurangi 1840-1881: A Historical Report Commissioned by the Waitangi Tribunal*. B. Rigby.

Robson, B., & Harris, R. (2007). Hauora: Māori Standards of Health IV. A study of the years 2000–2005. *Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare*.

Ross, J. O. (1980). Busby and the Declaration of Independence. *New Zealand Journal of History, 14*(1), 83-89.

Russell, L. (2018). *Te Oranga Hinengaro: Report on Māori mental wellbeing results from the New Zealand Mental Health Monitor & Health and Lifestyles Survey (Report*). Health Promotion Agency/Te Hiringa Hauora. https://www.hpa.org.nz/sites/default/files/Final-report-TeOrangaHinengaroM%C4%81ori-Mental-Wellbeing-Oct2018.pdf

Ryks, J., Kilgour, J. T., Whitehead, J., & Rarere, M. (2018). Te Pae Mahutonga and the measurement of community capital in regional Aotearoa, New Zealand. *New Zealand Population Review, 44*, 85–108.

Samuels, I., & Watene, R. (2023). Hauora Maaori o ngaa karu: Maaori ocular health review. *New Zealand Medical Student Journal*, (35), 37-40.

Schwartz, R. C., & Sweezy, M. (2019). *Internal family systems therapy*. Guilford Publications.

Sekhon, M., Cartwright, M., & Francis, J. J. (2017). Acceptability of healthcare interventions: an overview of reviews and development of a theoretical framework. *BMC Health Services Research, 17*(1), 1-13.

Signal, L., Ratima, M., & Raeburn, J. (2015). The origins of health promotion. L. Signal & M. Ratima (Eds.), *Promoting health in Aotearoa, New Zealand* (pp. 19–41). University of Otago Press. https://ebookcentral.proquest.com/lib/massey/reader.action?docID=4644104&ppg=20

Silvano, G. (2021). A brief history of Western medicine. *Journal of Traditional Chinese Medical Sciences, 8*, S10-S16.

Simmonds, S., Robson, B., Cram, F., Purdie, G. (2015). Kaupapa Maori epidemiology. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A reader. A collection of readings from the Kaupapa Rangahau workshops series* (2nd ed., pp. 125-130). Te Kotahi Research Institute.

Simonds, V. W., & Christopher, S. (2013). Adapting Western research methods to indigenous ways of knowing. *American Journal of Public Health, 103*(12), 2185-2192.

Smith, G., (2015) The Dialectic Relation of Theory and Practice in the Development of Kaupapa Māori Praxis. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A reader. A collection of readings from the Kaupapa Rangahau workshops series* (2nd ed., pp. 17-29). Te Kotahi Research Institute.

Smith, L. T (1999). Decolonising methodologies: Research and Indigenous peoples. New York, NY: Zed Books.

Smith, L. T. (2015). Kaupapa Māori research-some kaupapa Māori principles. In L. Pihama & K. South (Eds.), *Kaupapa Rangahau A Reader: A Collection of Readings from the Kaupapa Maori Research Workshop Series Led* (pp. 46–52). Te Kotahi Research Institute.

Smith, L. T. (2021). *Decolonizing methodologies: Research and indigenous peoples*. Bloomsbury Publishing.

Statistics New Zealand. (2023). *2018 Census place summaries*. https://www.stats.govt.nz/tools/2018-census-place-summaries/.

Stephens, M. (2001). A return to the Suppression Act 1907. *Victoria University of Wellington Law Review*, *32*, 437.

Sterling, R., Riddle, K., Tūrongo Brooks, R., Anderson, J., & Hudson, M. (2021). *Intellectual Property, Mātauranga Māori* [Report]. Te Kotahi Research Institute University of Waikato. https://hdl.handle.net/10289/14657

Stewart, G. (2020). *Maori philosophy: Indigenous thinking from Aotearoa*. Bloomsbury Publishing.

Te Aka Whai Ora. (2024). *Te kāwanatanga o Aotearoa – New Zealand government*. https://www.teakawhaiora.nz/en-NZ/about-us/whakapapa

Te Kupenga: 2018 (Final) – English. (2018). Statistics New Zealand. https://www.stats.govt.nz/information-releases/te-kupenga-2018-final-english

Te Whatu Ora – Health New Zealand. (2022). Ministry of Health. https://www.futureofhealth.govt.nz/health-nz/

Teicher, M. H., Tomoda, A., & Andersen, S. L. (2006). Neurobiological consequences of early stress and childhood maltreatment: are results from human and animal studies comparable?. *Annals of the New York Academy of Sciences*, *1071*(1), 313-323.

Theodore, R., Bowden, N., Kokaua, J., Ruhe, T., Hobbs, M., Hetrick, S., Marek, L., Wiki, J., Milne, B., Thambrew, H., & Boden, J. (2022). Mental health inequities for Māori youth: a population-level study of mental health service data. *National Library of Medicine Journal*, *135*(1567), 79-90.

Thom, R. R. M. (2022). Land loss, confiscation, arability and colonisation: the experience of iwi in Aotearoa, New Zealand. *AlterNative: An International Journal of Indigenous Peoples*, *18*(4), 556-565.

Thom, R. R. M., & Grimes, A. (2022). Land loss and the intergenerational transmission of wellbeing: The experience of iwi in Aotearoa, New Zealand. *Social Science & Medicine, 296*, 114804.

Tiakiwai, S. J. (2015). Understanding and doing research: A Māori Position. In L. Pihama., S. J. Tiakiwai., K. Southey (Eds), *Kaupapa rangahau: A reader. A collection of readings from the Kaupapa Rangahau workshops series* (2nd ed., pp. 77-94). Te Kotahi Research Institute.

Tremblay, M. C., Graham, J., Porgo, T. V., Dogba, M. J., Paquette, J. S., Careau, E., & Witteman, H. O. (2020). Improving cultural safety of diabetes care in Indigenous populations of Canada, Australia, New Zealand and the United States: a systematic rapid review. *Canadian Journal of Diabetes*, *44*(7), 670-678.

Turton, H. H. (1877). *Facsimiles of the Declaration of Independence and the Treaty of Waitangi*. By authority: G. Didsbury, government printer.

Waipū Scottish Migration Museum. (2023). *The great war*. [Exhibition of Waipū Village and Environs WW1 Exhibition]. Waipū, Northland, New Zealand.

Waitangi Tribunal (1999). *He Whakaputanga me te Tiriti - The Declaration and the Treaty*. www.waitanigtribunal.govt.nz.

Waitangi Tribunal (2019). *Hauora - Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry: WAI 2575 Waitangi Tribunal Report 2019. Waitangi Tribunal.* Retrieved from https://forms.justi ce.govt.nz/search/Documents/

Waitangi Tribunal. (2017). *The Ngatiwai mandate inquiry report. Lower Hutt: Legislation Direct.* https://www.waitangitribunal.govt.nz/publications-and-resources/waitangi-tribunal-reports/ngatiwai-mandate-inquiry/.

Waitoki, W. (2016). Ngā kete mātauranga: The baskets of knowledge: A curriculum for an indigenous psychology. In W. W. Waitoki, & M. Levy (Eds.), *Te manu kai i te mātauranga: Indigenous psychology in Aotearoa/New Zealand* (pp. 283-299). The New Zealand Psychological Society, Wellington, New Zealand.

Waitoki, W. E., & Levy, M. E. (2016). *Te manu kai i te matauranga: Indigenous psychology in Aotearoa/New Zealand*. New Zealand Psychological Society.

Walker, K. (2013). *History of pre-1865 Crown Purchase Reserves in Te Rohe Pōtae.* Ministry of Justice, New Zealand. https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_54717160/Wai%20898%2C%20A142.pdf

Whangarei Harbour. (2023). National Library. https://natlib.govt.nz/records/40710574?search%5Bdirection%5D=desc&search%5Bi

%5D%5Bcategory%5D=Maps&search%5Bpath%5D=items&search%5Bsort%5D=syndication_date&search%5Btext%5D=Whangarei+Harbour+

Wilson, D., Moloney, E., Parr, J. M., Aspinall, C., & Slark, J. (2021). Creating an Indigenous Māori-centred model of relational health: A literature review of Māori models of health. *Journal of Clinical Nursing*, *30*(23-24), 3539-3555.

World Health Organization. (2010). *Glossary of terms used*. Retrieved from www.who.int/hia/about/ glos/en/print.html

World Health Organization. (2018). *Fact Sheet. World Health Organization*. https://www.who.int/en/newsroom/factsheets/detail/suicide

Yacoub, S. M. (2023). *Western Colonization Patterns Influence Agreement with Us Foreign Policy: Evidence from UN Voting Patterns* [Unpublished doctoral dissertation]. Georgetown University.

Yehuda, R., & Lehrner, A. (2018). Intergenerational transmission of trauma effects: putative role of epigenetic mechanisms. *World Psychiatry*, *17*(3), 243-257.

Appendix A: Participant Information Sheet

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

MEDICAL AND HEALTH SCIENCES
SCHOOL OF POPULATION HEALTH

General Practice & Primary HealthCare
Building 507
28 Park Ave
Grafton
T+64 9 923 6746
www.auckland.ac.nz
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

Participant Information Sheet – Individual Interviews This form will be held for six years.	
PROJECT TITLE:	Developing a framework for improving mental health wellbeing and resilience
RESEARCHERS:	Dr Kyle Eggleton, Principal investigator

Researcher introduction
I am Dr Kyle Eggleton, Senior Lecturer in the Department of General Practice and Primary Health Care at the University of Auckland

This Project
This project is designed to develop a framework for improving mental health wellbeing and resilience. The framework will be based on tikanga and will aim to create a culturally safe mental health programme.

Invitation to participate
You are invited to participate because you are a kaumatua or kuia in Bream Bay and your expertise and knowledge are important in developing an appropriate framework. Your participation is voluntary. You do not have to take part in this study if you do not wish. Please take your time to read this document and feel free to discuss your decision with whānau or significant other support people. If you choose to participate you will be offered a $20 grocery voucher as compensation for your time.

Project Procedures
If you consent to participate, please contact the research assistant whose details are included below, and who will arrange to conduct an interview at a time that is convenient for you and at place that is convenient to you. The interview will last approximately 45 minutes and will be recorded. You are able to terminate the interview at any stage. If this occurs we can ensure that either your data is excluded and destroyed, or we retain the data until the interview was terminated, whichever is your preference.

Consent
The interviewer will ask you for your formal consent at the start of the interview. This will be via a signed form. Withdrawal of some or all of your data is possible for one month after the interview, with no reason required.

Duration
This project is taking place for one year from June 2022.

Benefits
This study will help to understand what a culturally safe approach to mental health wellbeing and resilience might look like for Bream Bay. This approach will be shared with the Bream Bay Community Support Trust and health funding agencies in order to help develop a mental health and wellbeing programme.

Risks
Dr Eggleton, the principle researcher, has been a doctor in Bream Bay and you may have been treated by him. As a result you may feel under pressure to participate. You need to be reassured that if you choose not to participate in the study your relationship with Dr Eggleton will not be affected in anyway. Likewise your decision to not participate will not affect your relationship with the Bream Bay Community Support Trust. If you experience any adverse events as a result of the study you will be offered support by the Bream Bay Community Support Trust social services team.

Funding

This study has received a grant from Research and Education Committee of the Royal New Zealand College of General Practitioners.

Data storage / retention / destruction / future use

The interview recordings will be stored electronically in University of Auckland managed digital storage for six years and then destroyed. Access to these files is limited to the researchers. Your interview and the subsequent transcript will be saved under a unique identifier code. Transcription will be done using a commercial transcriber who has signed a confidentiality agreement. This de-identified transcript will be analysed by the research team. Your name will not be used in any reports or publications.

Contact details and approval

Principal investigator	*Research assistant*	*Head of School*	*Tumuaki*
Dr Kyle Eggleton	Kimberley Te Rangi Smyth	Prof Robert Scragg	Prof Papaarangi Reid
k.eggleton@auckland.ac.nz	Kimberley.terangi.smyth@gmail.com	r.scragg@auckland.ac.nz	p.reid@auckland.ac.nz
021 686 487	0223508040	027 230 8933	09 923 4853

If you require Māori cultural support, talk to your whānau in the first instance. You may also contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324.

For concerns of an ethical nature, you can contact the Chair of the Auckland Health Research Ethics Committee at ahrec@auckland.ac.nz or at 373 7599 x 83711, or at Auckland Health Research Ethics Committee, The University of Auckland, Private Bag 92019, Auckland 1142

Approved by the University of Auckland Human Participants Ethics Committee on 29/6/21 for three years. Reference Number UAHPEC22658

Appendix B: Hui Participant Consent Form

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

MEDICAL AND HEALTH SCIENCES
SCHOOL OF POPULATION HEALTH

General Practice & Primary HealthCare
Building 507
28 Park Ave
Grafton
T+64 9 923 6746
www.auckland.ac.nz
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

Participant Consent Form - Hui This form will be held for six years.	
PROJECT TITLE:	Developing a framework for improving mental health wellbeing and resilience
RESEARCHERS:	Dr Kyle Eggleton, Principal investigator Kimberley Smyth Research Assistant

- I have read and understand the Participant Information Sheet dated 26 April 2023. I have had the opportunity to discuss this study and am satisfied with the answers I have received. I agree to participate in a hui interview.
- I understand that taking part in this research is entirely voluntary, and that I may withdraw from the hui at any stage without giving a reason. I understand that I can not ask for my contribution to the hui interview to be removed from the study.
- I understand that only the researchers will know the identities of study participants. I understand that no material that could identify me will be used in any reports of this study.
- I understand that assurances have been given by the Bream Bay Community Support Trust that my participation or non-participation will not affect my relationship with/access to the Bream Bay Community Support Trust.
- I understand the hui interview will be digitally recorded and then transcribed for the purposes of this research. I understand that transcripts and consent forms will be kept securely for 6 years, then they will be destroyed and that the digital recordings will be destroyed 6 months after recording.
- I understand that information provided by me during the interview will be disseminated via conferences and journal articles and hui.
- I have had time to consider whether I wish to take part and I know whom to contact if I have any questions regarding the research.

I wish to be sent a copy of the hui transcript. YES/NO

I wish to receive a copy of the hui audio-recording YES/NO

I wish to receive a summary of the results YES/NO

Name Address/email

Signature Date

Contact details and approval

Principal investigator	*Research assistant*	*Head of School*	*Tumuaki*
Dr Kyle Eggleton	Kimberley Smyth	Prof Robert Scragg	Prof Papaarangi Reid
k.eggleton@auckland.ac.nz	022350	r.scragg@auckland.ac.nz	p.reid@auckland.ac.nz
021 686 487	8040	027 230 8933	09 923 4853

If you require Māori cultural support, talk to your whānau in the first instance. You may also contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324.

Appendix C: Individual Consent Form

THE UNIVERSITY OF AUCKLAND
Te Whare Wānanga o Tāmaki Makaurau
NEW ZEALAND

MEDICAL AND HEALTH SCIENCES
SCHOOL OF POPULATION HEALTH

General Practice & Primary HealthCare
Building 507
28 Park Ave
Grafton
T+64 9 923 6746
www.auckland.ac.nz
The University of Auckland
Private Bag 92019
Auckland 1142
New Zealand

Participant Consent Form - Individual This form will be held for six years.	
PROJECT TITLE:	Developing a framework for improving mental health wellbeing and resilience
RESEARCHERS:	Dr Kyle Eggleton, Principal investigator

- I have read and understand the Participant Information Sheet dated xxx. I have had the opportunity to discuss this study and am satisfied with the answers I have received. I agree to participate in one interview, for up to 60 minutes duration.
- I understand that taking part in this research is entirely voluntary, and that I may withdraw from the interview at any stage without giving a reason. I understand that I may ask for my information to be removed from the study for up to two weeks after the interview, without giving a reason.
- I understand that only the researchers will know the identities of study participants. I understand that no material that could identify me will be used in any reports of this study.
- I understand that assurances have been given by the Bream Bay Community Support Trust that my participation or non-participation will not affect my relationship with/access to Bream Bay Community Support Trust.
- I understand the interview will be digitally recorded and then transcribed for the purposes of this research. I understand that transcripts and consent forms will be kept securely for 6 years, then they will be destroyed and that the digital recordings will be destroyed 6 months after recording.
- I understand that information provided by me during the interview will be disseminated via conferences and journal articles and hui.
- I have had time to consider whether I wish to take part and I know whom to contact if I have any questions regarding the research.

I wish to be sent a copy of my transcript so that I can review it for accuracy.	YES/NO
I wish to receive a copy of my audio-recording	YES/NO
I wish to receive a summary of the results	YES/NO

Name Address/email

Signature Date

Contact details and approval

Principal investigator	*Research assistant*	*Head of School*	*Tumuaki*
Dr Kyle Eggleton	Xxxxx	Prof Robert Scragg	Prof Papaarangi Reid
k.eggleton@auckland.ac.nz	Email	r.scragg@auckland.ac.nz	p.reid@auckland.ac.nz
021 686 487	Phone	027 230 8933	09 923 4853

If you require Māori cultural support, talk to your whānau in the first instance. You may also contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324.

Appendix D: Interview Schedule

Semi-structured interview schedule
Developing a framework for developing mental health wellbeing and resilience

Process:

1. Powhiri – includes himene and karakia
2. Mihimihi
3. Outline intention of study

   Tēnā koutou katoa,

   We are interested in understanding what a tikanga informed framework for developing mental health wellbeing and resilience might look like. This is because we are aware that current mental health programmes are not generally designed by Māori and are often culturally unsafe. The intention of developing this framework is to inform our work in advocating for and creating a tikanga specific programme that will address mental health issues. This programme is aimed at addressing mild to moderate mental health issues in primary care and is not aimed at addressing severe mental health issues that may require hospital level services.

   Just a reminder that this interview will be recorded (pause) and I am switching on the digital recorder now.

   SWITCH ON RECORDING

   - Now that we are recording, have you read and understood the information sheet that you have been given?
   - Does everyone consent to taking part in this study and having this interview recorded?
   - Is everyone aware that we can not remove your kōrero from the transcribed interview if you decide that you don't want to participate any more?
   - Are you aware the hui may take about 60 minutes or so?
   - Following the hui we can share some kai and a cup of tea

   We have already had a kōrero with a number of kaumātua and kuia and their ideas are as follows (describe proposed framework and give out copy).

   What do you think of this and what would this look like in practice?
   What additions or changes would you like to see?

   Thank you very much for talking with us, this has been very helpful.

4. Poroporoaki – describing process of transcribing interviews, developing ideas and then going to the Board of the Bream Bay Community Support Trust with a plan of creating a mental health wellbeing and resilience programme
5. Closing karakia
6. Kai and cup of tea