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**HE KĀKANO AHAU I RUIA MAI I RANGIĀTEA:  
ENGAGING MĀORI IN CULTURALLY-RESPONSIVE  
CHILD AND ADOLESCENT MENTAL HEALTH  
SERVICES**

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**Te Rarawa, Ngāpuhi, Ngāi Te Rangi, Ngāti Pūkenga**

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**Doctor of Clinical Psychology**

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## **ABSTRACT**

Meeting the mental health needs of Māori children and adolescents and their whānau in Child and Adolescent Mental Health Services (CAMHS) is a priority in Aotearoa/New Zealand. Māori living in urban areas are vulnerable to psychological distress due to compounding effects of colonisation, discrimination and socio-economic adversity, which is reflected in negative statistics around Māori health generally as well as mental ill health. Despite this need, engagement of Māori in CAMHS has traditionally been poor. One solution has been the development of Kaupapa Māori services. This research was undertaken with He Kākano, an urban based Kaupapa Māori team in Counties Manukau, Auckland, to investigate Māori perceptions of engaging whānau in CAMHS.

A Kaupapa Māori methodology was used to conduct semi-structured interviews with 20 service users consisting of eight rangatahi (youth) participants (aged 13-18 years old) and 12 whānau member participants (parents, caregivers). He Kākano perceptions of engagement were also gathered through a focus group conducted with 11 staff members.

Thematic analysis of interviews identified the importance of addressing barriers and initial concerns as well as building therapeutic relationships via whakawhanaungatanga during the initial assessment. Rangatahi, whānau and staff identified specific clinician/practitioner characteristics, skills and values that helped ongoing engagement: aroha (empathy and compassion), awareness of professional power dynamics and regular consistent contact. Culturally congruent interventions and practical coping skills were also imperative for ongoing engagement. The main barriers for whānau during the engagement were communication (language, interpersonal skills) and medication. Challenges of operating as a Māori team within a mainstream service were expressed by He Kākano team members. Finally, whānau pathways to wellbeing including whānau strengths, resiliencies and future aspirations for services were described. This research demonstrates the therapeutic value of tikanga (Māori practices) and mātauranga Māori (Māori knowledge) for engagement of Māori within CAMHS. It also contributes to understanding of factors that facilitate and inhibit engagement and offers recommendations on how to best align services and clinical practices with needs and aspirations of Māori in CAMHS.

# KUPU WHAKATAKI

## MIHI/ACKNOWLEDGEMENTS

### Te Mataara o Nukutawhiti

*E kau ki te tai e, e kau ki te tai e, e kau rā e Tāne. Wāhia atu rā te ngaru hukahuka o Marereao. Pikitia atu te aurere kura o Taotaorangi. Tapatapa rūrū ana te kakau o te hoe. E auheke ana, e taratutū ana i te puhi whatukura, i te puhi māreikura o tōku waka. Ka titiro iho ahau ki te pae-o-uta, ki te pae-o-waho. Piki tū rangi te kakau o te hoe, kumea te uru tapu o tōku waka ki runga ki te kiriwaiwai o Papatūānuku e takoto mai nei, ki runga ki te urutapu nui o Tāne e tū nei. Whatiwhati rua ana te hoe nā Poupoto, tau ake ki te hoe nā Kura, he ariki whatumanawa. Ko tō manawa, e Kura, ki tōku manawa ka irihia. Ka irihia ki Wai-ō-Nuku ka irihia, ka irihia ki Waiō-Rangi ka irihia, ka whiti au i te wheiao ki te ao mārama. Kia tupu kerekere, kia tupu wanawana ka haramai te toki i a haumi ē, hui ē, tāiki ē!*

### The Rallying Call of Nukutawhiti (Whakapākehā/Translation by Hōne Sadler)

*Be awash upon the tides, be awash upon the tides, oh Tāne. Divide the foaming tides of Marereao. Ascend the sacred current of Taotaorangi. The handle of the paddle is not held steady, it is descending into the savage surf welling up on the male plume and the female plume of my vessel. I cast my gaze upon the horizon ashore as well as the horizon out to sea. The handle of the paddle is now raised, to draw the sacred head of my vessel upon the shore of Papatūānuku laying yonder and also upon the sacred head of Tāne here standing. The paddle of Poupoto is breaking in two, as well as that of Kura, they are lords of aristocracy. Let your heart oh Kura be bound and suspended with mine. Let it be bound and suspended on the terrestrial waters, to be bound and suspended over the celestial waters. I will then traverse from the dim light into the world of enlightenment. Let the intense darkness bring forth wonder and awe. Proceed, proceed, we are all united in one accord!*

Nō reira, koutou te hunga mate, haere atu rā, haere atu rā. Kia Nunna, Maggie, Aunty Kuini, Uncle Jack, Aunty Mereana, Poppa John, Nanna Pat, cuzzie Patrick, koutou katoa, tēnei te mihi, te tangi kia koutou, moe mai rā. Ka hoki mai kia tātou, ngā kanohi ora o rātou mā, tēnā tātou katoa.

The karakia (incantation) of my tūpuna (ancestors) above is the rallying cry of Nukutawhiti guiding his waka (canoe) Ngātokimatawhaorua safely over the Hokianga Bar into the calm refuge of the Hokianga harbour after its long journey from Hawaiki to

Aotearoa. This karakia also represents the journey I have taken to complete this rangahau (research) and this tohu (degree). At times, it felt like I was navigating turbulent waters with the numerous life challenges I faced while completing this tohu. Many times I had to call on my support networks, my whānau (family) and my tūpuna to help me get through the choppy waves and reach the calm waters. The karakia also signifies the conclusion of a great undertaking and the beginning of a new undertaking. Similarly, when I stand at the heads of the Hokianga harbour I also get a glimpse of what my tūpuna saw and this vision instills peace in me. It also gives me sustenance to continue with excitement about what the future holds.

It has been an honour and a privilege to undertake this rangahau and I hope that this thesis represents the amazing kōrero that was gifted to me in my interviews with rangatahi, whānau and the He Kākano team. Nā reira, tēnei te mihi kia koutou katoa, ngā rangatahi, ngā whānau me ngā kaimahi i whai wā ki te kōrero mai ki ahau e pā ana ki tēnei kaupapa rangahau e hāngai ana ki te oranga whānau, tēnā koutou katoa. Thank you to all the participants in this research for giving their time, thoughts and reflections about engagement and for sharing their wisdom on wellbeing.

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te wā e taimaha ana ahau, tēnā koe mō tō kaha ki te tautoko i ahau me ō mokopuna hoki. Thanks Dad for giving me another wise and compassionate perspective on things and for your support with my boys. To my sisters: Manawa, for your funny chats, gentle encouragement and intellectual questions and ponderings. Hinewai, for your tautoko especially in the last stages of the writing, taking the boys up North and to your whare and for your 'real talk', reminding me to keep my focus on what really matters. Kia koe Rangimarie, tēnā koe mō tō kaha ki te tiaki i aku tama, mō tō wairua hari me tō kaha ki te whakakata i a mātou i ngā wā katoa. Also to my big sis Hana for your enduring aroha and tautoko and to my big bro Tama for your one-liners. He mihi hoki ki tōku Karani Pā Pāpā Here, ki aku karanga tamariki hoki, aku irāmutu James, Ash, Mahaki, Oha, Wai-o-te-Marama koutou ko Mingo Mereana. To my bros in law, he mihi hoki ki a Blaine kōrua ko Wikatana. Thank you to my beautiful cousins, Aunties and Uncles- you know who you are. Ngā mihi mutunga kore.

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## **PEPEHA**

Ko Panguru, ko Te Ramaroa ngā maunga

Ko Ngātokimatawhaorua te waka

Ko Hokianga te moana

Ko Te Rarawa, ko Ngāpuhi ngā iwi

Ko Ngāti Manawa, Ko Te Hikutu ngā hapū.

Ka huri ki Tauranga Moana,

Ko Mauao te maunga

Ko Mataatua te waka

Ko Ngāi Te Rangi, Ngāti Pūkenga ngā iwi

Ko Ngāti Hē te hapū.

## GLOSSARY

<b>Āhua</b>	to form, make, also refers to a shape, appearance, condition, character, likeness, nature, figure, form
<b>Aroha</b>	compassion, love, empathy, affection, an empowering action
<b>Atua</b>	supernatural being, literally translated in English as 'Potential being from beyond' (T. Smith, 2009)
<b>Āwangawanga</b>	concern, worry
<b>Awhi</b>	to embrace, cherish
<b>Haka</b>	vigorous dance with actions and powerful rhythmically sung words
<b>Hapū</b>	sub tribe, to be pregnant, conceived in the womb
<b>Hara</b>	wrongdoing, problem
<b>Hawaiki</b>	ancient homeland, places from which Māori migrated to Aotearoa/New Zealand
<b>Hinengaro</b>	mind, thought, intellect, consciousness, awareness
<b>Hongi</b>	traditional greeting, pressing noses
<b>Hui</b>	gathering, meeting, assembly, seminar, conference
<b>Ihi</b>	psychic force/essential force
<b>Ihi rangaranga</b>	energy or vibration, essential energy
<b>Iho matua</b>	umbilical cord (middle portion), both physical and spiritual, spirit energy that links through whakapapa to primal energy source (Mataira, 2011)
<b>Ira atua</b>	supernatural life
<b>Ira tangata</b>	human genes, however, as ira tangata come from ira atua, ira tangata is considered to have a more spiritual quality than human genes (Mead, 2004)
<b>Iwi</b>	tribe, bones
<b>Kai</b>	food, or to eat
<b>Kaitiaki</b>	guardian, guide, caretaker, protector
<b>Kākano</b>	seed
<b>Kapa haka</b>	Māori performing arts, performing group
<b>Karakia</b>	incantation, prayer, grace, blessing, church service

<b>Kaumatua</b>	elder(s)
<b>Kaupapa</b>	topic, policy, matter for discussion (also means platform, layer)
<b>Kaupapa Māori</b>	an approach that privileges the perspectives and protocols of Māori
<b>Kawa</b>	marae protocol, ceremony to open a new house
<b>Koha</b>	gift, present, offering, donation, contribution
<b>Kōhanga Reo</b>	Māori language preschool, Māori language nests
<b>Kōrero</b>	narrative, speech, conversation, discourse
<b>Koroua</b>	elderly man, grandfather, grand uncle, papa
<b>Kuia</b>	elderly woman, grandmother, grand aunt
<b>Kupu Whakataki</b>	preamble, foreward
<b>Kura Kaupapa Māori</b>	primary school operating under Māori custom and using Māori as the medium of instruction
<b>Mamae</b>	painful experiences, pain, hurt
<b>Mana</b>	a supernatural force in a person, place or object, mana goes hand in hand with tapu
<b>Manaaki</b>	to support, take care of, give hospitality to, protect, look out for
<b>Manaakitanga</b>	hospitality, kindness
<b>Manuhiri</b>	visitor, guest
<b>Māori</b>	indigenous New Zealander, indigenous person of Aotearoa/New Zealand, natural
<b>Māoritanga</b>	Māori culture, practices and beliefs
<b>Marae</b>	community facility where hapū collectives or groups discuss political and social matters, and host important events
<b>Matakite</b>	prophecy, prophet, seer, clairvoyant, special intuition, Māori healer
<b>Mātauranga Māori</b>	Māori epistemology, traditional and contemporary Māori knowledge, a body or a continuum of knowledge brought to Aotearoa New Zealand by Polynesian ancestors of present-day Māori.
<b>Mate Māori</b>	Māori illness

<b>Maunga</b>	mountain, mount, peak
<b>Mauri</b>	life principle, special nature, a material symbol of a life principle, source of emotions
<b>Mihimihi</b>	speech of greeting, structured communication, process of introduction and communication which establishes the unique Māori recognition of intimacy required to communicate effectively and appropriately (Matua Raki, 2009)
<b>Moana</b>	sea, ocean, large lake
<b>Mokopuna</b>	grandchild, descendant - child or grandchild of a son, daughter, nephew, niece, etc
<b>Mōteatea</b>	chants
<b>Ngākau</b>	heart, seat of affections
<b>Ora</b>	be alive, well, safe, cured, recovered, healthy, fit
<b>Pākehā</b>	New Zealander of European descent
<b>Papa kāinga</b>	original home, home base, village
<b>Pepeha</b>	a recitation of whakapapa and areas of significance
<b>Pōuri</b>	sadness, sorrow, gloom
<b>Pōwhiri</b>	invitation, rituals of encounter, welcome ceremony on a marae, welcome, transactional engagement that assists in the negotiation of a safe space for discussion to take place (Matua Raki, 2009)
<b>Pūkenga</b>	skills, abilities, expertise
<b>Pūmanawa</b>	natural talent, intuitive cleverness , strengths
<b>Puna Waihanga</b>	creativity centre
<b>Rangahau</b>	research
<b>Rangatahi</b>	youth, younger generation
<b>Rangatira</b>	esteemed, revered person, chief
<b>Rangatiratanga</b>	sovereignty, chieftainship, right to exercise authority, chiefly autonomy, self-determination, self-management, ownership, leadership of a social group, domain of the rangatira, noble birth
<b>Rangiātea</b>	Ancient name strongly associated with Hawaiki, both a physical place and a spiritual realm, literally a clear sky, clear spiritual realm, state of enlightenment, the

	uppermost heaven, also known as Ra'iatea an island north-west of Tahiti
<b>Raruraru</b>	difficulty, trouble, dispute
<b>Rohe</b>	boundary, district, region, territory, area, border (of land)
<b>Taiao</b>	environment
<b>Taha</b>	side
<b>Tamariki</b>	children
<b>Tāne</b>	men, males, husbands
<b>Tāngata</b>	people, persons, human beings
<b>Tāngata whenua</b>	local people, hosts, indigenous people of the land - people born of the whenua (of the placenta and the land) where the people's ancestors have lived and where their placentas are buried
<b>Tangihanga</b>	weeping, crying, funeral, rites for the dead
<b>Taonga</b>	gift
<b>Tapu</b>	the restricted and controlled access to other human beings (Tate, 2010)
<b>Tararā</b>	genealogical descent from the former Yugoslavia, Croatia, Dalmatia
<b>Tauiwi</b>	a person with no Māori tribal affiliation
<b>Te Aho Matua</b>	The philosophical base for Kura Kaupapa Māori education for the teaching and learning of children. Te Aho Matua is presented in six parts, each part having a special focus on what, from a Māori point of view, is crucial in the education of children: 1. Te ira tangata – the physical and spiritual endowment of children and the importance of nurturing both in their education; 2. Te reo – principles by which this bilingual competence will be achieved; 3. Ngā iwi – principles important in the socialisation of children; 4. Te ao – those aspects of the world that impact on the learning of children; 5. Āhuatanga ako – the principles of teaching practice that are of vital importance in the education of children; 6. Te tino uaratanga – the characteristics aiming to be developed in children.
<b>Te ao Māori</b>	the Māori world
<b>Te ao mārama</b>	the world of light
<b>Te ao wairua</b>	the spiritual realm



<b>Te reo Māori</b>	Māori language
<b>Te tapu o te tangata</b>	this refers to the intrinsic tapu given to every person at conception, and relates to our relationships with the atua, tangata, and whenua
<b>Te Tiriti o Waitangi</b>	the Treaty of Waitangi
<b>Tiaki</b>	to guard, keep; also to look after, nurse, care, protect
<b>Tika</b>	correct, appropriate
<b>Tikanga</b>	protocols, correct procedure, custom, manner and practice, pertaining to Māori
<b>Tinana</b>	physical body
<b>Tino rangatiratanga</b>	self-determination
<b>Tūhonohono</b>	joining, linking, connecting
<b>Tūpuna /Tīpuna</b>	ancestors, grandparents
<b>Tohu</b>	qualification, sign
<b>Tohunga</b>	skilled person, chosen expert, priest - a person chosen by the agent of an atua and the tribe as a leader in a particular field because of signs indicating talent for a particular vocation
<b>Tomokanga</b>	entrance, opening, entry foyer, gateway, entry
<b>Wāhine</b>	women, (wāhine singlar)
<b>Waiata</b>	song, chant
<b>Wairua</b>	spirituality, spirit, soul, quintessence - spirit of a person
<b>Wānanga</b>	seminar, conference, forum
<b>Wehi</b>	a response of awe
<b>Whaea</b>	mother, aunt
<b>Whaikōrero</b>	the art or practice of oratory
<b>Whakamā</b>	be ashamed, shy, embarrassed
<b>Whakapapa</b>	genealogy, lineage, descent (also means genealogical table)
<b>Whakataukī</b>	proverb, saying, cryptic saying, aphorism
<b>Whakawhanaungatanga</b>	process of establishing and maintaining links and relationships with others, relating well to others
<b>Whānau</b>	family and extended family, to be born, to give birth

<b>Whanaunga</b>	relative, relation, kin, blood relation
<b>Whanaungatanga</b>	relationship, kinship, sense of family connection
<b>Whāngai</b>	to raise, adopt, nurture (also means to feed)
<b>Whatumanawa</b>	the seat of emotions, deeper recess of consciousness
<b>Whare</b>	house
<b>Whare hui</b>	main meeting area of a marae
<b>Whenua</b>	land, country, ground, placenta, afterbirth

# CHAPTER ONE: INTRODUCTION

## Background

The whakataukī or proverb that is the title of this thesis is related to the idea of potential; it is also about being connected and belonging.

***He Kākano ahau i ruia mai i Rangiātea, e kore ahau e ngaro***

*I am a seed sown in Rangiātea, I will never be lost.*

Rangiātea is the original home for Māori, where tūpuna (ancestors) navigated from to Aotearoa. This research is based in He Kākano, a Kaupapa Māori (Māori-centred) Child and Adolescent Mental Health (CAMHS) team that derives its name from this whakataukī. It is also a whakataukī that was taught to me at Kura Kaupapa Māori (Māori immersion school) through Te Aho Matua (philosophical guideline of Kura Kaupapa Māori schools) which affirms one's sense of identity and belonging in the world (Nepe, 1991). In the whakataukī, people are likened to kākano or seeds full of potential. The underlying notion is that our unique conception into this world was purposeful and intentional and that we are linked to our tūpuna and previous generations as we all come from Rangiātea and therefore will never be lost or alone.

My interest in the topic of tamariki (children) and whānau (family) wellbeing is grounded in my passion to undertake research to better understand processes of Māori psychology (Durie, 2001; Waitoki, 2012) and how these relate to child and adolescent mental health. In addition, my whānau upbringing, life and work experiences all have influenced my pathway into clinical psychology and motivation to do this research.

My siblings and I grew up during the establishment of the Kōhanga Reo (Māori immersion early childhood centre) and Kura Kaupapa Māori movements in an environment where tikanga (Māori practices and protocols) and te reo Māori (the Māori language) was the norm and where being Māori was the norm. Before we were born my parents made a decision to live in the Hokianga to reconnect with our Ngāpuhi and Te Rarawa roots in Northland, New Zealand. I was born in Rawene, Hokianga and was named Pikihuia to link me to Nunna's (paternal grandmother's) side of the whānau (family). I was named after my

grandmother's sister and the name originates from our Taranaki whakapapa (geneology). My siblings and I were named after our tūpuna (ancestors), to carry on their names and to link us to our whakapapa<sup>1</sup>. I also have Tararā (Croatian, Dalmatian) and Irish whakapapa on my maternal grandparents side.

We lived in a small community in the Hokianga called Koutu under Whiria mountain and I attended Te Kōhanga Reo o Pākanae. Our way of life was picking pipi (shellfish), getting kanae (mullet) from our fishing net and crossing the creek on our boat at high tide or wading across on low tide. Our immediate whānau did not live near but we were loved and nurtured by our extended whānau in the community.

I learnt about people the importance of compassion, empathy and tolerance for difference through the experience of growing up with an older brother who had an intellectual disability. My brother Tamaora was and still is very much a character with his own distinctive āhua (nature) and hātakihi-ness (comical) way about him.

After spending my formative years in the Hokianga we moved to the city to Auckland and I attended Te Kura Kaupapa Māori o Maungawhau. Te reo Māori was the only language spoken in my whānau home growing up as both my parents were fiercely passionate about the importance of the Māori language. My parents were activists in the 1970s for Māori rights and te reo Māori and were both teachers at Kura Kaupapa Māori. As well as our reo, tikanga (values) that were instilled in us were: manaaki me te tiaki tētahi ki tētahi (nurturing others), hūmarie (humility), pono (integrity) and social justice (tika). Values of Te Aho Matua were also instilled in me as a child growing up within Kura Kaupapa Māori and still guide me in my life now. The importance of tamariki (children) was particularly emphasised within our whānau and our wider whānau. Education was also encouraged as well as the importance of working hard and perseverance. All of these tikanga were nurtured within my whānau, and were conveyed through strong practical and emotional support for each other.

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<sup>1</sup> My iwi affiliations in Hokianga are Te Rarawa and Ngāpuhi; in Tauranga are Ngāi Te Rangi and Ngāti Pūkenga; in Taranaki are Ngā Rauru and Ngā Ruahine; and Ngāti Raukawa in Ōtaki.

It was not until I entered mainstream schooling that I was able to clearly and distinctly begin to compare and contrast Māori and Pākehā worlds. I learnt to walk between both worlds, literally, going from a large mainstream Pākehā school, to a Kura Kaupapa Māori and home where only Māori was spoken.

My work experience further shaped my interest in the area of children and whānau as well as the experience of being a parent myself. I was a young parent at the age of 18, which posed some challenges in terms of continuing on in education. I was at the end of my final year of high school when I got pregnant, and with encouragement of my friend enrolled in university and was strongly supported by my mother, father, sisters and wider whānau to continue in my studies. My whānau continue to support me now to raise my three sons.

I have worked in various different organisations with children, youth and whānau such as the Ministry of Education Special Education, as a therapist for a private organisation for children with Autistic Spectrum Disorders, as a teacher aide at a high school, a learning advisor, mentor and coordinator for the University of Auckland Tuakana Mentoring Programme for Māori and Pasifika Psychology students and as a kaiāwhina (helper) at my children's Kōhanga Reo and Kura. I also completed a placement and a clinical psychology internship in He Kākano (Māori team) at Whirinaki CAMHS. Within these organisations I have observed many different approaches to service provision for children and for Māori. Furthermore, I have whānau members who have accessed mental health services in the past. These experiences have all contributed to my interest in the area of providing culturally responsive services for Māori.

In the mid 1990's Durie (1995) stated that there are many different expressions of what it meant to be Māori. Māori live in "diverse realities" and different strategies are needed if all Māori were to be reached by health services. In 2015, the diversity of Māori identity continues to be a relevant topic of debate for Māori. Attending to these varied and distinct characteristics of Māori identity is important, particularly in relation to the provision of mental health services for young Māori who constitute a fast growing group of the population (Statistics New Zealand, 2013). However, it is concerning that there is a high number of Māori in need of mental health services that are not receiving them. According to

recent data, nation-wide access rates for Māori to CAMHS are low (The Werry Centre, 2011). Furthermore, the responsibility of engagement is often placed solely on the young person or their whānau, as opposed to acknowledging clinician, service and system factors that contribute to engagement (Appleby & Phillips, 2013). In addition, mainstream treatment programmes may be limited in their effectiveness for Māori if they cannot deliver culturally responsive assessments and interventions (Elder & Tapsell, 2013). In response to this Kaupapa Māori services have been established with the intent to address cultural barriers to engagement for Māori in mental health by providing services that are in line with Māori conceptualisations and practices of health (Durie, 2011). Recent research suggests that culturally-appropriate services for Māori in CAMHS enable greater acceptability and access (McClintock, 2013). However, according to Herbert and Morrison (2007), overall there is a significant lack of research on the experience of working in and utilising Kaupapa Māori mental health services for effective delivery of health services for Māori. There is also limited research about engagement specifically with urban based Māori who attend specialist Kaupapa Māori CAMHS.

Before exploring the concept of engagement for Māori in CAMHS it is first necessary to provide an overview of Māori mental health and the impact of colonisation, specifically on Māori wellbeing, identity, health practices and socio-economic position. I then cover the issue of identity as it relates to current context for urban based Māori. Next, I review current mental health of Māori youth and in light of these statistics outline Māori paradigms of health that were developed to reinstate a Māori worldview and approach to health and wellbeing. In addition to the more widely known models of health, mātauranga Māori and other broader Māori models that pertain to children and youth are introduced. In the section following that I will detail the international western literature around engagement and then contextualise the literature specifically to Māori engagement practices.

## **Māori Mental Health**

The high mental health burden for Māori in Aotearoa, New Zealand is of critical concern. Māori are more likely to experience barriers to treatment such as delays; treatment often has little relevance (focus on symptoms rather than cause); and there is no comprehensive cultural assessment (Pitama et al., 2007). There are also restrictive entry criteria and Māori have limited choice about psychological intervention or medication

(Waitoki, 2012). Furthermore, Māori are more likely than non-Māori to be seriously unwell before they seek help, be younger when diagnosed, have a diagnosis of schizophrenia or other psychotic disorder, have an enforced admission and experience higher readmission/s (Baxter, 2008; Elder & Tapsell, 2013).

Māori Youth have higher 12-month prevalence of mental health disorders than other ethnic groups (Fergusson, Poulton, Horwood, Miln & Swain-Campbell, 2003). New Zealand has the second highest suicide rate in the developed world and Māori have twice the suicide rate of non-Māori youth (Mental Health Commission, 2011). These statistics are comparable to other indigenous groups around the world who have experienced colonisation including Native Americans in the United States and First Nations peoples in Canada (Gone & Trimble, 2012; Kohn, 2007; Walls & Whitbeck, 2011) and Australian Aborigines (Ware, 2013).

Youth 2000, a national survey of the health and wellbeing of secondary school students in New Zealand was conducted with students in 2001, 2007 and 2012. The Youth 2000 surveys enabled researchers to track trends and investigate new issues for young people over time. The most recent survey Youth '12 involved 8,500 students from around New Zealand and investigated issues around ethnic identity and culture, and a range of health and social emotional factors. According to the Youth '12 survey young Māori compared to Pākehā (New Zealand Europeans) are more vulnerable to suicide attempts, being a passenger in a car with someone who had been drinking, smoking tobacco, cannabis and drinking alcohol weekly or more frequently (Fleming et al., 2014). For Māori, there were difficulties identified with not being able to access health care when needed, lower rates of improvement or worsening of depressive symptoms, perceptions of people at school not caring about them, and lower perceptions that teachers expect them to do well at school. In addition, compared to previous surveys there was significantly worse deprivation and parental worry about having enough food as well as poor access to General Practitioner (GP) or school health clinic which is often the first port of call for many for accessing CAMHS (Fleming et al., 2014).

The significance of these findings for Māori reaches beyond adolescence. Mental health disorders during adolescence have been found in broad population studies to be

linked with a range of negative outcomes later in life, such as risk of major depression, anxiety disorders, nicotine dependence, alcohol abuse or dependence, suicide attempt, educational underachievement and unemployment (Fergusson, Horwood, Ridder, & Beautrais, 2005; Fergusson & Woodward, 2002; Kim-Cohen et al., 2003). Approximately three-quarters of adults with psychiatric disorders present before the age of 18 years (Fergusson et al., 2005). Treatment of mental health disorders in adolescence may help to reduce the mental health burden among vulnerable populations (Durlak & Wells, 1997; Leavey, Flexhaug, & Ehmanneavey, 2008; Shochet & Hoge, 2009). There is evidence that intervention during adolescence can lead to reduced severity of symptoms and improved adult mental health outcomes (Chanen et al., 2009; Durlak & Wells, 1997; Leavey, Flexhaug, & Ehmann, 2008; Shochet & Hoge, 2009).

However, despite the high need for adolescents, there are ongoing issues around access to primary and secondary mental health and addiction services. New Zealand research suggests that young people often find access to and the navigation of support services difficult as they find it difficult to ask for help and are reluctant to engage in mental health services (Clark et al., 2014). Furthermore, this situation may be worse for Māori young people than other groups (The Werry Centre, 2011; Ministry of Health, 2011). Māori youth often cite that there is a lack of cultural fit with services and practitioners (Jansen, Bacal, Crengle, 2008), suggesting that there is significant need for effective and quality services that are culturally responsive to young Māori and their whānau.

In summary, Māori are overwhelmingly suffering from high rates of mental ill health. However, to understand the context of mental health difficulties for Māori, it is necessary to consider historical factors that continue to negatively impact on Māori well-being today.

**Colonisation and Māori mental health.** Colonisation had a significantly harmful impact on Māori. The loss of land, resources, language, culture and health practises have very real everyday implications for Māori. Māori were adversely affected by the confiscation and forced sale of land which resulted in a loss of 96% of land (Glover, 2004). Not only was the dispossession of land economically devastating, but was particularly damaging due to the spiritual significance. Whenua (land) was the source of physical and spiritual substance for Māori (Pere, 1991). Comprehensive reviews of the impacts of



colonisation, oppression and historical trauma have been written by a number of other authors (see L. T. Smith, 1999; Pihama, 2001; Wirihana & Smith, 2014). In the following section I present three other processes of colonisation with particular health and psychological implications of relevance to Māori mental health; these are the impacts of the diaspora of Māori through urbanisation, the Tohunga Suppression Act, and assimilation agendas in education.

After mass land confiscation, many Māori moved to urban areas to making a living to support their families and for new opportunities. After the Second World War there was demand for workers in urban cities and Māori moved away their tūrangawaewae (tribal homelands) to pursue these economic opportunities (Kukutai, 2013). This period of rapid migration to the cities in New Zealand history is known as urbanisation. The process of urbanisation meant that the structure of Māori society changed from one where extended whānau (family and extended family) and hapū (sub-tribes) lived together on their papa kāinga (communal land), towards a more nuclear model of family where there was an absence of intensive whanaungatanga (family relationship) support systems. People shifted to narrower nuclear formations of familial relationships where whānau lived separately in individual households and were not in close proximity to other whānau. Furthermore, maintaining links between whānau in rural areas became difficult (Durie, 1985, 2001; Edwards, McCreanor, & Moewaka Barnes, 2007). For Māori who moved to urban areas, particularly up to the 1970s, most faced discrimination in housing, employment, sports and recreation (Barrington, 2005). Socio-economic vulnerability was brought about by concentration in poor quality housing, and jobs that were vulnerable to economic change (Belich, 2001).

As well as the loss of land and whānau support networks, the Native Schools Act introduced in 1867 aimed to assimilate Māori. The Act was particularly detrimental to Māori identity as it banned the use of the Māori language with Māori children. The Act was introduced as a form of cultural assimilation (Pihama, 2014). Corporal punishment was used on Māori children who spoke Māori at Native Schools (L. T. Smith, 1999). Many Māori also began to suppress the language in their own homes as a result of the internalisation of colonial beliefs (Parsonage, 1957). Thus the language went into a state of decline as many native speakers of te reo Māori did not then teach their children to speak Māori. Indeed, as

a result of a major sociolinguistic survey, it had been predicted in the 1970s that, unless the pattern of language shift and loss was attenuated, eventual language death would almost certainly occur (Benton, 1979). The punishment for speaking Māori in school had severe consequences for the Māori, according to Walker (1990, p.147), “the damaging aspect of this practice lay not in corporal punishment, but in the psychological effect on an individual’s sense of identity and personal worth.” It was believed that in order to succeed, Māori needed to put aside their Māori identity as being Māori was not seen to have any economic or educational value (Smith et al., 2001).

The Tohunga Suppression Act (1907) that outlawed tohunga practices was introduced with the underlying intention of assimilating Māori to Western constructions and treatments of health care as it was believed by the settlers that Western institutions were innately superior (Mikaere, 2006). Tohunga were skilled spiritual leaders, priests or experts in the area of health, but they had far reaching cultural significance. A further specific justification for the Act was that while tohunga had expertise at curing Māori (Māori illnesses) they had great difficulty halting the impact of new illness epidemics brought with Pākeha. As such, the Act was purported by some as a mechanism to ‘protect’ Māori health by focussing instead on public health initiatives.

However, the Act had far reaching implication for Māori beyond immediate health needs. While Māori practitioners were prohibited from working with wairua (spirituality), the knowledge base was further invalidated across theological, political and academic spheres. Durie (2001) referred to the Tohunga Suppression Act as the greatest blow to the organisation and protection of Māori knowledges. In addition, traditional Māori beliefs systems were perceived as being in conflict with Christian beliefs (Durie, 2001). The Act damaged Māori methods of transmitting traditional knowledge. Furthermore the denigration of learning of intellectual traditions and practices of wellbeing resulted in healers being “forced underground” (Durie, 1998, p.45) subverting Māori methods of healing.

Colonisation processes outlined above meant that people lost distinguishing factors relating to their Māori identity. Traditionally, Māori well-being depended on identity, which was sustained by links to the spiritual world and their ancestry, and nourished by the Māori

language and ties to the land. The process of colonisation in New Zealand meant that over many generations, Māori were deprived of their “understanding of wellness as well as wellness itself” (Jackson, 2011, p.3). Jackson (1988) suggested that the of Waitangi is the basis by which change can happen in New Zealand society and is central to the development of effective mental health services for Māori.

**Treaty of Waitangi.** The Treaty of Waitangi, signed in 1840, created a unique partnership between Māori (the Tangata Whenua or indigenous people) and the Crown, represented by the New Zealand government. It is the legitimate source of constitutional government in New Zealand. Representatives of some Māori hapū (sub-tribes) and representatives of the Queen of England signed the Treaty (Orange, 1987). Many iwi (tribes) did not sign the Treaty (Orange, 1987). Problems arose after the signing of the Treaty associated with breaches and failures of successive governments to honour the Treaty and different interpretations of the Treaty. Māori who signed the Treaty saw it as a means of ensuring protection and Tino Rangatiratanga (autonomy) over their taonga (treasure – including land, language, culture, knowledge), practices, and way of life. Māori agreed to governance by the Crown as a means to control the behaviour of settlers in the new colony but not to concede sovereignty (Walker, 2004). The Crown however interpreted the signing of the Treaty as Māori conceding sovereignty. The four articles of the Treaty will be outlined below in reference to implications for service development and delivery for Māori.

Article One outlines the obligations of the Crown as kawana of Aotearoa. Within this document, Māori agree to share governorship upon the condition that the Crown supports and protects Māori and their endeavours. According to this article, health services that meet the needs of Māori and non-Māori are required. All individuals are afforded the right to decide the appropriate services for their needs.

Tino rangatiratanga pertains to the right and responsibility of Māori to have autonomy of and protect their taonga. The health of Māori is considered a taonga, therefore Māori affirmed the right by the Crown to have control over policies and services that enable Māori health to be protected. In order to do so, it is essential that Māori define wellness and health, as well as how these are maintained, for themselves and that Māori knowledge around wellness is recognised as legitimate and valid as are Māori health practices. A logical

extension of this right is the development of services delivered by Māori, for Māori, in a Māori way as distinct from mainstream services that merely include Māori in their staff and consumer groups.

The third article of the Treaty states that Māori should be afforded the same rights and privileges as non-Māori. Responsibility is placed on the Crown to ensure that Māori not only have equal access to health services but also experience equal outcomes (Department of Social Welfare, 1989). However, this as noted in the previous section, high mental health burden continues to be of critical concern.

There also exists a very important, and seldom cited, fourth article that was developed during verbal negotiations of the treaty and most likely contributed to the final consensus regarding its signing (Orange, 1987). This article has important implications for Māori health as it is not only an extension of the first three articles but also specifically outlines the rights of Māori to their customs surrounding spiritual beliefs and the responsibility of the Crown to protect this right. The implication this article has for mental health services is the acknowledgement, acceptance, incorporation and education of Māori spiritual practices into service development, implementation and evaluation.

The Treaty has been interpreted in various ways in multiple policy documents. Three general principles are often referred to in terms of the spirit of the Treaty (Ministry of Health, 2007). These are partnership (Māori and Pākehā working alongside each other), protection (protection of Māori knowledges and taonga) and participation (Māori rights to participation in endeavours that impact on them).

The articles of the Treaty outlined above recognise and give a context for the development of Kaupapa Māori mental health services while also affirming Māori rights of tino rangatiratanga (autonomy) in being able to develop these services that legitimise Māori processes, knowledge and practices in health. The imbalance of power in Aotearoa, New Zealand caused by colonisation and breaches of The Treaty has meant that Māori continue to struggle against the government and the Crown for recognition of the rights affirmed in The Treaty of Waitangi.

## **Māori identity.**

Within the scope of responsive services for Māori affirmed in the Treaty is consideration for the complexity of Māori identity within the current context of te ao hurihuri, the ever changing modern world. Durie (1995; 2001; 2003) has written extensively about the need to have a broad and inclusive construction of Māori identity which recognises different expressions of Māori identity and the diverse realities that Māori now live in. Identity is considered important to Māori as it provides a sense of knowing, belonging and collective wellbeing. The strong sense of identity of tūpuna is underpinned by knowledge of whakapapa, relationship with the land and natural environment and understanding one's whānau history, kōrero tuku iho, tikanga and te reo Māori.

*“In the infinite yet very human wisdom of the tūpuna our people learned that insight and wellness both derived from the certainty of knowing who we were” (Jackson, 2011, p.2).*

Within Māori contexts, Māori use their pepeha to describe important landmarks to provide a reference point and source for their identity. Whakapapa or geneology defines a person's connections to land, ancestors in both a physical and spiritual sense. Knowledge of these aspects of Māoritanga as well as having strong connections to places named in pepeha is regarded as a highly desirable goal for Māori. However, in many situations Māori culture may not always be immediately accessible to Māori due to geographical barriers but also because of a loss of knowledge and connection to tūrangawaewae as a result of dislocation from traditional hapū and iwi during urbanisation, colonisation and assimilation practices and processes which denigrated the Māori language and culture (Jackson, 2011).

Many researchers have argued that a strong sense of identity is vital for psychological wellbeing for Māori (Durie, 2001, 2006b; Lawson-Te Aho & Liu, Moeke-Pickering, 1996; Quince, 2007; Tapsell, 2007; Te Puni Kōkiri, 2010). However, while identity provides the foundation for positive development, additional factors such as whanaungatanga (supportive family relationships) and environments that reflect cultural values and beliefs are needed to ensure ongoing wellbeing. Recent research by Le Grice (2014) illustrates the positive effects of the relational aspects of whānaungatanga such as the practice of aroha, manaakitanga and importance of attending to wairua, which

supported and encouraged Māori childbearing decisions in the face of various pressures from the influences of colonisation and dominant Western practices around beliefs about childrearing.

In mainstream New Zealand society however Māori identity is often positioned and defined as being associated with negative health outcomes, economic poverty and criminality amongst other things (Te Rōpū Whāriki, 2014). In contrast, Pākehā (European New Zealanders) as a group are shown as the norm, the media rarely refer to Pākehā by ethnicity and Pākehā ethnicity is typically not identified for criminal behaviour or other issues where there is a vested interest, for example “Pākehā MPs, or police are seeking a Pākehā man” (Te Rōpū Whāriki, 2014, p.2). Anti-Māori themes are regularly portrayed in the mainstream news media which serves perpetuate negative stereotypes about Māori within New Zealand society and normalise these negative connotations. In response to this deficit approach, there has been a critical analysis of the reporting of Māori in the media in a project called Kupu Taea: Media and Te Tiriti (Te Rōpū Whāriki, 2014). There has been strong encouragement for government and researchers to present statistics that show the diversity of Māori identity and as well as statistics that are useful for Māori wellbeing and aspirations (Cram, 2014; Kukutai, 2014).

In line with understanding the diversity of Māori identity, international indigenous research suggests that urban areas are now starting to be considered as “spaces of Indigenous resilience and cultural innovation” (Peters & Anderson, 2013, p. 2). Research on rangatahi (youth) living in the city reported that Māori youth had a strong sense of connection to the area in the city that they grew up in and established support networks with others in their community alongside pride in being Māori (Borrell, 2005). This piece of research challenged discourses of urban Māori youth identities as being inauthentic or less legitimate. Similar to other indigenous urban based groups, Māori living in the city demonstrate resistance against the pressures of assimilation and demonstrate the capacity to create new ways of being Māori in their environment (Peters & Anderson, 2013).

There is a strong argument for the benefits of having a secure Māori identity alongside supportive whanaungatanga networks and practices that enhance wellbeing. It is critical that mental health services provide access to opportunities to enable Māori to “live

as Māori” by exploring the meanings of this for Māori in today’s world and offering relevant and engaging strategies that will enable this to happen (Durie, 2003).

## **Māori Approaches to Mental Health**

Kaupapa Māori health services were established to address the need for Māori centred services that were aligned with Māori values and beliefs. The practices of Kaupapa Māori mental health services are informed by tikanga Māori (Milne, 2001). Services also incorporate traditional and contemporary Māori concepts of health. Te Whare Tapa Whā (Durie 1995), and Te Wheke (Pere, 1991) are two prominent models that were developed that continue to be widely used in health settings today (Ministry of Health, 2014). Other models of health are also presented below. These models espouse a holistic view of health and wellbeing which promotes the alignment of physical, mental, familial as well as spiritual aspects of health.

Te Whare Tapa Whā was developed by Mason Durie (1995). Te Whare Tapa Whā model is based on the philosophy that wellbeing is achieved by the positive alignment of taha hinengaro (mental wellbeing), taha tinana (physical wellbeing), taha whānau (familial relationships and connections) and taha wairua (spiritual wellbeing) (Durie, 1995). This therapy involves strengthening domains that are causing distress for a person. Positive whānau relationships and connection to identity are considered pivotal in Te Whare Tapa Whā (Durie, 2011). A recent study of Māori youth reported that family connection was associated with fewer suicide attempts and that family connection played a significant role in reducing risk of suicide if Māori youth perceive their families to be caring and supportive (Clarke et al., 2011). In addition, research found that programmes aimed at parents that enhance Māori families’ knowledge through whānau transformation processes, positive whānau development, and enhance mana (prestige and integrity) are more likely to actively engage Māori families (Eruera & Ruwhiu, 2014; Herbert, 2001).

Te Wheke developed by Rangimarie Rose Pere (1991) is a similar model to Te Whare Tapa Whā which uses the symbol of a wheke (octopus). The eight arms of the octopus are interconnected and function together. Each arm represents an important aspect of health and wellbeing: mana ake (uniqueness of an individual), mauri (life principle or essence), te hā a koro mā a kui mā (the breath of life from ones ancestors), whatumanawa (emotional

development and expression), wairuatanga (spiritual practises), whanauangatanga (both genders from each generation working together, hinengaro (mind sources of thoughts) and waiora (total wellbeing) represents the eyes of the octopus . The suckers on each arm represent the many facets of each of the domains of health.

The Meihana Model further extended Te Whare Tapa Whā by adding additional features of Māori beliefs and values to use in clinical assessments with Māori (Pitama et al., 2007). This model encourages clinicians to consider how the individual is placed within their whānau context and also consider the key values and beliefs their whānau practise. It also encourages clinicians to broaden their focus and to reflect on areas of incongruence between values and behaviours when an individual is unwell. The Meihana model provides a set of questions that aim to explore nuances associated with being Māori that all clinicians need to consider when working with a diverse range of Māori clients.

The framework of Mauri Ora, he kaupapa hiki i te ora o te Māori, provides a philosophy based on mātauranga Māori, traditional concepts and understandings of the components of Māori wellbeing (Mataira, 2011). The model is derived from the understanding that wellness was, and still is, about understanding the past in order to inform our future. This is captured in the whakataukī, “titiro ki te papa, titiro ki te kākano” (look to the ground; look at the seed) (Jackson, 2011; p3). History makes us who we are and traditional Mātauranga Māori provides guidance for moving forward. The Mauri Ora framework encourages every person to find a pathway to improve their wellbeing based on incorporating practises into everyday life to improve health and wellbeing.

Guidelines and practises are provided for improving oranga wairua (spiritual health). The origins and āhua (characteristics) of wairua (the spirit) and how they are expressed through various emotions, abilities, capacities of the body and behaviour are described for example mauri (life force/essence), mana (spiritual power), tapu (sacredness), ihi (psychic force/essential force), wehi (a response of awe). A person is imbued with tapu and mana from birth. Te iho matua links a person to their tūpuna (ancestors) and to the creator, other aspects of wairua include whatumanawa (seat of emotions), ngākau (heart), puna waihanga (creativity centre) and pūmanawa (unique abilities). Further health practices also outlined for oranga wairua (spiritual health), oranga tinana (physical health), oranga taiao



(environmental health), oranga whānau (family and social health). Indicators of good health are also delineated and the interaction between a person's spirit, their physical body, their whānau and environment are linked together. In this model it is emphasised that people receive important guidance about their wellbeing through their connection to te ao wairua (Mataira, 2011). Raising one's level of ihi rangaranga (energy or vibration) through activities that enhance oranga wairua, tinana, taiao and whānau can contribute to better connection to te ao wairua (the spiritual realm). However, actions and behaviours can interfere with this, such as alcohol, drug use and behaviours that hurt others. Tūpuna and kaitiaki (guides) can also be called on to assist with challenges and as a source of strength when needed. Similarly, karakia (incantion or prayer) strengthen people in a particular task, activity or to purpose.

**Importance of Tamariki.** Similar to the more recent Māori health models above, mātauranga Māori models based on traditional Māori epistemology provide an understanding of Māori and child development and wellbeing. According to traditional mātauranga Māori, human development incorporates an understanding of both physical and spiritual development (Mataira, 2011; Nepe, 1991; Pihama, 1993; Salmon, 1985). Traditionally when children were born their whenua (placenta) was buried in the whenua (earth) to keep connection to a particular place of significance (Yates-Smith, 1998). Following birth special ceremonies such as maioha, tohi or tūā were held (Mead, 2003). Oriori, or traditional songs, often referred to as lullabies were composed for children that contained complex and rich descriptions of the child's geneology, familial links and their tūrangawaewae to ensure children had an understanding of who they were and where they came from (Mataira, 2011; Mead, 2003).

Accounts from early European observations of how Māori children were socialised state "...[the] freedom given to children, made them bold, brave and independent in thought and act ... curbing the will of the child by harsh means was thought to tame his spirit, and to check the free development of his natural bravery" (Jenkins & Harte, 2011, p. 22). Children were regarded as tapu and therefore were not physically hit; this ensured they had confidence in themselves and that their abilities developed (Jenkins & Harte, 2011; Taonui, 2010).

Many whakataukī (proverbs) are based on the importance of children within the context of their whānau (Le Grice, 2014). Whakataukī, similar to the title of this thesis, *he kākano ahau i ruia mai i Rangīātea* and others still used currently illustrate the continued valued place of tamariki (children) in whānau (Nepe, 1991).

**Rangatahi development models.** Rangatahi or taiohitanga (youth) Māori models draw on pūrakau, (oral traditions) of Maui, an ancestor hero, as a tool for analysis and reference point for the implementation of youth development initiatives (Keelan, 2014). Maui stories are considered useful and relevant for youth today and they provide guidance of what to do and what not to do. Maui is an ancestor hero that is used to illustrate important lessons from an indigenous world view of youth development.

*“[Maui] was a change agent; he sought to make a difference and set about doing so. He never took no for an answer. He planned, took stock of and used his resources, created and invented when he needed to, and always looked outside the square. Whānau were important to him even though they did not know how to interact with him, and subsequently he was ruthless where they were concerned. He was both admirable and despicable, and we can learn from either quality... Māui is known to most New Zealanders, Māori and non-Māori alike, and he can be found in many of the stories of other Pacific nations. (Keelan, 2014, p. v).*

Pūrakau, such as these provide strong guidelines for the development of youth while also acknowledging their agency, unique abilities and the value of their roles/place within whānau, peer and community contexts. Relationships and environments that provide support and enhance cultural knowledge are valued by Māori youth (Simmonds, Harre & Crengle, 2014).

**Current issues for Rangatahi (Māori Youth).** A recent survey undertaken for The Māori Plan for Tāmaki Makaurau by the Independent Māori Statutory Board interviewed rangatahi to gain an understanding of pertinent issues for youth growing up in Auckland. The following graph provides a summary of their responses.

### **What do you think concerns youth growing up in Auckland?**

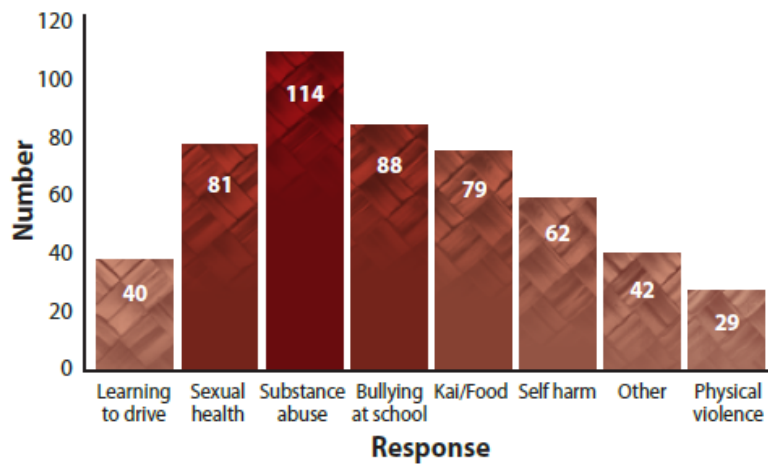


Figure1. Graph showing rangatahi response numbers for concerns of Māori Youth growing up in Auckland

Some of the key findings from the survey were that many of the rangatahi surveyed (67%) said that substance abuse, including cigarettes, alcohol and drugs, had a major impact for them in their communities. Rangatahi were particularly concerned at the ease of obtaining drugs and alcohol and wanted to limit/restrict pathways to accessing alcohol. Greater visibility of Māori identity and culture were identified as key aspirations. This included more te reo Māori signage, kapa haka and Māori art and imagery that celebrates Māori uniqueness and identity. Many rangatahi saw sport as a means to express their Māori identity. Increasing the ability to access kaupapa Māori education services and health facilities and working to further develop these services was considered important by rangatahi (Independent Māori Statutory Board, 2014).

Other research on current influences for rangatahi indicates high levels of rangatahi engagement with technology, the internet and social media (O'Carroll, 2014). Given access to services is difficult for many youth, there is potential to use the internet and social media to increase knowledge about mental wellbeing as well as providing information regarding access to services to assist youth who may be facing challenges. In addition, the internet and social media may be useful mechanism for government and services to improve accessibility and engagement with youth. This is an area that warrants further exploration.

In summary, the contextual factors pertinent to Māori mental health provide a background to understand the every-day impacts of colonisation on Māori. Māori approaches to addressing mental health disparities including Māori models of health, and broad models of tamariki (child) and rangatahi (youth) development give an overview of solutions and aspirations for Māori health, though there is limited documented literature on the application of these models and tikanga practices of Kaupapa Māori mental health services. Although engagement is highlighted as essential for positive health outcomes, there is a gap in the current literature on the processes of engagement within child and adolescent mental health services for Māori.

## **Engagement in Therapy**

**Understanding engagement from a Western perspective.** According to the international Western literature engagement is a broad construct which consists of behavioural engagement and attitudinal engagement (Staudt, 2007). The behavioural dimension of engagement is typically measured by attendance, retention and attrition rates. Effective behavioural engagement ultimately leads to ongoing active participation in services and interventions. According to the engagement model for child and adolescent mental health services (CAMHS) proposed by Staudt (2007) and further adapted by Haine-Schlagel and Walsh (2015) there are three levels of behavioural engagement: the first is help seeking initiation, including seeking out CAMHS. The second level is attendance at CAMHS. The third level in the process of behavioural engagement is active meaningful participation by the young person and parents in the intervention. While behavioural engagement is typically and easily measured by attendance (and retention rates and disengagement measured by attrition) it has been more difficult for empirical studies to measure familial (young person/parent) participation. Understanding the various factors that contribute to meaningful participation in CAMHS has been identified as an area that requires more attention in the research (Haine-Schlagel & Walsh, 2015). This is also an area of interest for Māori engagement in CAMHS.

The other core dimension of engagement is attitudinal engagement, which relates to the client's cognitions and perceptions regarding the relevance and acceptability of a service or intervention and the extent to which they expect to benefit from it. Several models are relevant to considerations of attitudinal engagement including the health beliefs model

(Rosenstock, 1966; Spoth & Redmond, 1995), the theory of reasoned action behaviour (Ajzen & Fishbein, 1975), expectancies (Morrissey-Kane & Prinz, 1999; Nock & Kazdin, 2001) and self-efficacy model (Bandura, 1977). According to these models, family members' beliefs, attitudes and expectancies about the treatment intervention process, about the practitioner, about the setting and about expectation of outcomes of the intervention, affect their level of engagement. When families have positive perceptions about the service and intervention they are more likely to engage. For example, if they perceive there to be a strong need for treatment, if they expect that participation will result in positive outcomes, and if they have high self-efficacy or confidence in their ability to make changes in their lives, then they are more likely to engage. Conversely, the theories propose that if families do not have positive perceptions of services or intervention, if they do not believe the service is relevant to their needs, and they have low self-efficacy, then they are less likely to engage. If they do attend and their goals and expectations about the intervention are different to the practitioner's objectives, or if their expectations are not fulfilled, families may disengage and drop out of the service prematurely (Morrissey-Kane & Prinz, 1999). These cognitions and attitudinal components of engagement are less often measured in studies on engagement with CAMHS despite the fact that theories of engagement and behaviour change suggest that cognitions influence behaviour (Staut, 2007).

Kemp, Marcenko, Lyons and Kruzich(2014) suggest that attitudinal engagement focuses on both the extent to which clients invest in treatment (motivation) as well as the perceived benefit of treatment. The combination of investment and positive expectation has been referred to as "buy-in" (Kemp et al., 2013; Yatchmenoff, 2005). According to Staut (2007) buy-in is at the "heart of engagement" (p. 189) which is seen to be a necessary pre-requisite for active sustained behavioural engagement in services and thus meaningful change. Buy-in also acknowledges the young person and family's contribution to the process of engagement, including the importance of recognising that efforts to improve engagement must be in line with families' needs, goals and aspirations so that services are not perceived as being coercive or intrusive. Buy in is considered essential to both assessment of needs as well as enhancing ongoing support for families (Yatchmenoff, 2005).

Also relevant to attitudinal engagement is the concept of motivation. The transtheoretical model of motivation (Miller & Rollnick, 2002; Prochaska & Velicer, 1997)

proposes that individuals and or families are at different stages of readiness to change and that enhancing intrinsic motivation assists individuals within the family to engage in changing behaviours. Motivation derives from family members' unique values, reasons for wanting to change and self-efficacy.

**Factors that influence engagement.** Staut (2007) has proposed a framework for engagement in child and family mental health treatment which includes five key elements, each of which has influence on the level of engagement in treatment: treatment relevance and acceptability; cognitions and beliefs about treatment; daily stresses; external barriers to treatment; and the therapeutic alliance. Familial characteristics associated with engagement are the most commonly studied and there is comparatively less attention paid to practitioner, intervention type and service level characteristics associated with engagement. The effect of this, implicitly at least, is to give the impression that responsibility of engagement is located primarily within families rather than service providers.

Studies that have been conducted with the focus on service provision rather than family characteristics, show that a number of factors contribute to family engagement (see Kim, Munson, & McKay, 2012) including practitioner background and experience ( level of experience and training, cultural competence and case load), intervention structure (frequency and duration of sessions), intervention content (skills and strategies provided), supervisory support, stability of service funding, low practitioner turnover and location in a low resource community. The impact of modifying and testing engagement interventions for systems level factors has not yet been developed (Haine-Schlagel & Walsh, 2015; Ingoldsby, 2010).

The social-ecological framework for engagement proposed by Bronfenbrenner (1986) is based on an understanding that families are embedded in interdependent social and environmental contexts. This model highlights the importance of addressing the broader ecological context and factors that may interfere with parents' wellbeing and ability to engage in needed services. Thus the practitioner's choice of intervention/service type is critical to outcomes. Evidence based interventions are unlikely to benefit disadvantaged children and families if they do not address the barriers in the ecological context. Those who are socio-economically disadvantaged, experiencing stressors such as family conflict, sole

parenting, parental mental health and psychopathology and associated distress, are the least likely to engage in therapy. Economic, social and racial marginalisation can complicate the practitioner. Each level in the ecological system (culture, community, family) has potential to facilitate or impede engagement with needed services, and barriers encountered by families at each level have an impact on their ability to seek help, attend and actively participate in mental health services for children and adolescents.

In addition, families from marginalised populations such as urban ethnic minorities and indigenous cultures have lower rates of engagement in mainstream services than mainstream cultural groups. According to international research families from ethnic minority cultures and other marginalised populations commonly report that difficulties with engagement arise from different cultural values, language barriers, and mistrust of services, fear of losing autonomy and a shortage of practitioners from similar cultural backgrounds (Stern et al., 2014).

Similarly, New Zealand based research has consistently reported that health practitioners and services often have an ethnocentric approach towards Māori (Crengle, 2007; Harris et al., 2006; Johnstone & Read, 2000; Lawson-Te Aho, 2002; Penney, Moewaka-Barnes, & McCreanor, 2011). Māori are underrepresented across almost all health professions, particularly in frontline clinical roles (Curtis et al., 2015; Ministry of Health, 2011). Māori make up around 15% of the New Zealand population (Statistics New Zealand, 2013), however, in 2010 only 4% of registered psychologists in New Zealand were of Māori descent (Ministry of Health, 2011). Furthermore, Māori health beliefs and values are often not reflected in health services (Cram, Smith & Johnstone, 2003).

There is a large body of literature supporting the critical influence of the therapeutic alliance on child, adolescent and family engagement, participation and retention (Elvins & Green, 2008; Bickman et al., 2012). Families are more likely to remain engaged in interventions when they develop a strong bond with the practitioner and a collaborative relationship in developing remaining tasks and goals for treatment (Thompson et al., 2007). Some therapeutic models such as cognitive behavioural therapy (CBT) have traditionally placed less emphasis on the therapeutic relationship, though importance is acknowledged. Duncan et al. (2004) argue that there has been far too much preoccupation with the

therapeutic technique or pill, whereas the primary focus needs to be on establishing and maintaining the therapeutic alliance as it is the factor we have the greatest influence on. Despite the consistent finding that the therapeutic alliance is critical for effective outcomes in mental health, Drury and Munro (2008) contend it is too frequently relegated to a secondary role or ignored in research and policies regarding practice due to the emphasis on standardisation of manualised treatment.

According to Bright, Kayes, Worrall and McPherson (2014) engagement appears to be conceptualised in two inter-connected ways: as a gradual process of connection between the practitioner and client; and as an internal state, which may be accompanied by observable behaviours indicating engagement. While engagement is commonly considered a patient or client behaviour, the review findings suggest practitioners/clinicians play a pivotal role in client engagement (Bright et al., 2014). Conceptualising engagement as a co-constructed process may help clinicians be more aware of their role in family engagement, so that the responsibility to engage shifts from the client to the therapeutic dyad (Bright et al., 2014). Challenges in engagement may be a prompt for the practitioner/clinician to reflect on how she/he is working and whether different ways of working may be beneficial.

**Strategies for enhancing engagement.** Intensive engagement strategies that address barriers at the start of treatment enhance levels of attendance during initial stages of engagement (Becker et al., 2015; Lindsey et al., 2013). Addressing practical and perceptual barriers, also termed accessibility promotion, has been identified in reviews of randomised-control as the most common component of effective engagement interventions. Practical barriers to engagement include lack of transportation, child care difficulties, financial concerns and scheduling. The Enhanced Engagement Phone Intake (EEPI) approach was a contextually responsive strategy used during initial intake call to engage multi-stressed families seeking CAMHS at an urban based setting (Stern et al., 2014). This intervention addressed interpersonal and practical barriers during the initial phone intake and showed increased rates of attendance at initial face to face appointments. McKay and colleagues (McKay et al. 1996a; 1996b; McKay & Bannon, 2004) developed a similar strategy to strengthen the therapeutic alliance and reduce barriers to engagement for low income innercity families during initial contact with services. These early engagement



interventions showed greater rates of initial engagement as they made services convenient, accessible and user-friendly in order to proactively encourage and increase participation.

In a recent review conducted by Lindsey and colleagues (2013) psychoeducation was another common element associated with effective engagement interventions, where families concerns were carefully addressed, information given on potential benefits of the services, and the roles of the practitioner and client in therapy discussed. Instilling hope and emphasising positive expectancies were also key components of successful engagement strategies (Becker et al., 2013). Underpinning these elements of interventions is the clinician's knowledge and skill in fostering a meaningful relationship and facilitating a responsive engagement process.

Family systems factors have also been suggested to influence engagement. Family communication and interaction patterns and lack of support for involvement in CAMHS from some family members have predicted lower engagement in family therapy (Perrino et al., 2001). The Strategic Structural-Systems Engagement (SSSE) intervention is an intensive approach based on brief Family Systems Therapy (Santisteban et al., 1996; Szapocznik et al., 1988). Some of the methods included identifying resistance within the family prior to the first session, then during the first face to face session joining with the family system to understand their concerns and values, facilitating trust in the practitioner's abilities to address family problems, and negotiating and reframing problems to instil hope. This engagement intervention showed improvement in families' rates of completion of programmes (Coatsworth et al., 2001; Ingoldsby, 2010; Santisteban et al., 1996; Szapocznik et al., 1988).

Engagement strategies that are based on the principles of Motivational Interviewing (MI) have shown effectiveness for engaging families as they address barriers throughout the treatment intervention process. These engagement approaches have been integrated into family based intervention programmes and addressed motivations, expectation and needs for interventions. MI practitioners communicated empathy, avoided confrontations or arguments, highlighted discrepancies between present behaviour and desired outcomes, elicited self-motivational statements and collaborative behavioural plans which were

hypothesised to decrease resistance and strengthen commitment to the intervention (Miller & Rollnick, 2002; Nock & Kazdin, 2005).

Another brief engagement approach based on Participation Enhancement Intervention (PEI) was integrated into a parenting programme for child conduct difficulties (Stern et al. 2014). PEI involved three components including psycho-education about the importance of engagement, eliciting self-motivational statements from parents about participating in the programme, and collaboratively addressing engagement barriers that impede attendance, such as lack of social support and perceptions that the programme was too difficult. These three components were delivered in 5-10 minute doses at three different time points during the programme. Parents who were given the PEI reported higher rates of motivation and greater rates of engagement compared to controls (Stern et al. 2014). These MI based studies demonstrated success in improving levels of family engagement and retention in interventions, particularly the PEI that aimed to motivation and engagement throughout the course of therapy.

In contrast, simple measures such as phone reminders for appointment and providing extrinsic awards to increase engagement in CAMHS have mixed or no evidence of effectiveness for increasing family engagement (Ingoldsby, 2010). Offering monetary incentives increased families' initial interest and enrolment but had no impact on later attendance or programme completion (Guyl et al., 2003; Fleischman, 1979).

Strengths based practice has been proposed to enhance family buy in and receptivity to intervention. A small but growing body of literature links strengths based interventions to improved levels of child and parental, motivation, investment and confidence that involvement with services will lead to positive change (Kemp et al., 2014). Green, McAllister & Tarte (2004) identified three pathways by which strength-base practices enhance success of programme outcomes: by influencing engagement in service, by increasing family efficacy and empowerment, and by enhancing families' relational and supportive networks. Qualitative research of the strengths based intervention indicated that parents felt empowered, were treated with respect and made to feel capable. Further to this, parents scored highly on a measure of empowerment which was positively related to the practitioner's score for parental engagement and self-reported frequency of service use

(Green et al., 2004). In a similar vein, others have identified the importance of naming the parents' capabilities and skills, and bolstering self-esteem and sense of efficacy during the initial stages of establishing the therapeutic relationship (Sain-Jacques, Drapeasu, Lessard, & Beaudoin, 2006). Parents have been found to have positive perceptions of practitioners who had a strengths-based collaborative approach (Martin, Barbee, Antle, Sar & Hanna, 2002).

Kemp et al. (2013) examined the impact of a strengths based practice on parental engagement in the child welfare setting. In child welfare settings there are significant challenges with engagement and parental buy-in due to mandated treatment, the stigmatising nature of involvement with child welfare services, and the frequent negative interactions between parents and practitioners due to mistrust of services; all of which are exacerbated by the forensic nature of risk-focused investigations of parents to identify child safety risks (Kemp et al., 2013). In their study, level of engagement and buy in was examined against parental perceptions of the practitioner's use of strengths based approaches. Parents were asked to give ratings on the following questions to ascertain their perceptions on the use of strengths-based practice; the extent to which the practitioner: was strongly interested in learning about them and their family, asked about things they did well, thought they had more problems than strengths, asked them about their strength as a parent, and only focused on their problems. Findings of the study indicated that strengths based practice significantly increased parents buy in, willingness to engage with practitioners and services and provided empirical support for the importance of interventions that are responsive and capacity focused (Kemp et al., 2013).

In summary, literature reviewed above outlines engagement interventions and strategies developed from within Western constructs of engagement. There is evidence of the effectiveness of various engagement approaches, however, it is not known if these strategies are relevant or applicable to indigenous populations, particularly Māori.

**Engagement from a Māori perspective.** Māori philosophies that are culturally and contextually responsive to Māori provide the basis for an inclusive approach to engagement with whānau. The centrality of whānau and building strong relationships within Māori models of health also translate into practices in psychology, mental health services/

organisations and interventions. Whanaungatanga (family connectedness) is seen as fundamental Māori social behaviour (Chadwick, 2001; Pihama et al., 2003, Tate, 2010). It is also one of the underlying principles of therapeutic intervention with Māori in mental health settings. Whanaungatanga is also a core value within the Counties Manukau DHB where the current study is based, which prioritises the importance of promoting activities that enhance and strengthen whānau participation in healthcare and encourages practitioners to make appropriate links and relationships in order to enhance participation (Counties Manukau DHB, 2011).

Whakawhāungatanga, the act of building relationships and making connections has been promoted in Māori centred approaches to therapy such as Paiheretia (Durie, 2003) and emphasised as a core skill/practice to build and inform psychological assessment (Durie, Macfarlane, Blampied & Macfarlane, 2011; Manna, 2002; Palmer, 2005; Pitama, Huria & Lacey, 2014; Pitama et al., 2007; Waitoki, 2012). Whakawhāungatanga is identified as crucial for building therapeutic relationships with tangata whaiora (clients) and whānau and as key to Māori engagement with therapy for a range of mental health difficulties including depression (Bennett, 2009), psychosis (Taitimu, 2007), acute crisis (Eade, 2014; Wharewera-Mika, 2012), whānau violence (Cooper, 2012), child traumatic brain injury (Elder, 2012; 2013) and trauma (Wirihana, 2014). Whānau attending CAMHS also present with a range of complex difficulties. Given the complex nature of these issues and difficulties of dealing with these for whānau, taking time to build meaningful relationships via whakawhāungatanga provides the foundation to facilitate engagement with whānau. Whakawhāungatanga is also the natural way for Māori to engage with each other in any other every-day interactions (Durie, 1997; 2003).

Whakawhāungatanga is also distinctly Māori process involving reciprocal interaction where both the clinician and whānau share information, including judicious self-disclosure by the clinician. Lacey and colleagues (2011) noted that self-disclosure may be particularly challenging for established clinicians who have been taught not to disclose information in order to maintain professional boundaries. However, identifying appropriate information to share enables clinicians to facilitate a rapport while maintaining safe boundaries. Bennett and colleagues (2014) found that CBT therapist's disclosure of tribal

affiliation, working history and family background was crucial for engagement with Māori in a culturally adapted CBT programme.

Along with whakawhanaungatanga, the traditional formal process of engagement for Māori is the pōwhiri (welcoming ceremony). Processes such as the pōwhiri are often utilised as an encounter for healing and achieving balance. Durie (2003) talks about the pōwhiri process as an encounter to “reduce space and distance between two groups and explore the basis of relationships. Two goals – sometimes contradictory – is to create a sense of cohesion between groups and to affirm the different identities of those represented” (pp.53-54). An important concept related to identity and pōwhiri is Turangawaewae (home base), which relates to the whenua (land) and rohe (area) from which a particular group comes from. As tikanga across different areas could vary, it was important for the hosts or locals of an area to protect their tikanga and educate other groups about expected standards of behaviour.

Although culture is recognised as being central to psychological assessment, Mcfarlane et al., (2011) argue that there has not been given much guidance as to the extent tikanga or processes should be utilised in assessment, particularly in regards to the appropriateness to the context and level of formality and integrity of the particular methods used. The ability to delineate culturally appropriate and responsive methods of engagement during the assessment and further interactions requires cultural competency, understanding and knowledge of Māori interactive cultural nuances and subtleties in behaviour to avoid making erroneous assumptions (Durie, 2007; Hirini, 1997; Mcfarlane et al., 2011).

While there have been some positive developments in terms of incorporating Māori worldviews in to the practice of psychology, according to Mcfarlane and colleagues (2011) there is still a “lingering lack of understanding of a Māori worldview on the part of many professionals” (p. 10). Concern regarding cultural competency was also identified by Waitoki (2012) as a matter that required urgent attention in clinical psychology. Given that psychology is heavily dominated by Western models that are laden with the dominant culture’s values, it is argued that psychologists and other practitioners continue to develop knowledge of Māori worldviews and philosophies to gain understanding of culturally congruent therapeutic processes and practices for Māori. Cultural self-assessment has been

suggested as a useful starting point for practitioners to ascertain gaps in knowledge, skills and awareness (Mcfarlane et al., 2011). Furthermore, working alongside Māori Cultural Advisors, Kaumātua and Kuia is a way for psychologists and other mental health practitioners to continue enhance their clinical competencies and to inform the processes, practices and the comprehensive care plans for tangata whaiora (Mental Health Commission, 2004).

**Māori cultural knowledge.** Mātauranga Māori and tikanga consist of many methods of traditional healing and coping skills using various treatment modalities. Māori practices that facilitate healing in trauma were outlined by Wirihana and Smith (2014) to assist with psychological trauma, grief and loss. Methods of healing such as waiata (singing/songs), mōteatea (traditional songs), haka, whakanoa and whanaungatanga are used within Māori communities as Māori (normalised) practices to assist with easing distress and enhancing wellbeing. Māori have high rates of emotional expression that often more evident physically rather than verbally (Matthews, 2004; Wirihana & Smith, 2014). This is illustrated by high levels of emotional expression during tangihanga (funeral ceremonies) where there is acceptance and support for the expression of remorse through tears and tangi (wailing) and the encouragement of the flow of hupe and roimata (Durie, 1985; Nikora et al., 2010).

A high level of engagement is seen across age groups with kapa haka (Māori traditional dance) and music, from kōhungahunga (early childhood) to tamariki (children), rangatahi (youth), mātua (adults), Koroua and Kuia (elders). Performing arts, music, waiata (singing) and pūoro (traditional Māori musical instruments) have therapeutic value for Māori in times of distress, sadness, anger, grief but also provide enjoyment, entertainment and pleasure leading to increased wellbeing (Melbourne & Nunns, 1994; Sheehan, 2014; Wirihana & Smith, 2014). Also, it demonstrates the use of kapa haka as a form of self-expression, to reclaim tribal or hapū (sub-tribe) identities, mātauranga Māori and to make political statements. In addition, kapa haka and musical practices allow and encourage the expression of ihi (essential force), wehi (a response of awe in reaction to ihi) and wana (inspiring awe) which are considered routes and forms of healthy emotional expression (Paenga, 2008).

In addition to skills, the inclusion of wairuatanga or spirituality in psychological therapies is central to Māori conceptions of wellbeing. Research on psychosis demonstrated that Māori who used wairuatanga to make sense of their experiences had lower levels of distress compared to others (Taitimu, 2007). Elder (2013) found that whānau saw wairuatanga as being more important than other aspects of wellbeing for understanding traumatic brain injury. Wairua has often been referred to as difficult to define, however, processes and practices that appropriately attend to and support Māori understandings of wairua may be beneficial for Māori experiencing mental health difficulties.

Understanding and promoting whānau engagement is important for several reasons. Firstly, there is a consensus amongst policy makers (Ministry of Health, 2012, Te Rau Matatini, 2011), researchers (Clark et al., 2014; Durie, 2003; McClintock, 2013) and services/organisations (Counties Manukau DHB, 2011) that whānau (young person, parent and wider family) engagement is essential for treatment effectiveness. Further to this, evidence based treatments for children across many disorders require effective engagement approaches to be successful (Dowell & Ogles, 2010). In essence, effective whānau engagement approaches assist with improvements in the quality of care and better outcomes in mental health for tamariki (children), rangatahi (adolescents) and their whānau (families).

## **Summary**

This literature review presents a synthesis of research on Māori mental health and engagement for Māori in CAMHS. Relevant international research was reviewed outlining Western theoretical engagement frameworks. Difficulties with engagement and variables that contribute to the complexity of engagement were discussed and linked with effective engagement approaches in CAMHS. The research was then contextualised with literature outlining fundamental components of culturally responsive mental health practices and interventions for Māori. Together this section of the literature review combines and presents key considerations for engagement with Māori in CAMHS.

While there is some evidence in the literature of the key components of effective engagement strategies, the relevance of these for Māori children, adolescents and their whānau in CAMHS has not been established.

## **CHAPTER TWO: METHODOLOGY**

### **Overview**

The first aim of this study was to capture Māori perceptions of engagement with CAMHS. The second was to elucidate effective engagement strategies and practices utilised by He Kākano. The final aim was to present an analysis of these perspectives of engagement in order to contribute to knowledge and understanding factors that facilitate or inhibit engagement with Māori in CAMHS and offer recommendations on how to best align services and clinical practices with needs of Māori. More generally, the study aimed to gain a more detailed understanding of the needs of Māori with regard to CAMHS.

Taking into consideration the historical and current contexts of Māori in New Zealand, the study sought to address the aims by gathering, documenting and attempting to understand the experiences and perceptions of rangatahi (youth) and whānau members (family members) who had engaged with He Kākano, a Kaupapa Māori CAMHS team based at Whirinaki at the Counties Manukau District Health Board (CMDHB). The perspectives of He Kākano kaimahi (staff) team members were also gathered.

This chapter outlines the methodological framework for this study which informed the approaches taken and how the research was carried out. This study was based within a Kaupapa Māori research framework, utilising qualitative research approaches.

### **Kaupapa Māori Methodological Framework**

In practice, Kaupapa Māori research has been described as operating from a Māori-centred philosophical base which includes the critique of research processes with/for Māori (Pipi et al., 2004; L. T. Smith, 1999). It is an approach that "... accords full recognition of Māori cultural norms, value systems and practices, providing cultural legitimisation of both the processes and outcomes of research (Smith L. T., 1999). Kaupapa Māori research, both related theory and methods, grew out of an increasing desire among Māori for tino rangatiratanga, or self-determination, for the creation and legitimisation of knowledge about Māori.

Amongst Māori communities, there has been an historical mistrust of research due to past injustices committed by non-Māori researchers who have misrepresented Māori



experiences and had control over the legitimisation of research involving Māori (Bishop, 2005; L. T. Smith, 1999). Some challenges for Māori researchers have been to convince Māori of the value of research involving Māori, as well as advocating the validity of Māori knowledge and Māori input into research (L. T. Smith, 1999). Kaupapa Māori approaches to conducting research have been offered to assist Māori researchers to meet these challenges.

Kaupapa Māori research is often aligned with other frameworks or theories of a similar nature; such as critical theory (Pihama, 1993) and social constructivism (Eketone, 2008), feminist, and indigenous theories (Pipi et al., 2004). These theories have commonalities and similar concerns, including the displacement of oppressive knowledges and a social change agenda. Others note how strongly Kaupapa methodology aligns with other theories of emancipation and liberation proposed by internationally renowned authors such as Paulo Friere (Kiro, 2000; Mahuika, 2008; G. H. Smith, 2000).

However, Kaupapa Māori is contextually suited to Māori as it was developed by Māori for Māori. According to Moewaka Barnes (2000) what makes the approach distinctive is simply the fact that it “stems from a Māori worldview” (p. 9). In this regard it is inherently connected to Māori values and aspirations. Fundamental elements of Kaupapa Māori research include the following:

- It is related to ‘being Māori’;
- It is connected to Māori philosophy and principles;
- It takes for granted the validity and legitimacy of Māori, the importance of Māori language and culture; and
- It is concerned with the ‘struggle for autonomy over our own cultural wellbeing’.(G. H. Smith, cited in L. T. Smith, 1999, p. 185).

Kaupapa Māori research can be carried out through a variety of approaches; for example, surveys or other quantitative tools and qualitative approaches such as interviews (Cram, 2006; Cram, Smith & Johnstone, 2003; Jones, Ingham, Davies & Cram, 2010; Moewaka Barnes, 2000; Walker et al., 2006). Although there appears to be increasing interest in utilising a range of methods within the framework of Kaupapa Māori research, an examination of the literature reveals that qualitative approaches are utilised for the vast

majority of Kaupapa Māori research projects. This may be due to the desire to reduce power imbalances between the researcher and participants by increasing discussion and collaboration around the process of the interview (Cram, 2006), and/or to allow for greater depth of enquiry where there is limited published Māori knowledge (Cram, 2006). It also allows an exploration of success as research on deficits have already been extensively documented elsewhere (Irwin, 2011).

The use of qualitative forms of inquiry is generally considered appropriate when studying a process such as engagement because qualitative methods allow for detailed descriptions of the phenomena under study (Patton, 1990). According to Denzin and Lincoln (2000), “qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them” (p. 3).

Qualitative research enables rich data to be collected, and allows for thick, deep, dense, and detailed accounts of the participants' stories (Denzin & Lincoln, 2000). A qualitative approach is also more appropriate for research with Māori rangatahi and whānau members who have engaged with CAMHS, because qualitative research methods are fluid and flexible. In addition, it allows the researcher to understand the subjective experiences of vulnerable peoples, for example, youth who experience mental health difficulties (Liamputtong, 2007). Additionally, qualitative approaches can be appropriate where service features are not easily quantifiable, such as when services are innovative, where the focus is on understanding consumers' perceptions of the service, and where it is not practical or ethical to manipulate variables of interest (Patton, 1990).

There is a strong emphasis on the importance of the processes for engaging with Māori for research. Linda Smith's (1999) guidelines on engaging respectfully and ethically with Māori in research provide guidance for research. Suggested guiding principles for interactions with research participants, stakeholders and communities in Kaupapa Māori research are:

- Aroha ki te tangata (a respect for people; allowing people to define their space and meet on their terms),
- Kanohi kitea (the seen face; that is, understanding the importance of presenting yourself to people in person/face to face),

- Titiro, whakarongo, ... korero (observe, listen, develop understanding, and then talk),
- Manaaki ki te tangata (share and host people; be generous; take a collaborative approach and aspire to reciprocity).
- Kia tupato (be cautious; be politically astute and culturally safe; be reflexive about your insider/outsider status),
- Kaua e takahia te mana o te tangata (do not trample over the mana of people; engage fully and meaningfully when discussing ideas, informing people, and disseminating results), and
- Kia māhaki (be humble in your approach and attitude; do not flaunt your knowledge; also share your knowledge and use your qualifications to benefit the community) (L. T. Smith, 1999, p. 120, and expanded commentary in brackets discussed in Cram, 2001; Pipi et al., 2004).

These guidelines, along with fundamental tikanga processes such as whakawhanaungatanga were essential throughout the process of this research. Whakawhanaungatanga was particularly important with rangatahi and whānau participants as I was tauhou (a stranger) to them.

Also pertinent to this study is the concept of ‘insider’ research, an element commonly associated with Kaupapa Māori research. Although debate continues around involvement of non-Māori in such projects, Kaupapa Māori research is considered as ‘by Māori, for Māori’ (e.g., Cram et al., 2003; Jones et al., 2010). Within Kaupapa Māori research, a key concern related to involvement of ‘outsider’ researchers is the issue of control of the research. However, there is suggestion that outsider involvement is possible as long as positions of control for the research are clarified and the integrity of Māori research are maintained (Bishop, 2011).

In addition, insider researchers are likely to be sensitive to how research is gathered and interpreted which can be considered a safeguard for participants to ensure misinterpretation, misrepresentation and resulting marginalisation are minimised (Ormond, Cram & Carter, 2006). Furthermore, the insider position enables much deeper understanding of the existing dynamics, idiosyncrasies and significance of the various issues within the community being researched (Kiro, 2000; Walker et al., 2006). Critiques of insider

research include that the researcher may come from a position of bias and may be limited in their ability to take a critical approach or deal with challenging findings (Bishop, 2011; Smith, 1999). However, this does not mean that insider research is automatically flawed as a result. Instead, what is required is reflexivity. According to Smith (1999) there are methods to ensure the researcher is close and critical at the same time, “at a general level insider researchers have to have ways of thinking critically about their processes, their relationships and the quality and richness of their data and analysis” (p. 137).

The data collection process and the interpretation of the data are influenced by personal, interpersonal, institutional and emotional factors (Mauthner & Doucet, 2003). Qualitative research acknowledges this subjective nature of the research process (Morrow, 2005). Thus, throughout the process of research it is important to consider the potential influence of these factors on the data. As mentioned above, reflexivity is required to understand and report the outcomes within the context of these multiple facets of influence. Through reflecting on both personal responses to the data as well as methodological choices, it is important to highlight how these elements may have impinged on the analysis, therefore enabling a more thorough understanding of the reported outcomes.

Given that my own motivations and experiences have the potential to influence analysis, it is appropriate to give an explanation of these. My upbringing, background and interest in this research was outlined earlier in the introduction. Given that I have worked for over ten years with Māori children, adolescents and whānau and have whānau members in various education and health services and completed my clinical psychology internship at Whirinaki in He Kāhano, these experiences and motivations will have influenced my understanding and interpretation of the interviews as well as the interview content.

In addition, I recognise that although I am Māori, I have not lived in Manukau and therefore may be considered an outsider. I further acknowledge that being a doctoral researcher, I hold a relative position of power over my participants and this may have influenced the participants’ responses to my queries. Being an adult and potentially viewed as an authority figure has the potential to influence the rangatahi interactions with me.

Furthermore, my training as a clinical psychologist has been focused more on pathology rather than strengths, potentially affecting the interview content.

Regardless of insider/outsider status, a number of authors across the fields of Kaupapa Māori research, and other indigenous research, argue that it is the possession of appropriate cultural knowledge and practice of associated skills by researchers that is vital to the integrity and validity of the research (Bishop, 2011; O'Donnell, 2006). A key advantage of these attributes is that they can "increase the cultural compatibility of any recommendations or interventions" (O'Donnell, 2006, p. 4) that may be developed. This is of particular relevance to the notion of research that is 'by Māori, for Māori' and interested in addressing and enhancing wellbeing. This is true for the current study.

This study uses several interpretive paradigms that encompass epistemology and ontology (Denzin & Lincoln, 2000). I draw on critical realist ontology to inform my interpretation of the data using thematic analysis (Braun & Clarke, 2006). The critical realist stance aims to capture the lived 'reality' of participants' everyday experiences as much as possible, whilst acknowledging that it can never really be fully understood or even identified (Denzin & Lincoln, 2000; Willig, 1999). In addition, Māori epistemology (Sadler, 2007) and Māori centred social constructionism (Moewaka Barnes, 2010) inform the epistemology for this research in order to draw out facets of Māori cultural norms and assumptions that inform the participants' ideas and behaviour.

Overall, Kaupapa Māori research provides a framework within which to meet the research aims in a way that is as culturally responsive, responsible, and as useful as possible. Given the nature of the research topic, it is also useful and appropriate to draw upon the broad discipline of clinical and psychology approaches. As noted above, qualitative research methods fit well with Kaupapa Māori approaches.

## **Method**

**Setting.** He Kākano is based at Whirinaki, the child and adolescent mental health service (CAMHS) of Counties Manukau District Health Board (CMDHB). CMDHB provides services to an estimated 512,000 people who reside in the catchment area (Counties Manukau Health, 2015). Māori make up approximately 81 930 or 16%. Māori youth make up approximately one-fifth of the 0 to 19-year-olds in this population (Ministry of Health,

2014). The Māori population is young, with a mean age of approximately 21 years. The largest single group of Māori in the catchment area are 0 to 3 year olds, making up 15% of Māori, and almost one-third of all 4 year olds are Māori. The Counties Manukau population is growing at 1-2% per year; an additional 8-9,000 residents each year (Counties Manukau Health, 2015). This rapid growth mirrors growth in the metro-Auckland region, and places a significant load on health service provision, particularly in relation to the expected access rates set in the Blueprint for mental health provision (Mental Health Commission, 2012). The access rates for Māori at CAMHS nationally are 3% of the population (Mental Health Commission, 2012).

***He Kākano team.*** He Kākano is a Kaupapa Māori rōpū (specialist Māori) clinical team within a CAMHS in Manukau, Auckland, New Zealand. He Kākano is based within the wider mainstream CAMHS called Whirinaki and delivers mental health services for 0 to 19 year olds and their families according to the contract specifications from the New Zealand Ministry of Health (Elder et al., 2009). He Kākano's vision has been "to put into action cultural and clinical knowledge and practices in an attempt to increase access to mental health services for Māori whānau to CAMHS and to enhance health outcomes" (Elder et al., 2009, p.2). This vision aligns with existing policy frameworks (Counties Manukau Health, 2015; Ministry of Health, 2012). Recent evidence of the activity of the team shows increased access by Māori to CAMHS above the expected 3% target, rates for Māori access to Whirinaki for 2014 peaked at 4.58% (Counties Manukau District Health Board, 2015), and increased tangata whaiora (consumer) participation and satisfaction (Counties Manukau District Health Board Health; 2013; Elder et al., 2009).

**Participants.** There were a number of reasons for deciding to interview both rangatahi and whānau members. It was believed that the rangatahi and whānau could give different perspectives on the experience of engagement, both of which were important to understanding factors that influence engagement in CAMHS. Alongside the mental health challenges, rangatahi were facing different developmental challenges that could impact their experiences. Whānau members were able to provide richer contextual information about mental health difficulties and whānau factors. By interviewing rangatahi, whānau members, and He Kākano practitioners it was possible to gather a depth and richness of their understanding of engagement.

Interviews were conducted with 20 consumers including eight participants who were rangatahi and 12 who were whānau members. A focus group was also conducted with 11 He Kākano practitioners.

In the description of participants that follows, and reporting within the Findings section, no identifying information about participants is given in order to protect their anonymity, as agreed in the ethics approval process. Only general descriptors of the group are given. In total, 16 interviews were conducted with four including rangatahi and whānau together, nine involving a whānau member only, and three with rangatahi alone.

***Rangatahi.*** Criteria for inclusion of rangatahi included that they were 13 years or older, who had attended He Kakono in the past 6 months, some of whom were current clients. Rangatahi self-descriptions of why they had attended He Kākano included that they had experienced a number of stressors within their whānau, peer groups and community. These difficulties included bullying, pregnancy, miscarriage and abortion, sex and relationship difficulties, whānau relationship difficulties, negative influence of peer groups, problems with drugs and alcohol, unsafe school environment and physical health problems.

***Whānau member participants.*** Whānau member participants included those who were related to adolescents and younger children. Criteria for inclusion were that they were adults (over 18 years) who are whānau members of clients (ranging in ages from 4-18), who had attended He Kakono in the past 6 months, some of whom were current clients. Participants included people who self-identified as Māori as well as other non-Māori who were caregivers of clients who were Māori. All whānau member participants were female. Many were sole parents; others were aunties/caregivers, grandmothers and older siblings. These participants indicated that they were experiencing a number of stressors within their whānau including financial hardship, transport difficulties, multiple whānau stressors, parental mental health difficulties, pressures of managing child's mental health, pressures of sole parenting, and difficulties with 'the system'.

***He Kākano practitioners.*** He Kākano had a multi-disciplinary team of which 11 practitioners were included in the focus group; 10 were Māori and one was Tauwiwi (non-Māori). By professional background, two were nurses, two were occupational therapists,

one was a social worker, one a clinical psychologist and two were Taurawhiri (Cultural Advisors). Years of experience within the He Kākono team ranged from 1 year to 22 years.

### **Interview schedule.**

***Rangatahi and whānau.*** The semi-structured interviews with rangatahi and whānau covered topics seen as potentially influencing engagement that have been previously identified in the literature, as well as from discussion with He Kākono staff members who gave insight into important topics from a frontline perspective. Topics covered the referral process, initial contact, and ongoing engagement. In addition, open ended questions were asked regarding what helped and what hindered engagement, and advice for improvement of service. General topics were introduced then followed by prompts in order to facilitate further talk. All interviews followed a semi-structured format in accordance with the interview schedule (see Appendix G).

While many of the same topics were covered in the whānau and rangatahi interviews, there were some differences to explore their different situations. For example, different questions were asked regarding their experiences within the whānau, and the impact that this had on each of them. The language was also adapted for the different groups of participants. There was also flexibility within the interview approach that allowed the participants to highlight topics that were important to them. As mentioned above, due to the variation of mental health presentations it was imperative to have the flexibility of an inductive approach to cover other topics as they arose and were meaningful to the individual rangatahi and wider whānau.

Interviews with the rangatahi lasted between half-an-hour and one-hour. The interviews with the whānau lasted between one-hour and an-hour-and-a-half.

***Focus group.*** The staff focus group interview was one-hour long. Similar to the service users' interviews, the focus group interview covered the topic of engagement in a broad sense. Within the interview I asked further information about the following topics: referral process, initial contact, what helped engagement, what were the barriers, and ideas for improvement of service. The interview included those questions as outlined in the rangatahi and whānau schedule.



## **Procedure.**

**Ethics approval.** Ethical approval for this study was granted by the Health and Disabilities Ethics Committee, the Counties Manukau DHB Ethics Committee and the Counties Manukau DHB Māori Ethics Committee. The details of this approval were included on the Participant Information Sheets and the Consent Forms for the study (see Appendices A-F).

**Recruitment.** A letter about the study along with the participant information sheet (PIS) was sent by the He Kākano team leader to all clients who had accessed He Kākano within the past six months including current clients. Those interested in taking part were able to contact me via phone or email which was provided on the Participant Information Sheet (PSI). In addition, follow up phone calls were made by the Senior Taurawhiri/Cultural Advisor or team leader to potential participants who had not responded to the letter. He Kākano practitioners also approached clients to invite them to take part in the study. If rangatahi or whānau indicated they were interested in participating a PIS was given to them and their contact details were provided to me by the He Kākano team leader. I then phoned them. At phone calls I explained the research and gave participants and answered any questions they had.

**Interviews.** A suitable time and location for interviews were arranged with those who agreed to take part in the study. Consent was obtained before interviews commenced.

Participants could request they be provided with a brief summary of the research once it was completed. Most of the participants wanted to hear about the results and provided an email or postal address for a summary to be sent to them. Participants were also offered the opportunity to view transcripts of their interviews to review and adapt if they felt necessary, however, all participants declined and preferred to receive a summary of findings instead.

All participants were interviewed by me, which coincided with a time I was 7-8 months hapū (pregnant). Whakawhanaungatanga took place at the beginning prior to beginning the interview. I explained my iwi (tribe) affiliations and background in order to make connections and facilitate rapport. Many participants made positive references to my

pregnancy at the start and end of the interviews; I felt a sense of mutual manaakitanga (respect and care) in this regard. Karakia (prayer) was offered to all whānau prior to commencing the interview. After the recording was stopped, participants often engaged in less formal kōrero (discussions) about topics related to the research and other reflections that they had about mental health in general. This was not transcribed, but noted by me in a research diary, as I felt it served a purpose for extra information about the study. Rangatahi and whānau interviews were conducted at a place mutually suitable to both participant and researcher. The majority of whānau participants were interviewed in their homes in the wider Manukau area. One interview was conducted at The University of Auckland in a meeting room. One rangatahi interview took place at a school in a meeting room and one interview was conducted at a local community space. Participants were provided with a \$40 grocery or petrol voucher koha of their choice. Many participants expressed that they enjoyed the interviews, and there was a sense of having contributed to something useful for other Māori in CAMHS in the future.

To help participants feel relaxed and comfortable, they were given the option to have whānau members present during the interviews. Rangatahi were given the option to be interviewed with whānau, siblings or friends or without. As previously mentioned, five rangatahi were interviewed with their whānau and three were interviews with rangatahi alone. These three rangatahi did not have other whānau members participating in the study.

After karakia and whakawhanaungatanga, I began each interview with open-ended questions that were designed to set the scene and enable the participants to talk about their experience of engagement with Whirinaki, unhindered. The semi-structured format ensured that areas of practical and theoretical importance were covered and allowed the interviewer the ability to raise and follow up topics where appropriate. This inductive approach provided room for additional inquiry and discussion of individual issues. Some participants spoke about topics that were at times sensitive, therefore a respectful approach was taken to ensure that participants felt safe sharing this information. Additionally, I was mindful of being respectful about topics that participants did not want to elaborate on.

Some of the participants in this research had experienced trauma and/or psychosis and spoke about experiences with Matakite (seer or gifted person also referred to as a Māori Healer) and Mate Māori (Māori illness). As mentioned above I was mindful of my approach to these topics to ensure that participants felt culturally safe at all times. As mentioned earlier participants were also offered karakia at the beginning and end of the interview to attend to this. In regard to cultural safety, it was also important for me to debrief after some interviews. I did this by either using karakia (prayer) or speaking with my supervisors to facilitate the transition from these topics in to a place of safety.

In addition, some participants were living in stressful environments. Talking to clinicians about contextual information helped me be prepared for the interview and to be aware of sensitive areas. However, no risk issues arose for any participants in the course of interviews.

## **Data Analysis**

The interviews with rangatahi and whānau and the focus group were digitally recorded and then transcribed verbatim. I transcribed the first few rangatahi and whānau interviews to increase familiarity with the participants and with the research material. All other interviews were transcribed by professional transcribers who had signed a confidentiality agreement. All interviews transcribed externally were carefully checked by me. Hard copies of transcripts were stored in a locked filing cabinet at The University of Auckland. Electronic versions were password-protected and stored on a secure server at the University. As far as possible, all identifying information was removed from the transcripts including names of individuals.

The rangatahi and whānau participant interviews and the staff focus group were analysed separately giving me two separate data sets: one for the rangatahi and whānau data, and another for the He Kākano staff focus group. Once the data sets from rangatahi and whānau groups had been analysed the two data sets were considered against each other. Common themes were identified and the data was combined into themes whilst maintaining awareness of any differences between each group. The He Kākano team focus group was analysed separately, and is reported below in its own chapter.

Interviews were analysed following the six-step guide given by Braun and Clarke (2006). After each interview, the transcripts were read and re-read to increase familiarity with the data and initial ideas were noted down. Next, the data was organised into initial codes by cutting and pasting data into separate excel spreadsheets, each representing a different code. This was comprehensive with little material left out. Several attempts were made at coding the material as different ways of conceptualising the data were tried. The final coding strategy attempted to represent the participants' stories as completely as possible rather than "fit" the literature.

Codes were then grouped into themes and subthemes. These were reviewed multiple times and refined. Codes were discarded or collapsed into each other as it became clear that they did not contain enough unique material to warrant a separate code. Themes were likewise refined, merged or separated out to best represent the data. In each case, care was taken to ensure that no material important to the participants or the research questions went unrepresented. Throughout this process, intensive discussion with my academic supervisor and Cultural Advisor guided the analysis and the shape and understanding of the data.

Once the material was coded and organised into themes, my primary academic supervisor and a Cultural Advisor checked them for validity. Each person was also given transcripts with these codes identified. They were then asked to determine whether or not they believed that each theme, subtheme and code was perceptible in the data and if it was adequately described. This was then discussed and changes were made accordingly. Themes and subthemes were finalised when it was felt that each represented the data set well and adequately addressed the research questions.

The prevalence of each theme and subtheme across the data set was noted. In contrast to quantitative methods, qualitative methods do not seek to enumerate data (Mays & Pope, 1995) as this can give inaccurate weight to some aspects of the research while obscuring other important elements. As such the specific frequency of themes is not reported. However, giving an indication of the prevalence of a theme can provide the reader a gauge to its pervasiveness. In-line with qualitative reporting conventions, the following constructs were used to report prevalence: 'most participants', 'many participants' and

'some participants'. It is important to note that prevalence does not necessarily indicate significance (Braun & Clarke, 2006), and the small sample size and qualitative focus of the project should be kept in consideration when viewing the analysis.

# CHAPTER THREE: RESULTS – RANGATAHI AND WHĀNAU INTERVIEWS

*Table 1: Rangatahi and Whānau Data Themes and Sub-themes*

Topic	Theme	Sub-theme
Initial engagement	Whānau Worry about Engagement	Fear of being Judged, Whakamā and Shame Uncertainty about the Service Mistrust of Mental Health Services
	Positive Interactions at Initial Contact	Warm Environment Recognition of Māoritanga Making a Connection Active Whānau Involvement
Ongoing engagement	Clinician/Practitioner Relationship Skills	Humility and Power Dynamics Communication Skills and Empathy Taking time to build rapport Role of Taurawhiri/Cultural Advisors Flexible Approach Regular Contact Integrity and Following Through Empowering Whānau Home Visits
	Practical Support	Strategies and Skills Increasing support Youth Community Living Services
	Engagement Barriers	Negative experiences of Medication Language and Interpersonal Skills
Whānau approaches	Whānau Strengths and Coping Strategies	Whānau Connectedness Other Supports Identity and Belonging Whānau Wisdom Holistic Approach
	Aspirations	Collective Support Mātauranga Māori/Māori Knowledge Pūmanawa, Understanding Unique Strengths Hopes and Aspirations

## Initial Engagement Period

The first category of thematic analysis covers themes of perceptions about being referred to the service as well as the experiences of the initial engagement period. Presented first are two themes, the first theme explores the concerns and uncertainties the participants struggled with before engaging and during the initial engagement period. While this is an area that practitioners/clinicians may not be able to directly influence, prior to engagement, awareness of these issues can assist with strategies to reduce anxieties about attending during the initial contact period. The second theme relates to the factors that assisted engagement when participants first started to attend Whirinaki.

**Whānau worry about engaging with Mental Health Services.** Most participants struggled with fears of being judged, feelings of whakamā or shame, worries about the stigma associated with mental health, not knowing what to expect as well as a general aversion to mental health services. Some of the perceptions of the participants were based on societal stigma associated with mental health, past negative experiences of health services or Whirinaki itself. Other concerns were based on whānau perceptions of mental health services.

***Fear of being judged, whakamā, shame.*** Many participants expressed that approaching mental health services for help was difficult. Participants worried about talking about their difficulties and subsequently being judged by clinicians and or others about attending a mental health service. Many rangatahi participants were particularly concerned about being judged, as one participant noted:

*Yeah, at first I was like that, because I thought they would judge me. Because telling people your stuff and that, I thought they would be, like at first I thought they'd be like, I don't know, just straight away judge me. (R10)*

Many rangatahi participants also shared feelings of whakakamā or shame about attending a mental health service as they worried that others outside the CAMHS would criticise them because it was shameful and there was a stigma associated with it.

*I would think everybody would be looking at me, like, oh look at her, she's got problems or something like that. (R10)*

*He [Name of young person] hates it, it's a stigma because Whirinaki is, you know, mental health and he can't differentiate or he can't, I don't know what the word is, you know, he just sees mental. He doesn't see mental health, he just sees mental, and he's already just made up his mind that he's mental, so he'll act mental. Because, he believes he is mental because he's going to a mental health place. So, it'd be one thing if they could change that, don't know. (WH14)*

Asking for help was difficult and some participants conveyed that it was particularly difficult for Māori as they often felt whakamā or embarrassed to seek help from outside of their own whānau network. One participant reported that although she was engaged with services her parents who had also been caregivers for the young person came from a generation that held a belief that you should not ask others for help.

*I'm guessing, like, you know, this is just a Māori and a Polynesian thing, that you're very proud. You know, why should we be asking that person to help [...] And I can see that in my own thing, like my mum and dad, we've always told my mum, you know, if you need any help you just have to ask, but it doesn't come down till the last crunch that she'll ask. If she did ask at all. Until you find out later. So I think that's probably the biggest thing, is that you shouldn't be ashamed to ask. Like these are things that are here to help us be better parents or caregivers or whatever. (WH15)*

Some parents and whānau members also were not confident about seeking out help for their children.

*I've noticed too these days, a lot of parents, they don't know what to do in these sort of situations and a lot of them are too shy to come forward and admit that there is a problem. But yeah, no, it is, it's sad that some of our people I notice are very whakamā about that sort of thing. (WH9)*

This participant recognised the difficulty of approaching a doctor who was often the first port of call. The experience of whakamā was considered especially true for Māori, who



she thought felt hesitant to ask for help as their views were often minimised by doctors or other health professionals in positions of authority:

*....I think it's because, to me, I think it's a lot, because when they approach doctors they seem to feel shut down because it's as if we, like even if we know, we have a fair idea what's going on, it's the doctors opinion's back to you and you think, oh yeah, no, you're the professional so we sort of back away from it. But yeah, no, that's what I honestly think it is half the time, our people. (WH9)*

One participant's was allocated to another team outside of He Kākano , her wider whānau was not supportive of engaging with mainstream mental health services due to perceptions about differing health beliefs and worldviews. This participant reported that the approach of the clinicians resulted in her feeling as though her whānau was being scrutinised:

*They were really nice, really, really nice, Whirinaki. I mean the do their best to help you, to put you in the right place, but at the same time they're trying to examine [Name of young person] and they're trying to find out what they need to know. It's like there's no hidden agenda but you just feel that there's a hidden agenda, you know. It's like [...] really they're thinking he's crazy or is it us that are the crazy ones that are looking after him why he's crazy. You can't help thinking that that's what they're doing. They're looking really at the family more, how crazy are we, why he's gone crazy. And they try to make you feel comfortable that they don't do that but you just can't help it. (WH2)*

The participant acknowledged that although the clinicians were polite and attempted provide the right support, the overarching impression of the experience was that the whānau were being judged.

***Uncertainty about the service.*** Some participants commented on the lack of information about mental health services for children and adolescents:

*They talk about mental health a lot on TV for adults but they don't really talk about it a lot for children, do they? (WH14)*

*Some people out there don't even know they've got it, so I think that's why there's not much awareness about it. (R4)*

Most participants shared a similar experience of not knowing how and where to go for help. Participants were unfamiliar with the services Whirinaki offered or that the service was available to them before they attended.

*You can't just go there you know if, if you've got a problem with a child, as a parent, and get the help, it's hard to find out where you can go for help and what organisation to turn to....And Matua said oh go doctor, the doctor can do it. So now whenever they ask me I say go see the doctor and tell them you want to be referred to. But you know there's a lot of people out there that don't know that. (WH8).*

*...you hear Whirinaki, but what exactly are they. I know more now than I did before, you know. I would go past there all the time, I would see this Māori name and I'm thinking what is it.... Unless, you know, that's the other thing too, unless you have these kinds of illnesses, that's the only time you ever know. You know, your doctor's not gonna sit there and say hey, Whirinaki's available for this and this and this. (WH11)*

Others commented that they felt anxious as they did not know what to expect when they attended Whirinaki:

*You don't know what you're gonna be asked. (R6)*

**Mistrust of mental health services.** The pressures of having to attend the service were felt by many whānau participants. Some participants talked about tensions of attending mental health services as other whānau members had a general aversion to mainstream mental health services, some also reported that wider whānau members perceived services as being in contrast to their own belief systems. The imposition of conflicting values was noted by one participant:

*...and we wanna make sure that, you know, when you have been brought up Māori and you know that you don't do things like that, and you're going against your Māori ways and you're trying something new. (WH2)*

As noted earlier, this participant was not placed within the He Kākano team and therefore the distinction between Māori cultural practises and Western practises could have been more evident to her. Another participant's wider whānau were unsupportive of the young person attending as they had previously had a negative experience with Whirinaki in the past:

*Cause, they have their opinions, they have their opinions and they would disagree completely. Completely disagree with him being there. Cause, they think he has problems but they think, for him to be in that Whirinaki is a wrong thing. They think it can be worked out with the family, sort of thing. (WH14)*

In this case, the whānau believed that they were able to provide the right support for the young person within their own family.

Another participant reflected on the distress of the process of engaging with the service due to concern of how she would be treated by the service, for this participant the predominant fear was that she was in some way at fault:

*I always felt, I remember feeling a bit like, a little bit oppressed by it because and I because you know I didn't understand it for me. And I felt oh God are they gonna, I know I have this child under my care, aren't I doing something right. (WH1)*

This participant expressed feelings of internalised self-blame which stem from a history of negative interactions with CAMHS and professionals in general. This sentiment was also shared by other participants and related to a sense of caution with which some participants approached services.

Despite challenges and hesitations prior to and during the initial period, participants chose to 'give it a go' and engage with Whirinaki to seek help for the young person who was experiencing mental health difficulties. The lack of awareness of the service and burden on the parents and caregivers was eased when the professionals who made referrals to the service assisted and encouraged whānau to attend Whirinaki, it also increased trust in the service. As one participant mentioned:

*It was nice of her and him, the counsellor, to come out to my house and try and figure out what can they do to help and things like that. I didn't even know they had a social worker. All I knew was that they had counsellors. But it was her that referred, you know, tried to make a plan and assessment for what's good for her. She said Whirinaki would be a great place to start because they have all the facilities, they know all the organisations, whether you're Pākehā, Māori, Indian. They have all that range, and she said plus you'll feel not only comfortable with me but also comfortable with them too, because they have all the needs that she needs. (WH11)*

Some participants talked about being relieved that they were able to push through their initial fears. Many rangatahi participants felt reassured by the clinicians' non-judgmental approach when they attended Whirinaki. As one participant put it:

*I think it's because they think I've got mental issues, or I've got massive problems. That's what I thought when I was going there. That's why [...] I didn't wanna go there. I was like nah, I don't wanna go there, they'll probably think I'm mental or hospital or whatever. But then when you go there, they're totally different. They don't act like oh, we're gonna make sure they don't harm themselves or whatever. They're like, they're just nice, they're good (R10).*

One participant who had a bad previous experience with the service was initially ambivalent about engaging but found that her negative perceptions of Whirinaki were abated when she did attend as the service had improved.

*My expectations were like, this is gonna suck [...] yeah, I didn't really want to (laughter) after my last experience, I was expecting to see all the same people (laughter). Yeah, I didn't know what to expect, my expectations were that it was gonna be probably the same, very clinical, very, I don't know. I want to use the word emotional but they just, there's more of a connection this time around, it could be whole whānau thing. Last time it was just not, yeah, I did. My expectations were gonna be like, ah, and I'm gonna do this, give it a go, not really wanting to. But, put my needs aside, it's about [young person] and I was a little bit, yeah, but I've been pleasantly surprised. (WH14)*

This participant noted that the most recognisable change with the service was there was an inclusive whānau approach and clinicians were more personable, this contributed to a better therapeutic relationship. The same participant also commented on how her son was embarrassed about attending the service and so the clinician made an effort to ensure she respected his privacy amongst his friends at school.

*I think that we're living in an age now where it's just more talked about and accepted, but kids don't know that.....No, they don't. I mean, [Name of Young Person] would die of humiliation if any of his friends knew, absolutely, you know, [Name of Clinician] is his big sister when she comes and that's it (laughter), and she's okay with that. (WH14)*

In summary, participants had many fears about attending Whirinaki, some were related to previous experiences of mental health or the health system. Negative perceptions and stigma in society about mental health was a common comment made by participants. Many participants did not know about the service. Participants identified that reaching out and asking for help can be hard for Māori because of feeling whakamā, shame, fears of being judged. However those who pushed through their fears and 'stayed with it' felt relieved that they got assistance from clinicians who were non-judgemental, warm, personable and whānau orientated.

**Positive interactions during initial contact.** During the interview, participants were asked about the initial contact period and initial stages of engagement. Although many participants found it difficult to recall specific information about the initial encounters, they were able to reflect on their first impressions. Participants recalled that having a warm environment and having Māori specific cultural practises integrated in to sessions helped put them at ease. Having a 'connection' was important to most participants. The ability of clinicians to relate to rangatahi and whānau encouraged them to be more open and less intimidated by their perceptions of mental health services.

**Warm environment.** The overall impressions of the first sessions were often based on the approach and nature of the clinicians. This reflected positively on their experience of the team and service as a whole. Most participants reported that they had a positive experience and liked the way they were treated by staff when they first attended Whirinaki:

*That lady we saw, what was her name, she was beautiful. I went to the first one with her, amazing. (WH6)*

*...it was really comforting; she [Name of clinician] was good (R6)*

*She's lovely, she's top dog. She's choice. (WH13)*

*It was awesome. (R3)*

One participant recalled feeling welcome and staff smiling which helped to put her at ease.

*...it was warm and inviting[ ...]yeah, you did, you felt welcome. And I mean even the people that work there, if they see you sitting in the waiting area they smile at you [...] And you've never met the person or anything but you know they're part of the Whirinaki team, they just smile at you as soon as they walk past. I mean an example is one day when we went to our meeting, the last time, a woman walked past three times, [Name of young person], I don't know if you noticed it, and all three times she smiled (laughter)[ ...] Even though they don't know you, yeah, it does, it means a lot. Just little things like that. (WH9)*

Many rangatahi participants expected that sessions at Whirinaki would be too formal and somewhat rigid and restrictive however were pleased when they attended that they were able to relax, as one participant put it:

*When I went there, coz when I went it was just like like this. The mindfulness stuff and that it was kind of kick back. I thought it was going to be like one of those, what are those Patrick Clare therapy seats and a desk and I thought I was going to be one of those, but it wasn't so it was all good. Pretty kick back so it was alright. (R12)*

Another participant recalled how the clinician helped put her at ease despite feeling anxious about attending Whirinaki.

*I was just really shy, yeah but [clinician] was really nice to me. (R13)*

Some participants expressed feeling relieved about getting assistance from Whirinaki after struggling with mental health difficulties for some time before attending the service.

*I was just glad that they saw that I did need help. (R6)*

One participant who was unwell and was transitioned from the Child and Family Inpatient Unit (CFU) at the hospital felt especially vulnerable and afraid during the initial period with Whirinaki, however, clinicians made her feel safe.

*It was good. They were welcoming and they helped me, yeah, 'cos I was scared when I first, I was confused about everything. I didn't know what was happening and they, like every day they told me 'it's alright, we're here to help you'. (R9)*

The use of humour also alleviated initial anxiety and contributed to building the therapeutic relationship.

*Yeah, especially the [Name of clinician], yeah. She was lovely... She was, she was good. She was, like, open about everything and she'd make jokes and stuff. (R9)*

*They were really good with talking and they were laughing with me, so that really helped. (R4)*

**Recognition of Māoritanga.** Many participants acknowledged aspects of the initial meetings that were specifically Māori that were done during the initial engagement. Participants felt at ease when they saw there were Māori clinicians as it was natural and what they were normally accustomed to.

*Just going in and actually seeing that it was a Māori environment like how it was with my doctors. (R4)*

During the initial meeting clinicians offered karakia or prayer/incantation to assist in the process of settling the young person and their whānau. Many of the participants conveyed that this practise assisted with putting them at ease.

*The first thing was karakia wasn't though wasn't it [Young Person]? The very first thing honey, it was beautiful, she had a way about [it].... (WH6)*

Another participant reported that although she was not familiar with the use of reo (Māori language) she appreciated that clinicians carried out the whakawhanaungatanga

(process of establishing relationships) during introductions at the beginning of the first session.

*When I went, well we went with his Dad and [Name of Young person] for me because I don't talk Māori and it was okay that they felt that they had to do that. I was alright with that. I had no idea what they were saying though when they were doing their introductions [...] I think that it's good they're culturally sensitive[...] That they, from what I see they seem to respect the culture more than what I do. But that's not my fault. And they seem genuinely interested (WH 8)*

Most whānau participants found it helpful that the whole whānau was included in the initial meetings. Participants appreciated that clinicians provided space to express emotions and a pathway forward to support the young person.

*Yeah, it was open to anybody that wanted to come along and it was just us that chose to go, just family, close family. But yeah, 'cos even my mum, I remember her aye [Name of Young Person], she was sitting there and she started crying too, 'cos she kept saying 'that's not my moko, that's not my moko. That's why we're here, 'cos we need help'. And no, from there they already action planned what steps we were gonna take and kept us informed the whole way through on what they were doing. .... Yeah, it was very emotional because that's where she, she had to express her feelings and yeah, no, it was really emotional for all of us. ... But they were very supportive. (WH9)*

Having an environment that felt Māori, natural and familiar, where clinicians smiled and they felt welcome and was important to participants. The use of practices such as whakawhanaungatanga and karakia were also very important to whānau, even for those who were not familiar or proficient with such practises as they believed it demonstrated genuine respect and care for the whānau. These processes also facilitate building the therapeutic alliance, rapport and spiritual comfort with rangatahi and whānau.

**Making a connection.** Many participants identified the value of having a good connection with clinicians. There were several elements that were considered pertinent to making a good connection such as the ability to relate to young people and compatibility of



personalities. Other participants reported that they had instant connection with clinicians because of their shared understanding of being Māori. One participant reflected on the importance of complementary personalities for the development of a positive alliance:

*...people that like usually they just work with one person like one on one. I don't know but I think like whoever that is like they suit you. Like match your personalities or I don't know. (R13)*

Another participant talked about the importance of knowing about current contemporary influences on young people, having an understanding of their worldview and their language:

*... in terms of their own rangatahi connect language which can be a whole mixture of their music, their likes and dislikes, that rangatahi today have that connect and obviously I don't, even though that I'm their aunty and Māori. (WH1)*

Many participants acknowledged how the skills of the clinicians were well suited to working with rangatahi. One whānau participant talked about her son being responsive to the straight-talking style of the clinician.

*...so I think it was [Name of Kaumātua], big guy, [Name of Kaumātua], we wanted him to stay on board. .... Yeah, he was like straight up with [Name of Young person], you know. And [young person] really liked it. (WH5)*

The same whānau found that when there was a good therapeutic alliance the young person was more open to talking and sharing his thoughts.

*..... some of the times [Name of Young person] didn't want to see the doctor. The thing was, every time [Name of young person] faced a doctor he always had his head down. He didn't want to lift his head up and I don't know whether he was hiding his inner thoughts, feelings but yeah, he wasn't actually communicating with the doctor. .... If he didn't like them, he won't speak to them. But if he liked you then yeah, he'd open up. That's what happened from [former clinician] to [new clinician], yeah, he just absolutely changed. (WH5)*

This participant also appreciated how they were able to change clinicians to find someone more suitable for them and that it allowed for greater whānau-clinician collaboration:

*Yeah, they actually got me another nurse....[Name of young person] could relate to her, and I could relate to her too. .. she was more or less working with us, like working together. [The other clinician], she was working but she wasn't getting that connection between her, me and [young person], so there was nothing there. (WH5)*

Many participants commented on the familiarity of having a Māori clinician working with Māori whānau.

*Yeah I mean I can spot a Māori from a mile away and I know just by look that oh choice, you know, oh choice. I can relate to someone. Not all bad whether it's thing, but I can connect and that's the thing. (WH1)*

The same participant admitted she noticed that despite her efforts she could not naturally relate with Pākehā in the same way as she did with Māori.

*But yeah I still struggle today with Pākehā, yeah to be able to connect. (WH1)*

The cultural alignment of services was particularly important for one participant who cared for a young person with a serious mental illness and had negative past involvement with clinicians who had limited cultural knowledge.

*I suppose it's finding out if your child is the right person for them. Not everybody suits that mental health, or this mental health, you know. I think a cultural thing is involved, plays a good part of where you should be placed and if you're child is culturally, they've been brought up their way, then you should try those services first before you go and try any other service. Try your own culture, what's out there for your culture because the person who's not well, they can relate a lot easier instead of you having to be the person in the middle trying to explain and then they may become more open and can talk better and have better services without you having to explain 'cos they know. And then it just gets that part out of the way. (WH2)*

The capacity to grasp the clients' perspective and the ways in which they understand themselves and the world around them is a key component of building a good therapeutic alliance. It appears that these participants reported that they were more likely to engage and continue in a service when they have a common and genuine connection with the clinicians. This connection is more likely to occur with Māori clinicians who have an understanding of what it means to be Māori. Although two whānau were not in He Kākano while they were with Whirinaki, they both expressed that they preferred to be in a Māori team that was culturally responsive.

**Active whānau involvement.** The importance of whānau being active in the process of engagement was also talked about by some participants. Young people and whānau investing effort to engage gained the most benefits of Whirinaki.

*Yeah and the system, they can only do so much[...] yeah and you can't blame them for anything, it's not their fault, they're all still learning too. (WH2)*

*I feel anybody who is not happy with Whirinaki hasn't played ball [ ...] And the other thing eh you have to want to help yourself. Like you can't just go oh no it's hard. Like you actually have to work for it. You've got to want to get better and want to get help –Because like – And be prepared to accept. And I've had times like that where I don't want to help myself but I want everyone to help me and make me feel better – Everybody to fix it for you eh[....]if you take their advice or their guidance, it's up to you. (R13)*

*... the resources are good but it's really. It's what the person makes of it ay. It doesn't fix it ay but it's just there as a guidelines. (WH 8)*

In summary, positive interactions and first impressions are significant during the initial attendance as they can determine whether or not clients continue to engage with the service to gain the benefits of the interventions. The key factors participants recalled about the initial contact was the importance of a warm environment, Māori specific practises and having a good connection with clinicians. Together these factors contribute to the development of a positive alliance between clinicians, young people and whānau.

## Ongoing Engagement

Maintaining the positive alliance developed during initial attendance was essential for the ongoing engagement with whānau. Most participants had positive experiences once they attended the service. Many also acknowledged that coping with mental health issues was difficult, however, the relationship skills of the clinicians enabled mutual communication of information, needs, attitudes and values. The provision of appropriate practical support, skills and strategies helped whānau [individuals and families] to achieve positive outcomes. Some participants also provided information on barriers that hindered their engagement with the service.

**Clinician/Practitioner relationship skills.** Participants identified a number of fundamental clinical skills and qualities that enabled ongoing engagement. Many participants conveyed that these factors fostered a sense of trust, respect and comfort during their engagement with Whirinaki.

**Humility and professional power dynamics.** Many participants observed that they felt more at ease when clinicians were mindful of professional power dynamics. Participants appreciated that clinicians worked towards ensuring whānau felt they were respected as though they were of equal status to clinicians and their knowledge was valued.

*It wasn't as bad as I thought, because I thought they were gonna be people there that would talk down to me kind of thing. But after a while nah, they were real kind and real nice to me so it was pretty good. (R4)*

Some participants perceived that acting in a 'professional' manner was synonymous with being whakahīhī (condescending and arrogant) as this may have been their experience of professionals in the past. One participant gave a good description of what she thought of mental health professionals and how the relaxed approach of the clinician was important to building rapport:

*Yeah [Name of Clinician (Doctor)] sometimes I thought I like him I wonder if he believes me or whatever I say. But he's like pretty kick back, he like just rocks in and like kicks back in his seat and folds his legs and puts his hands behind his head. And*

*he's pretty kick back and but see, oh because like they're professional but they're like kick back professional. It's pretty cool. (R12)*

The participant was asked what she thought was the difference between a professional that was 'kick-back' or relaxed and one that was not:

*It's like you can like listen to their mind, but then if it's like real like, everything it's kind of like awkward and kind of like got to sit up straight and it's yeah, so yeah. (R12)*

Others appreciated the ease with which the clinicians fit in with the whānau/family.

*She's the kind of person that comes in and slots in, like part of the family, immediately. And she talks like she's one of the family, she talks on that level. You know there's no sort of authority or professionalism there. It's just plod in and sit down and have a cup of tea and you know and she talked to [young person during crisis] that day and won her confidence over. (WH13)*

The same participant also stated that the clinicians had a sense of humility that was consistent both in their own home and when they went to Whirinaki.

*See they don't come in, they don't walk into your home, or even when we used to go out there to Whirinaki, well those two ladies anyway. They don't act like they're a doctor or professional this and they know more than you, they don't come on to you like we know more than you so just shut up and listen, you know [...] They talk with you not at you. (WH13)*

The clinicians' ability to make young people and whānau feel at ease by collaborating and working at the level of the whānau was valued by many participants, this approach made a significant impression on one participant:

*The thing that really stands out for me, especially in regards to Whirinaki is like she said, they make you feel like a friend, not like a client. Yeah, and it's almost as if they work with you, like they're on the same level as you sort of thing and they do, they give you that confidence to just be open with them and, yeah, no, I'll tell you, I'm so thankful for them. (WH9)*

One participant thought that others outside of the CAMHS were more likely to judge her whereas Whirinaki clinicians were non-judgmental and respectful towards her:

*I think if they [others] don't know what Whirinaki is then they don't really know. But I think when they do it's kind of like a surprise or something, like they're shocked or something [...] so I don't like talking about it to like other people. Like even though they're like not in the same pod as me, like Whirinaki lot they're like, they like know so it's alright [...] and I don't feel like they would like judge you like majorly like maybe like somebody else.... (R12)*

Even though the participant felt that she was different to her peers she felt that clinicians treated her with respect and did not make her feel that she was abnormal or label her as 'crazy'.

*It's, I reckon it's all good. I reckon because they don't like do a whole big like study, test thing on you and then they just bomb on you with a bombshell like you're crazy and this is what you've got, it's rrrrr, it's really bad. Not like that. It's like they're mellow how they go about it so it's cool, it's alright. (R12).*

**Communication skills and empathy.** The calm, non-pressuring manner in which clinicians worked with rangatahi and whānau aided engagement. Many participants appreciated having someone to talk to and felt that clinicians cared about them.

*They offered what [Name of young person] really needed. They didn't actually pressure him, they didn't demand or anything. They actually waited on him, you know, and they were there for us when we needed them. (WH5)*

*Yeah, and I noticed too, she felt relaxed around her, being able to open up to her and so forth. (WH9)*

*[Name of Clinician] had a sort of a calming influence [...] She's very calm. She's very nice. You know somebody could be quite rude to her [...] but she, for every abrupt thing that people say to her she replies in a really nice manner. (R13)*

In general, most participants appreciated having someone to talk to about the difficulties they were experiencing. Many rangatahi participants found it helpful to talk to people who were experienced and knowledgeable as well as understanding.

*Yeah, [Name of young person] felt free, he could talk about it, eh [Name of young person]? (WH3)*

*She just made me feel comfortable [...] Oh I just, I felt like she understood me (R13)*

One participant found that just talking was more beneficial to her rather than the actual therapy intervention itself.

*To be honest it's the paperwork she gave me 'cos I can't really remember a lot, like the conversations we had, but I don't know, just talking with her really helped more than anything, more than the therapy, yeah. She was really nice. She gave me a CD, like a meditation thing. (R6)*

Another participant appreciated being able to have a space to talk rather than ruminating on her difficulties. It was particularly helpful talking to clinicians that had expert knowledge on mental health.

*.... good yeah, like things are off my chest. Because I talk to them about everything that's going on in your head and it's like they get it. It's like you're talking to like another person but there's something about them that makes it more better than talking to another person. Because like when you talk to other people about it it's like to me it feels like you're thinking oh my God you're fucked up. But they're just like that's okay, and you should write it down and stuff. So yeah it feels better talking to them about it than other people. (R12)*

Having someone to talk to outside of the whānau was important to many rangatahi participants.

*Yeah, I find it helpful because when I do have things happen I feel uncomfortable telling my Mum... (R10)*

This participant felt relieved she could talk openly to clinicians at Whirinaki. Clinicians were able to encourage rangatahi to have the confidence to talk when they had difficulties talking to others:

*Since she's been doing Whirinaki and stuff she's joined the choir at school so she's got this confidence [...] them working side by side with Mahitahi plus Whirinaki, it's kind of balanced things out. She loves hanging out, she loves talking to [Name of clinician], and you know, before you wouldn't get boo out of her. [Name of clinician] can tell you that one. (WH11)*

*They help me talk more, because before I came out of hospital I was quiet, I didn't want to talk or anything. But they made me comfortable talking in front of them. (R9).*

*...there's been a big change. Given her confidence. (WH13)*

**Rapport and trust.** Young people and whānau needed time to build trust and rapport with clinicians before they felt they could be open with them about their difficulties. One whānau participant was initially doubtful about the clinician and acknowledged how her concerns dissipated over time once she got to know and trust the clinician.

*... I just felt like she [Name of clinician] was one of these people going by the rules in the book [...] I don't know what I felt really. I just wasn't confident of her....Me being older I thought she's young, she's had no experience, she doesn't know what she's talking about, she hasn't got any kids of her own, dah dah dah. But now –I was still coming up and you know I admit that it's you know. But as time went on I mellowed....And then I started listening to her. But at first she was just always looking at papers. (WH13)*

Once the whānau knew that the clinician was reliable and consistent they felt the relationship was safer for them to open up and talk.

*It was for me like and it takes you a long time to like gain some confidence and stuff [...]I thought they were gonna be like other places that just like see you for a little*



*while and then they just move you on to the next person. Yeah but so it took me ages to like get to trust [Name of clinician] but once I did it was really good. (R13)*

The same participant talked about building a trusting relationship with the clinicians over the period of a couple of months and that she felt the clinicians were considerate in how they went about taking the time to build rapport as well as timing in the sessions themselves, this careful and considerate approach to engagement conveyed respect to whānau.

*And they take their time, they never, well you've got an hour and next in, right out. ...right, times up out the door....They do run to a timetable but they don't make you feel like they do. (WH13 and R13)*

This example is an indication of practices of engagement that differ from Western clinical practice. 'Taking the time' to engage in this way presents a challenge to the convention of one-hour appointment schedules or a set number of allocated appointments per client.

**Role of Taurawhiri/Cultural Advisors.** All of the participants who were engaged with Taurawhiri (Cultural Advisors) reported that they related well to them. Participants felt that the knowledge, skills and manner of the cultural advisors corresponded well with the needs of the young person and their whānau. One participant noted that the cultural advisor was particularly mindful of the importance of making people feel at ease about attending a mental health service:

*Gosh, that personality she just fits in and makes people so welcome. That's one thing I noticed with her [...] she just breaks down those barriers. Which is really good and people who have got that stigma and have got that nah, mental health service, and she'd get in there and she'd just make it all better which she is good like that. (WH14)*

Another participant recalled the cultural advisor providing a safe presence during a crisis intervention:

*[Name of cultural advisor] was sort of the initiator from Whirinaki originally. After [Counsellor] from school referred us there. It was [Name of cultural advisor] that we*

*saw first. Yeah she came, we first met [Name of cultural advisor] in Crisis Team, she's in the Crisis Team. She came here because we had an incident [...] But they're very, yeah it's a very good place... I always think of [Name of cultural advisor]. ..... I don't know where she would be now without you, without them. (WH13)*

The participant noted how the cultural advisors were skilled in the way she was able to build trust with the young person when the young person was feeling vulnerable:

*You trusted [Name of cultural advisor] too when she came that time eh. She came with a group and she was the only one that won your confidence. (WH13)*

*Yeah I didn't talk to anyone else. (R13)*

Another rangatahi participant spoke of the respect that he had for the cultural advisor and recalled feeling that he was there to provide the support that the whānau needed:

*Yes, I remember the Kaumātua over at the old Whirinaki and yes, yeah and he was helpful and again just sat in to listen. But then I'm going to, I'm of that era that I'm going to listen to what he says (laughter) and take on board and [...] He did kind of care for us and that yeah. Not really, just was there for us and I appreciated that too of course. It made me feel comfortable. (R1)*

Similarly, another whānau participant recalled a story of how the cultural advisor had the respect of the young person and was able to get him to listen to him when he was absconding and disengaging with other clinicians.

*....when it came to interviews with [Name of clinician], he [Name of young person] kept disappearing. He would take off, so what I did, I rang [Name of cultural advisor] and said [Name of cultural advisor] we're not able to come into the appointment. He goes what's the matter. I said [Name young person] has run off again. I found out he was at my Aunty's at Otara .... so [Name of cultural advisor] went down there to pick him up. And [Name of young person] just got up and just[ ...] Yeah, but I think it was [Name of clinician] who went up first and he wouldn't move. But when [Name of cultural advisor] went up, he just got up and walked freely. (WH5)*

Not all whānau participants were able to access the support of the cultural advisors at Whirinaki, however, a few participants described how their skills and reputation well were known amongst the local community. One participant noted how the respect she held for a particular cultural advisor would have enhanced her engagement with the service:

*From, from a whānau perspective and I believe [Name of cultural advisor] is here at Whirinaki I would've loved to have [Name of cultural advisor] there because I would've felt more at ease. I would've been able to and it's not a, I don't want to say it's, sound like it's a cultural or a race thing but I connect better, you know. (WH1)*

This participant was reluctant to state she preferred working with Māori, perhaps because having a preference for working with Māori could be perceived by others in mainstream society (in the dominant culture) in a negative way; for example the Māori for Māori model of care may be perceived negatively by the dominant Pākehā (NZ European) culture as a privilege rather than an accepted and normalised model of care.

**Flexible approach.** Many participants noted how clinicians were responsive and attuned to their needs and were able to provide the most appropriate therapeutic intervention and support for them. One rangatahi participant talked of how her clinician anticipated when she needed help before she asked:

*... if I did need more help instead of me having to ask for it she would have really know. 'Cos she had a few things set up when I was still there. So through my experience I would say it's really good. They help without you kind of having to ask for heaps of help [...]and I noticed that if I wasn't comfortable with how things were going, she would change it or something like that. (R6)*

Another participant commented that when the clinician realised that the type of therapy was not compatible with the young person and adapted it, the young person made more progress and engaged better in therapy.

*Probably, I mean, I was really impressed with the service from the get go, but probably when [Name of clinician] realised that this is not, we're doing it the wrong way. Yeah, we're totally doing it the wrong way. Probably then, that wasn't that long ago either (laughter)[...] In my heart I knew it but I didn't know how to [...] but I*

*just, kind of, thought, you know, say I don't think this is working. But, she kind of clicked to it (laughter) [...] [Name of clinician] just[had a] light bulb moment, wow. This is not how [Name of young person] (laughter) learns. Yeah, we need to do practical, and since then it's just, he's become so much more sure of himself. (WH14)*

The young person also gained confidence when the therapy was appropriately modified to suit his learning style.

Some rangatahi participants had a good understanding of what worked for them and what did not. One rangatahi participant reported that she was able to access different forms of support from her two clinicians/ case team and found it helpful that one clinician made regular check ins whereas the other clinician provided Cognitive Behavioural Therapy which was suited to her:

*I think working with [Name of Clinician] mainly. Because [Other clinician] was more like, she didn't give me strategies and stuff. She was just, like, how are you. She kind of did, but it wasn't like, it was mainly with the way I was thinking. (R10)*

**Regular ongoing contact.** Clinicians' making regular consistent contact was a theme that strongly resonated with participants. Participants appreciated that clinicians were proactive in their approach by keeping whānau informed about the intervention pathway. 'Keeping in touch' also demonstrated that clinicians cared. One participant who had a negative experience with Whirinaki in the past noticed the improvement in the contact she had with clinicians:

*They, kind of, keep you informed the whole way, you know, this is what's gonna happen, this is what's gonna happen, you know. The follow-up is a million times better than it used to be. Constant e-mails back and forward, constant progress reports. (WH14)*

Most other participants also commented that constant and regular communication was a strong aspect of the service they received, as one participant noted:

*By their communication through just calling me, they keep in touch with me quite often. I mean on one occasion, I think one last week alone I got, like, five phone calls*

*just to keep onto, you know, make sure that I've got her blood tests and all that all done, to take her to the GP because they were concerned about her weight gain and all that. I said, yeah, no, not a problem, I'm onto it, I'm onto it. And it's just having that constant line of communication with them, it's good. Even though we might not see each other, like we see each other every week but actually hearing from them every other day and it does, it just shows me too that they care just as much as I do.*  
**(WH9)**

One participant talked about how she appreciated it when her clinician made the effort check in with the young person:

*Like the other week [Name of clinician] was in the area and so she just popped in. And it was still at course but just popped in. And then she waited for her, because you [young person] were due home. Yeah.* **(R13)**

The same participant was pleasantly surprised that the clinicians were always available and consistent in their contact.

*Yeah like whenever I've needed them they've like always been consistent. And they're always there. I'm really surprised at this.* **(R13, WH13)**

Some participants also enjoyed receiving positive feedback from clinicians about their children:

*....it is cool, it's very cool. He's enjoying, even [Name of Clinician] emailed me yesterday and said, you know, he's got something, passion for food, he can see it. He's doing really well.* **(WH14)**

The ongoing care provided by clinicians demonstrated a commitment to the recovery and wellbeing of the young person:

*....we stayed with her [Name of clinician] until [Name of young person] was discharged from them. And she always kept in touch to see how [Name of young person] was and do you need any help or anything.* **(WH5)**

***Integrity and following through.*** Many participants commented on how clinicians supported them to continue to engage. Participants reported that there was a sense of integrity that the clinicians went above and beyond and followed through with their commitment to the work.

*Because I've had, just because I've had like a lot of people like they just say that they're going to do one thing but they don't follow up on it. Like mental health organisations and stuff. Yeah like they actually do like promise yeah and then they just talking I don't know. .... Yeah. They tell you what they, they do what they say. They do, yeah. .... Like oh they said that they wouldn't leave me [during crisis] until I'm ready to go. Like until I'm ready and they stayed with me like this whole time.*  
**(R13)**

One participant recalled how it helped when her clinician encouraged her to attend the session even when she did not feel like going:

*Yeah, and one time I just wasn't feeling up to going and she told me to come in just so, you know, in the future, I can't explain it. Just so she could help me through it in the future and stuff like that.* **(R6)**

Another participant used an analogy of an ambulance to explain how Whirinaki arrived during a crisis and continued to provide necessary care until her daughter mended, unlike other services she had been involved with:

*And the funny thing is that they're there on the scene. It's just like an ambulance driver getting to the situation first, before a fire engine. You know, or if there's a fire then there's the firemen and then the ambulance. It's kind of like that, you know, Whirinaki didn't put a plaster and run away like the rest of them.* **(WH11)**

Another participant also echoed this sentiment:

*Well I find Whirinaki a really good, good place to be. There's no other like it eh. Yeah. Because our family had a lot to do with counsellors and mental health problems and such like. I've never in all my years I've never come across any organisation as good as that.* **(WH13)**

Many participants were grateful for their involvement with Whirinaki and the support they were provided during the difficult times:

*Now that I've been through it all, I'm like, oh thank God for Whirinaki, thank God for the psychologist and the doctors, because I don't, I really don't know what we would've done. Like I think it's hard for us as it is and we've had to deal with all these things but I'm sure there's a lot worse out there. (WH15)*

*And yeah, no, the ongoing care they gave was really really helpful and I mean they even, they would come in sometimes and just take her away for an hour or two because at first when we were still transitioning into her being discharged from hospital, she was still a bit edgy. (WH9)*

Another participant also felt that Whirinaki went above and beyond to ensure that the young person got well again and how the young person responded well to the care he was being provided:

*Yeah, and ringing taxis to get us out there ..... yeah, she just went that extra mile to make things really easy. And that's where I think [Name of Young person] felt comfortable with her, and it's all about being comfortable with the person that he really trusts. And that was the same with [Name of Kaumātua], you know, [Name of Kaumātua] said if you want to get into any sports I've got sport providers. It actually just picked him up. (WH5)*

Clinicians giving young people time and seeing them in a positive light made a significant difference for many rangatahi. As one participant put it:

*But honestly if it wasn't for Whirinaki and Mahitahi my daughter probably could've been ten times worse, and probably a death certificate. There's a lot of kids out there that's just like her. If somebody gave them the benefit of the doubt, that'd be fantastic, you know. (WH11)*

**Empowering whānau.** The encouragement of the clinicians was valued by many participants. Some participants noted how the clinicians were able to work well in collaboration, complimenting the existing strengths within the whānau.

*I can see their concern is just, just as huge as mine [...] yeah, they care just as much as I do, yeah. 'Cos I know I have my limitations on what I can do for her but I know they can take it beyond that, which they have done for us. (WH9)*

*You know the ones that I see, they seem genuinely interested. (WH8)*

Participants also felt that their Māori identity was validated and honoured by clinicians. One participant described how when her daughter was unwell the clinician instilled a sense of pride by telling her that her Māoritanga was a source of strength:

*But the other thing I loved about [Name of Clinician] too, and I think you'll agree with me, was I loved the way she, she always brought across her Māoritanga...proud to be a Māori, very proud to be a Māori and she constantly reminded her, 'you're a strong Māori girl', you know? And yeah, no, that was encouraging aye? (WH9)*

Overall, many participants felt the clinicians empowered whānau and fostered a sense of hope for their children; this was something that was considered important to this participant:

*I believe they've instilled hope for us. For us both, not just her but for me as well. (WH9)*

While most participants had positive experiences with Whirinaki, a small number also had negative experiences during their involvement with the service. One participant who was not in He Kākano spoke about the service being somewhat detached:

*Yeah so Whirinaki had, I mean don't get me wrong they it's a good thing but they need to be more oh comfortable with them and less clinical. (WH1)*

This participant described feeling as though her child was being 'put in a box' pathologised and treated as 'just another case':

*In terms of I guess for you know for me it was I'm questioning my, now I'm getting to the point where I'm having to question this boy that I love. And they're saying there's something wrong with him and I don't understand what's wrong with him*



*and[...]yeah like you're saying this but my mum and them reckon there's nothing wrong with them. (WH1)*

This participant also noted that the way information was written about her child came across as being judgmental and detached:

*And you know and on top of that you know I read, I kept a lot of all his stuff. And found it can be quite detrimental. A lot of those records of reports and I'm quite [...] the way that it's written and how they portray. I mean obviously they've got the information but now. Yeah a lot of things that I found yeah quite hurtful from the reports [...]. Remember that you're looking not only at the child but you're looking at the family. Yeah. (WH1)*

The participant felt upset at individualistic, deficit focus of the clinicians and how they documented information about the child. This experience was detrimental to the whānau who saw the child as a treasure. When the child was labelled negatively in reports this was seen as whakaiti (belittling) not just towards the child but also towards his whānau who had an interconnected identity and wellbeing. .

Another participant also reported the diagnostic assessment process frustrating as felt like they were trying to fit her child in to a box:

*Yeah, tryin' to say well we think it could be low Asperger's, you know, and I'm like, well, I don't agree because of this[...] I know what I'm talking about, sort of thing. Well, he's my son, and I know my own son, kind of thing. And, it was professional versus non-professional. It was intentional, I wasn't trying to be, you know, but that didn't go very well (laughter). (WH14)*

**Home visits.** Most participants appreciated the way clinicians offered home visits as it helped them feel at ease within their own environment and also assisted with transport.

*Yeah, they came out and they asked me if I would feel comfortable there or here. And I said I prefer here [...] I don't like going to other people's houses. I don't feel comfortable. Like I said, I'm a bit claustrophobic, I don't know too many people and I feel more comfortable and I can talk more [...] Yeah, and that was kinda cool, they*

*said yes we'll come out to you instead of you coming out to us. But if you want us to pick you up we can. I'm not really into that kind of thing, but they cater for me and they cater for my daughter. That was good. (WH11)*

Most participants had transport difficulties:

*I just haven't had time to take him. It's like oh, I just can't get him there at that time. I'm always, like if you really want to see, like the morning sessions, or have to be after his school hours. (WH3)*

These participants were relieved that home visits were offered to address this barrier.

*...that was more the main the part of it, getting there and back, that made a big world of a difference (WH6)*

*...because they offer taxi services eh, that's like all no, like getting there is real good. (R12)*

*...they come out to us (WH13)*

*[Name of Clinician] would come out here to pick us up and transport us back to Whirinaki. So she went out of her way. (WH5)*

Some whānau participants had worked out a plan with the clinicians so that there was a mixture of home visits and sessions based at Whirinaki which was perceived as being accommodating.

*...we alternated, like we will go there or they'll come here every other week sort of thing, yeah. And just followed up with her and just had meetings with the doctors, yeah. But no, they have been very very helpful. (WH9)*

In summary, the recognition of power differentials and the empathetic manner of clinicians were valued by both rangatahi and whānau participants. Many participants also appreciated that clinicians kept in regular contact with them. The importance of being responsive to the needs of the young person and the whānau, being able to adapt interventions where necessary was helpful and demonstrated respect and commitment to

providing the best care. In addition to these factors, the expertise and approach used by the cultural advisors strongly resonated with participants. Whānau commented on how instilling hope encouraged them to 'keep going' and remain engaged with the service. Home visits greatly assisted many whānau who had difficulties with transport, it also helped put people at ease.

**Practical support.** Many participants commented on the importance of learning practical skills and strategies to assist with increasing their repertoire of coping strategies. The following subthemes describe the various interventions that participants identified enhanced their engagement with Whirinaki: strategies and skills, increasing support and Youth and Community Living Services.

**Strategies and skills.** Clinicians were knowledgeable and were able to provide practical interventions. Clinician treatment expertise was identified as something participants valued, as one rangatahi participant put it:

*I reckon. I reckon they know their stuff at Whirinaki. (R12)*

Psycho-education and strategies to manage difficulties assisted whānau to have a better understanding of how to get better. Most participants valued getting tangible practical information from clinicians such as information sheets:

*She even came home with a folder full of all this work that they had done with her, and I was like, oh wow, this is cool because it helped me understand too. Yeah, and it was like what to do in situations where you hear the voices, how to get yourself out of that place, like find something relaxing, listen to music (WH9)*

*....from what I can remember. Gave a picture or a diagram to explain, like the very beginning of it, that's the part I'm just trying to remember aye, on a wall or board. My memory's good then. When she first came in the room she explained, like a picture and a diagram, like the beginning....She just told me to write down people, like family and friends that I can go for help or something. (R6)*

*...respect other people and respect myself. And like I've got like a whole folder of how to do this stuff. Yeah. (R13)*

Clinicians offered support with particular/specific difficulties they noticed that rangatahi needed help with, participants appreciated that clinicians pre-empted this. Comprehensive understanding of the client's presentation and knowledge of interventions was valuable to one participant:

*...because the other thing to, he asked if she wanted help, because she doesn't like small spaces and even if we're sitting in a room she always likes the door to be left open. Even at doctors, everywhere we go, even at our meetings at Whirinaki, the door has to be left open, just partly ajar for her, and he said, you know, would you like help with that, and she said 'yeah, of course'. You know, it's just little things like that. You know, just tackling them all, head on, one by one. Yeah, just baby steps.*  
**(WH9)**

Another participant appreciated learning new skills that helped improve her quality of life:

*She like, each time that I go and see her she gives me a paper and like it'll be about how to have better sleeps and stuff like that. Or how to like avoid conflict and stuff like that. So it was learning new ways to deal with things.* **(R13)**

Many participants reported that coping strategies such as listening to music, physical activity were helpful as they were activities that resonated with young people:

*But, since he's been seeing [Name of Clinician] and doing some hands on stuff, really enjoying it. Doing cooking and practical stuff, it's a lot different this time around.*  
**(WH14)**

*... he plays his music a lot now. Before he used to play it a lot but it was the type of music he was listening to that I didn't like. It was like depressing, really depressing slit your throat music sort of thing[...]He's listening to more livelier music now which is, thank goodness for that.* **(WH8)**

Getting young people involved with activities outside the house was also helpful, particularly for one participant who before she was unwell, had many friends and was very active socially:

*That I'd get involved with stuff, more involved, 'cos I don't really like to do stuff but[...] they said that I'll get involved with more activities, yeah. And that's what they feel, there's a need for that too because I still think too that she has a fear of being out there in public. (WH9)*

Finding the 'hook' or what the young person really enjoyed doing as a way of increasing behavioural activation as well as self-esteem was also appreciated:

*He just is like, if it doesn't work out from the first time he'll just abandon ship and give up. So, [HK Clinician's] helping him reach his potential. (WH14)*

One participant also talked about the usefulness of cognitive behavioural therapy (CBT) techniques to assist her with her difficulties:

*... he said if you have straight away automatic thoughts and then you have your feeling after that, and then that affects the way you feel and act and behave. And he wants me to stop the way, like the thought straight away, or the image and then deal with that. And then I'll be okay. And I find it's really good, it's worked. (R10)*

*he teaches me things like he compares, like he said the reason why you feel like that is because of the thoughts that make you believe that. And if you look at that first then it won't affect the way you feel, and then go downhill. Now I do sometimes, but I know how to deal with it. (R10)*

However another participant reported that CBT was not the right fit for her as it was challenging to adjust her thought patterns:

*It was but for me I think I didn't really take out much from that, I don't know why. I just found it a little difficult to change my thought, the thinking process, like what I believed my whole life, I couldn't change it. (R6)*

This participant found that she gained more from talking to her clinician, and the supportive whanaungatanga relationship rather than the therapy itself.

In summary, most participants commented on the usefulness of learning new skills and strategies from clinicians to assist them to get well. Overall, participants engaged best

with techniques that were appropriate to their own individual preferences and needs. Many participants valued the inclusion of physical activity, music in addition to the standard models of therapies such as CBT.

**Increasing support.** Providing support for the whole whānau enabled them to support the young person. Sometimes this was the provision of support to assist with social needs other times it was help with managing stress associated with the young person's mental health difficulties. Participants appreciated that there was a holistic approach at Whirinaki:

*...they work with the family as well as the client. (WH13)*

Taking the time to ask how the parent was coping was important especially when parents/caregivers were struggling with their child's behaviours:

*[Name of Clinician] has been good like that, she does ask a lot of questions and, you know, how are you and perhaps I tend to be, maybe I haven't come right out and said, I need help. Cause, I want them to think I'm this altogether mother that's not going downhill (laughter) fast. (WH14)*

This participant reported that she was able to open up to her child's clinician about the difficulties she was experiencing and the clinician subsequently made a referral to adult mental health service.

*Yeah, there's a lot out there but I didn't know there was a lot out there for me, and I didn't know I could ask. Cause, I probably would've asked sooner (laughter). I never thought to even ask cause it was just all about [young person]. (WH14)*

The social support provided to assist with basic needs alleviated the stress on the whānau system and strengthen whānau capability to manage mental health difficulties. (Addressing disadvantage, collaboration with services comment in discussion maybe) One participant was grateful for the way that Whirinaki was able to reduce sources of stress:

*Whirinaki is really good though. When I needed to get clothes or like we needed to get food or something and they like hooked us up. They've got many services. Heaps. Everything. They even brought us firewood once. They would be just like what I'm*

*thinking of, like what things are like stressing me out [...] They've got everything you need. They've got all the services. Yeah and they match you up with the right people. (WH13, R13)*

On the other hand, another whānau participant felt that there was a lot of support for the young person, however, there was limited attention directed at the wider whānau who were also in need of support:

*One thing is that, you know, like for us, okay so [Young person's] got ADHD, he's come from my parents, he's had all these people but we sort of didn't have anyone.... You know, like to, I guess because of his behaviour and its effect on the relationship and the house and especially because my daughter's not, she's finding it hard [...]but there was nothing sort of, everything was for [Name of young person]. You know, his medicine, his schooling, his behaviour, all that kind of stuff. And the people did say, you know, if you've got any questions, but it was like, now that you're asking, I can't see anything for parents or the caregiver. And I know that's how my mum felt because she used to ring me up crying saying, I don't know what to do. (WH15)*

**Youth Community Living Services (YCLS).** Most participants also commented on the involvement of (YLCS) through the organisation known as Mahi Tahi to support the young person in the community. Mahi Tahi is a support service that is contracted by the Counties Manukau District Health Board to work in collaboration with Whirinaki to increase social interaction and assist rangatahi to achieve their goals for mental wellbeing. Participants valued having another practitioner who was able to support them in addition to the work they were completing with their clinicians at Whirinaki.

Boredom and rangatahi having lots of spare time was a problem identified by many participants. Many participants reported that they enjoyed being able to go out and do activities with Mahi Tahi. One participant reported that her support worker took her out and was also available to talk to when she was lonely:

*I see this other lady from Mahitahi Trust, something like that. But they more like take you out and do stuff with you...like movies, show you round places, malls and that. Get you out and do stuff with other kids. I find her really good to talk to. ... She*

*takes me out and she's more like a friend, a close friend....Yeah, she's good and she talks to you and that ....she's trying to keep me busy for the whole week. Because it's mainly Sunday and Saturday that I still feel down when I'm alone. (R10)*

Having another service providing mentoring and support was hugely valuable to many participants. One participant appreciated that her son was able to learn new sports with his support worker:

*Yeah, he really wants to learn basketball and it just so happens that his Mahitahi person is a basketball person is a basketball player as well. So, they're gonna start training from Monday. (WH14)*

Parents appreciated that Mahi Tahi support workers were experienced and skilful at working with youth with mental health difficulties:

*But then I see [Name of Mahi Tahi support worker] with cars filled up with teenagers that have all got the same issues [...] and I'm thinking you would have to have a really good personality to get a lot of teenagers with issues. (WH11)*

In summary, participants valued learning new skills and strategies to manage their difficulties. Clinicians also assisted by providing other essential support to relieve pressure from the whānau.

**Engagement barriers.** Participants were asked if there were any barriers that hindered their engagement with Whirinaki. Although most participants overall had a positive experience with Whirinaki, some participants reported that they experienced negative incidents which impeded on their engagement. Some incidents occurred during the most recent engagement and some were during previous referrals to the service, these were touched on earlier in previous themes. The participants identified barriers with medication and interpersonal difficulties. These phenomena provide information to help clinicians to gain a better understanding of how they might reduce these barriers to engagement.

**Negative experiences with medication.** Some whānau spoke of having a general aversion to the use of psychiatric medication. Of the participants that commented on



medication, some reported that their wider whānau were not supportive of the young person being on medication.

*I think my dad didn't like it at all, he was totally against, you know, why do you need a medicine to make the kid better? (WH15)*

One rangatahi participant also reported that he did not like taking medication and found that it was ineffective for him:

*It was just the medication that they gave me. I didn't like it. I refused to take it. Only the inhaler I took, the rest of it I just left it. Give me sleeping pills and they don't even work. (R3)*

Another participant stated that her whānau were against her attending CAMHS and saw the medical model of treatment in direct contrast to their own values:

*A lot of it is my family's not into Western medicine full stop. You know, that's just how they are. (WH2)*

Despite this, the participant decided to explore the medication pathway and found it difficult to navigate the different tensions between her whānau and the service:

*And we were sort of going Whirinaki. So we were doing everything for Whirinaki, we were going against our own family. 'Cos we had to be the ones in the middle to hear rather than hear your side and hear your side, and then we'd talk to [young person]... (WH2)*

The same participant reported that she thought that medication was a form of controlling people who were unwell rather than a therapeutic treatment option:

*I think there's more behind, because a pill is just a pill and all they were doing was administering these pills just so that they can get the information so it was to keep him, I don't know if it's like control, to control, so that they don't lose him[...](WH2)*

After exploring the medication option and trying several different medications she decided that she wanted to withdraw her child from medication and explained how she was threatened with court action:

*And then I was told that they could take me to court but it should be alright because the judge shouldn't have a problem seeing that he's not a danger to him or anyone else. And I said they'd be idiots if they take me to court because they know that, they've got nothing to on apart from if they're angry because they've lost him 'cos he was a good kid. He was a good experimental monkey. (WH2)*

Another participant similarly reported that her whānau were sceptical about medication from the start and when she explored that pathway and had negative experiences, it reinforced their perceptions about the harmful aspects of psychiatric medication:

*So in all aspects, I guess what I'm trying to say is in terms of the pills whānau had a huge impact about that. And a lot of it was, and I guess it's a lot of misinforming or misinterpreted information on the effects on what it would do. And once we saw the effects of what it was doing we didn't like so therefore, at the stage, when he was little we withdrew from that. [...]They're still prescribing it but he refuses to take it, you know. (WH1)*

Many whānau participants that commented on medication reported that they felt pressure to consent to medication and often felt their fears about medication were disregarded or not given adequate acknowledgement:

*I was mad because the doctor didn't diagnose him properly. I mean like we went in and then said a little bit and then he's like well okay this is next drug that you'll take. But it's like hang on. (WH8)*

This participant noticed that her child changed dramatically in his personality and also academic competence while he was on medication. He dropped from being the top student in his class. The family had their own understanding of how the medication was impacting on him:

*Well I think too when your body is all good and then you go and drown it with. (WH13)*

The same participant reported that she had a series of negative experiences with misdiagnosis.

*Yeah I was searching for that when I got out of the hospital and they decreased his meds. And I was saying I need to know more information because of what happened with me with the doctor and me believing the doctor. And then all of a sudden finding no that's wrong, they've overdosed my son so it's like no I need to know now. Instead of having that trust. But it's, but then I thought no that's it and I just made the choice to take him off myself and just use my own instincts **(WH8)***

This participant commented on how this led her to mistrust medical professionals and medication.

Other participants talked about how they were not given much information about the medication they were prescribed by their General Practitioner (GP):

*The first time they gave me, I didn't know what the hell they were called, then I found out they were antidepressants.... It was like he gave it to me, hey take this, it will be gone in like a week or something. That's the impression I got. **(R6)***

These narratives reinforce the importance of taking the time to ensure whānau are given full information about medication as well as adequate time to consider and consent to this treatment option.

On the other hand, some participants stated that they found medication helpful and that it assisted them manage their mental health difficulties:

*It actually calmed him down. It made him restless and he wasn't sleeping at night so they had to prescribe him with those tablets [...]Yeah, because we needed him to rest. He was up all hours of the morning, walking, talking to himself so yeah, I had to get onto it quick. You know, get him that help straight away. They prescribed him with tablets that actually did the job, for at night. It gave him a lot of rest during the day, so yeah, it was a bit of an up and down thing. **(WH5)***

One rangatahi participant reported that she liked the overall multi-faceted approach to therapeutic intervention and found that medication complimented the other forms of therapy:

*I would say stay with it I suppose... go and stay with it because it's I have, yeah I think it's fucking good, way good. You get to talk to like someone, you know like therapy or something about the stuff that's going on your head and things like that. Like for me and I'll, and, and yeah just doing that stuff instead sitting there thinking wow, that's really crazy. And medication probably helps. (R12)*

**Language and interpersonal skills.** Using appropriate language and communication style was a factor that was strongly identified by participants. One rangatahi participant noticed that her clinicians often used clinical jargon that she was unable to understand:

*...he was telling like there's was fancy words, like a lot of fancy words but like really big clever words [and I] kind of skip listening (R12)*

This participant was aware of the purpose of technical terminology in mental health however reported that there was a need to explain things in simple terms:

*One of the things I think about was they were telling me about the medication is that the words they were using and I was kind of like all jibber jabber and stuff and I couldn't kind of catch it, what they were saying. So they were like that like towards each other in their science way and they need to explain it. (R12)*

Another whānau participant also reported that her son already had difficulties with comprehension and this was sometimes exacerbated when the clinician used words and language that was unfamiliar to the young person:

*And, [Name young person] was getting to a point where he was like mum I don't want to go this sucks. And, then [Name of Clinician]'s saying, all these hard words she's using I don't even listen to anything she's saying. And, that's around the same time that she started think, this isn't working (laughter). (WH14)*

Another rangatahi participant also identified that they use of clinical language was a barrier for engagement:

*Yeah, but I couldn't really talk to her because of the way she was speaking and stuff, I didn't really understand it properly[....] Yeah, was way outta my league. (R4)*

One participant who was not placed with He Kākano (or placed with non-Māori clinicians) described instances of cultural miscommunication where she felt misunderstood and the clinicians were unable to relay information appropriately.

*Yeah I connect better and feel like I mean [Name of Non-Māori Clinician] was lovely and that but a few times when I would get her report back there had to be corrections done because she's either misinterpreted or, and I had, and I don't know what it is. (WH 1)*

She remarked that if she had her time again she would seek out a Māori practitioner who was able to effectively explain important information to her:

*Ask for a Māori kaitautoko or you know a support worker that's there that can hopefully answer or give a different perspective on, on what the doctors or the psychologists are saying to you. Because we would sit there, honestly I would sit there and go man I must be really thick, I don't understand a word she's saying (WH1)*

This participant reflected upon the importance of understanding finer nuances amongst Māori that is often evident in the way we talk:

*I think we have a language even within our, apart from Te Reo but our broken language in English as well that sometimes people just don't connect. (WH1)*

According to this participant, language, regardless of whether it is English or Te Reo Māori, can serve as a means of enhancing the relationship between clinicians and service users.

Other participants commented on experiences where the clinician lacked interpersonal skills. One whānau participant described a clinician who was abrupt:

*But he came at you like a bull in a china shop. (WH13)*

Both participants described feeling uneasy during their interaction with the clinician during a crisis:

*I felt very intimidated. [...] I just felt uncomfortable. I thought he was going to put me in a straight jacket or something. Yeah he was like that. Pretty scary. (R13)*

The rangatahi participant recalled the manner of the clinician being loud and forceful:

*He was loud [...]He was telling me this is what you have to do and you're going to do it. Like go on your medication and stuff. But then [Name of Clinician] said no she doesn't want to do that[...]And he had a very loud voice –And I couldn't understand him. (R13)*

The impetuous approach of the clinician during a crisis was unhelpful particularly because the client was vulnerable. However the assertiveness of the other clinician was perceived as supportive.

Another rangatahi participant recalled an incident where a clinician did not make any effort to build rapport with the young person:

*I remember there was this white fella just signing a piece of paper, and he walk out the door [...] I guess if you want to leave an impression on someone yeah you'd need to be involved more eh, especially for a child. You just remember a white fella giving you a piece of paper and walking out the door well then. (R1)*

In this case, the clinician's hasty manner was perceived by the rangatahi as a lack interest and genuine care towards him. The young person specified the clinician's ethnicity in his description of the incident because he may have interpreted the clinician's lack of care to be related to the cultural differences between them and the fact that there were other instances of cultural misunderstandings that occurred throughout the time he and his whānau were engaged with the service.

In summary, the barriers that participants felt hindered their engagement were presented in two subthemes; medication as well as language and communication. There was a range of whānau perspectives on medication. Some participants and their wider

whānau were critical of the medical model of treatment. However, those participants who had negative perceptions of medication still explored this option of treatment. Some participants expressed that they felt coerced in to taking medication. Some participants also had negative experiences with misdiagnosis and side effects of medication. However, not all participants had negative experiences with medication, some reported that it helped them get better alongside other therapeutic interventions.

Another major barrier was the use of technical and jargon-laden language in therapy with clients/service users. Participants reported that inappropriate use of language led to ineffective communication. It was felt that there was a need to make language more relevant and understandable to people who are accessing the service.

Finally, lack of interpersonal skills and abrupt manner were noted as barriers to engagement as it showed a lack of concern and respect for the rangatahi and their whānau.

## **Whānau Approaches to Wellbeing.**

**Whānau strengths and coping strategies.** Participants identified that the positive outcomes during the engagement period were due to a combination factors; the strengths the rangatahi and whānau possessed as well as the support received from He Kākano. Though not asked directly about strengths, participants were forthcoming with information about self-coping strategies and what their whānau did to make positive changes. Individual and whānau strengths enabled effective collaboration with clinicians to achieve wellbeing for the whānau as a whole.

Participants who presented to Whirinaki came from a range of different backgrounds, some who already had many strengths within their whānau, others who built up their resilience and strengths during the process of coping with struggles while they were engaged with the service. This theme attempts to describe the resources, social supports and strategies that reflect whānau resilience and includes the following associated subthemes: whānau connectedness, other supports, identity and belonging, whānau wisdom and holistic approach.

**Whānau connectedness.** When participants were asked what helped them to get better while they were engaged with Whirinaki, most identified strong investment from

whānau members in the young person's wellbeing as well as the closeness and support of their whānau network.

*...it's love. There's not enough of it going around. A person can feel unloved, their feelings aye. (WH2)*

Most participants commented on the importance of the whole whānau unit coming together to assist with helping the young person get better while they were with Whirinaki.

*Yeah it's a package, the team, putting the whole thing, I call the whole parcel. (WH6)*

*As a family. That's the key word. You need the family there behind our young ones. I mean honestly, it's not just seeing it through her but seeing all these other young ones around here too. (WH9)*

All whānau participants acknowledged that it was important to foster a good relationship with the young person who was experiencing difficulties. Many parents talked about being committed to the wellbeing of their children, being open and listening to their difficulties. One participant reflected on the importance of being attuned to her daughter's needs especially when she was experiencing difficulties:

*I don't want her to ever think that she can't come and talk to me, whether I'm angry or pissed off or whatever, I want her to come and tell me things. And you know, I've just noticed a few things and I just ask a few questions and she would know that I'm asking a specific question that I'm trying to get at, because I'll ask it ten different ways. She knows I know something, she just doesn't know what. Like, I can tell if she's not happy and stuff. (WH11)*

Another participant also echoed the importance of getting alongside the young person, talking with them and guiding them:

*Also just talk with them not at them. And even if they do seem like they're going on the wrong way just still [try] and guide them. Don't go dude you're wrong cause that's when they'll shut off and they'll be like oh no I don't want to talk cause then they feel like they're not getting it right [...] See son I was like get him a pet, occupy him .... (WH8)*



Another participant spoke about knowing and relating to her daughter in a unique way that others may not be able to relate to and that this enabled a greater depth of understanding of what she was going through:

*Yeah, she was always a good writer, yeah. Sometimes I'd notice, like, when she'd write things out, some people wouldn't understand what it was all about but it was weird because when I used to read, I'd go, 'yeah, I know what you're talking about'. (WH9).*

Importance of adjusting the way the whānau interacted with the young person and giving them a voice within the whānau was noted by one participant:

*Our support, at first we didn't give her much support and we didn't give her much airway. The reason why is because we couldn't trust her at that stage. Now I've given her airway and trust, and it's all up to her now. She's older and she's wise and that, and I thought to myself that no, we need to give you the airspace, we need to give you the trust[...]So she's actually become the girl that we want her to be. She's starting. (WH7)*

Many whānau participants reported that they felt they had formed a closer and stronger relationship over the course of time, going through and overcoming difficulties together:

*But going all this especially with her, I believe it's helped us to bond more, aye miss? Rangatahi: Yeah. Whereas before our, our relationship was like always in each other's face, yelling at each other, yeah, but now it's completely different. It's been a complete 360 turnaround for both of us and we're able to actually sit down and talk properly, you know, not yell and scream like we used to aye (laughter). But no, I put that all down to efforts on her part and the help and support we've had through the hospital and Whirinaki. Because without them I don't know where we'd be (WH9)*

*And I'll tell you what, it made us, it made us, all this. Brought us a lot closer (WH9)*

Strong relationships also resulted in rangatahi being able to feel the difficulties they were facing were validated by their whānau. One young person was experiencing suicidal

ideation as he was coming to terms with his sexuality and feelings of being attracted to someone from the same sex:

*So I told him that I know that he's attracted to another guy hoping that and then it stopped[. ..]Well it [suicide ideation] stopped, all of that stuff stopped. Yeah so I was thinking maybe it was a way of trying to let me know without him having to say it. By going right around everybody else. That was what I was thinking [...] I just said to him that I'm not worried about that part I'm more concerned about him trying to end his life yeah. And then he sort of came around. He's been a lot better since then.*

**(WH8)**

Some young people who were experiencing a lot of difficulties with their mental health required intensive support from the whānau to assist them to get better. For many participants, other whānau members were key supports for them during difficult periods, going above and beyond to ensure that the young person who was unwell had the care they needed.

*....making sure that Whirinaki was doing their thing and making sure that [Name of Young Person] was getting to this and doing that thing, but they still believe that he still needed a primary caregiver. Somebody who's gonna walk side-by-side with him and write everything down 'cos it got to the stage where my youngest daughter became everything to him, she actually gave up a lot of her schooling because she sat up with him. She said when you're not in a good place or you're not well and you need somebody, just wake me up, it's alright. Well he surely did coz he'd wake up and my daughter would be there like this, and no school today. But they do, they need somebody who's there when things get tough. **(WH2)***

Some participants commented that the young person was not herself/himself. The wider whānau had a sense that something was not right and were able to mobilise support.

*... this came about when she was staying with him [ex-boyfriend], yeah, then, no, that's how we noticed a big change in her behaviour and, well the family saw a need and it was actually my sister that admitted her into hospital..... Yeah, 'cos her, she*

*had completely changed and the family were saying things are not right here. And yeah, it was my sister that ended up admitting her. (WH9)*

There was also firm sense of purpose and fortitude to ensure that their child got better. One whānau participant spoke of being determined not to let their child's unwellness take away their identity:

*Yeah, and it was real frustrating. If you've got Māori sickness or whatever it is, mental illness, they just say things out of the blue, and he kept making me angry. I said no, this isn't [Young person], I need to do something, I'm not going to go through all these years with that. So yeah, I'm glad I did it [...] Yeah, if anything happens with my kids I wanna just get out there and get whatever help I can instead of letting them drift with it, drift away. So I said no, I have to do something. (WH5)*

The importance of doing everything within their power to support the young person was also echoed by another participant:

*....find out and do your research about all the different, it's so easy to get all the answers If you go online and you put in mental health and you have a big list there and look at all of them, find out which one suits your child, their behaviour coz they could end up going down the wrong path. It can easily be done because the person who's sick is relying that you know everything about how they feel and if you don't really know that person, well you could be going on your own path about how you feel because it's not about you. And that's all it was, it was feeling for [Young Person], was trying to be his thoughts and feelings and everything. (WH2)*

For this participant it meant finding the best suited services for the young person by having a close understanding of his unique needs.

Other whānau members not living with the young person were also a key source of support as it offered a space for respite. Many young people had good relationships with their grandparents in particular:

*....she'd just go over for the weekend sometimes, you know, she loved hanging around my mum, I don't know why (laughter). But my mum loved having her there too, so it sort of gave us a break as well. (WH9)*

The same participant also appreciated the way that her mother's wisdom and humour was used to alleviate her daughter's distress with hearing voices:

*Yeah, and when she stayed at my mum's, my mum used to always look forward to her going over there because she'd do the vacuuming, you know? But sometimes she'd stop in the middle of what she's doing, she'd go, like she'd say to me, 'mum, they [voices] called me a bitch', 'Nan, they [voices] called me a bitch'. She goes, 'tell them to get lost'. (WH9)*

**Accessing other supports.** Some participants also have other key supportive networks within their community. One rangatahi participant recalled how he was involved in a fight at school where six adults were needed to stop him, however he had a teacher he had a good relationship with:

*I had one person at [Name of school], it was the school counsellor. Whaea ..[teacher]... Always went to her office... Nah, when I was mad....[she] just told me to just be calm. 'Cos my knuckles bled when I was going to have that fight with that boy[...] my knuckles bled, both of them, 'cos I was tensing too hard. (R3)*

Another whānau found that attending information seminar helped:

*[Seminar].....about mental health and it was about hearing voices and that, it was for me, people who look after people that are like that, so that we have more of an understanding of what they're going through. It was awesome as, it was really, really good, it was so good it went... (WH2)*

Some participants reported that they utilised the internet to access information about mental illness.

*I've got an iPod app and it's got all the mental illnesses, there's so much. (R6)*

*Just accessing ay. So it's good now that it's online. There's stuff online like John Kirwan and his depression.org. That's good. (WH8)*

**Identity and belonging.** Some participants commented the importance of having a sense of identity and belonging within the whānau. One participant reported that the young person knowing who they were and being valued made a difference:

*...it's the caring that everybody's giving him. Everyone's got their own opinions and he knows all of us so he knows how we all are and probably is taking what he can out of each one of us to use for him. Yeah a lot of it is just so he knows that we do care about him and I think that he just needs some foundation; where am I who am I? Sort of thing, you know, here is my family, you know. His home where he calls home, like up in [Northland] he's been brought up there with my nan...(WH2)*

Whānau also had a positive regard for their child, valued them and viewed them as a gift. One participant reported feeling upset that others had labelled and pathologised the young person:

*...and this is the hard thing about it, you know you, on the good side of things I, you know, what our people are saying, fine. What the Lord has given us this is him. This is who he is, you know. And even the old man would say, oh he reminds me of so and so and so and so. He was like that. You know, nothing wrong with him. And yet the schools and teachers are saying, I had one teacher say he's unteachable. (WH1)*

Another participant described a similar experience of valuing the young person and being accountable to their whānau for the child's wellbeing during the process of seeking the right treatment pathway for him:

*...at the end of the day we don't want to lose [Young Person], he's a valued part of our life [...] you have to learn everything and you have to find out. Coz if something does happen, if something does go wrong, you've got to know how to answer that to your family, that your intentions were good. (WH 2).*

This sentiment alludes to a sense of collective wellbeing which is shared amongst the whānau for the young person. It also supports the notion of child being a treasure, in line with mātauranga Māori or traditional Māori beliefs and values.

One whānau participant noted that her sense of the importance of her pride in being Māori was not realised until later in life however it was a source of strength that she instilled in her daughter to help her cope during difficult times:

*... I think when you're young and you go through different phases of your life, for me I've woken up a lot more. Maybe because just opened up and get to a certain age and it's like next minute, who cares, you know. And it's something to be proud of that we're Māori I think, any Māori [...] Nothing stops a Māori ngākau, nothing stops it. (WH6)*

Some whānau stated that maintaining connection to turangawaewae (original homelands) was an important aspect of health and wellbeing for Māori. One whānau participant spoke of ensuring that her children knew where they came from:

*I would go up there every holiday, take my kids, it was only because I wanted them to know [Name of place]. I wanted my kids to grow up and know, yeah, [..] and well it's worked because naturally they just go home now, I don't have to go, it's in them. It worked.....Yeah and now the heart is [Name of place] you know. (WH2)*

Another rangatahi participant who had moved to Auckland reported that travelling back home to her tūrangawaewae was difficult however when she was able to go back there and spend time with her whānau it helped her feel better:

*Me, Mum and my brother, we moved down here together. It's a bit hard because we've got no whānau down here either, so taking a four hour drive back home is not that great[....]Going back up north for a couple of weeks, that really helped. My grandfather's birthday so that was really good. (R4)*

Some whānau commented on how hard it was to cope with the difficulties of the young person's mental health and the impact on other members of the whānau. A few whānau participants had become caregivers for children due to parental death or parents

being unable to care for them. One participant described the impact of this on her daughter, who she described as usually being placid and cooperative:

*... she broke down one day [...]she goes, 'why is he so annoying 'cos he never listens and you always have to tell him', and then she turned around and says 'oh I wish he never come here'. And I wanted to cry but at the same time I said to her, I said you've got a mum and dad', I said [young person's] got no mum and dad'. And I told her what, I didn't, she doesn't know that my sister took her life, but I said, you know, 'Aunty passed away, his dad is nowhere and he's only got nanny and papa and us. And if we tell him to go away, where's he gonna go to'? [...] I said, look, we're doing this to help him so that when he grows up he can be a good man and he'll be a good dad. (WH15)*

Despite the difficulties this participant still persevered as she saw the importance of investing in children while they were young:

*...if you teach kids the right things when they're young, and that's what my parents and my partner's parents taught them, when you're young you learn all the things that help you make you a better person so that when you go out to start your own family it's easier.(WH15)*

Some rangatahi participants reported that they lacked whānau support. One participant stated that she attended Whirinaki alone as her mother did not want to support her to get better:

*I think she [mother of young person] just didn't believe that I had it, she didn't want anything to do with it. I tried to get her to come along, so I was like, oh, come on. But nah, she didn't want anything to do with it. (R4)*

Another participant also shared a similar experience, where the father of the young person was unsupportive of the young person's mental health difficulties:

*It's like he's saying, what's wrong, she shouldn't be like that. He's the type like he doesn't talk; he just sorts it out on his own. It's like snap out of it, not in that thing*

*way, it's like you'll be alright, you'll come right, but it wasn't, it was the physical part of it too aye. (WH6)*

**Whānau wisdom.** Many participants shared their understandings of what strategies they used to support the young person with their mental health difficulties. Whānau member participants often had knowledge of behaviours and strategies that they had learnt themselves or had been used in their whānau to express emotions and help process problems. Many parents were able to relate to and have empathy for their children as they had similar experiences in the past:

*Yeah and I remember being a teenager, I've been there. So when we're taught I understand what she's saying but trying to explain it to them at that age, you know what I mean. (WH6)*

Another participant also had a history of struggles and used her experience of resilience as a basis to instil hope in her child:

*My daughter, I've been there too myself, years ago, you've been in a house with no doors, no windows, no opportunities and no alternatives. And my daughter, you know, I've always told her that it doesn't matter how hard life is, there's always, if you look hard in a corner somewhere there's always a window, there's always a gap, there's always some way of getting out of things. It's just that you've got to learn that there's always hope, there's always dreams and to aspire to those you have to learn to have a stepping stone. (WH11)*

**Holistic approach.** Some whānau commented on how mental health was interconnected with wairuatanga (spiritual) and physical health and emphasised the importance of the expression of these:

*I thought she was gonna have another one [panic attack] [...] so this is what I did, I thought bummer this being Māori, you know, we're spiritual people, we don't want to hurt, we don't want to cry [...] so I brought her here, parts of it, whether she wanted screech or cry to just get it out so this was me, shake it out, shake it all. I made her stand and screech and cry and scream it out. And I think that probably did help some part of it. And then I thought some more, some more, I really wanted her to just, I*



*don't care who heard, the house was closed [...]Yeah you wanted to cry or screech, that's part of going through it, in the beginning part cos your body, your body's feeling so confused. (WH6)*

Another participant also spoke of the importance of using physical exercise and healthy eating to increase mental wellbeing:

*Plus we need to go and do exercise, yeah just eat well. It's what every human needs aye, eat well, drink water and exercising, you know, and you're healthy, healthy in mind, healthy in body. Yeah the whole approach, it's not only the physical...(WH2)*

Another participant also expressed a similar sentiment and thought that there needed to be a broader approach to managing mental health:

*I mean because they're going through what they're going through they need a follow up to keep them away from the thinking of the mental issue. But get them focussed on something else, so they can more or less blend it in. Instead of just one side, you're relying on one side but you don't know what the other side of your brain wants. Yeah, just getting them involved. I mean, education, but it's got to be education that would actually suit them, for their age. Not something that he shouldn't be in, when you already know he shouldn't be there. (WH5)*

Other participants reported that accessing traditional Māori healing practises were important as there was a strong emphasis on wairuatanga (spirituality). One participant overall had a positive engagement experience with Whirinaki, however, she accessed support from a Marae based Matakite to resolve difficulties that she attributed to Mate Māori (Māori sickness).

*I felt that there was still something wrong with him, so I took him to [Marae] because of their healers and all that, the Matakite's there [...] we went over to him and he goes what's the matter, and then we told him exactly what the situation was. And like within ten minutes, he snapped [Young Person] out of it. I said what happened to him, what was it, and he goes it was a Māori sickness. He explained to [Young person] that your shoulders are feeling nice and warm, nice and hot now eh and [Young person] goes yes. He could feel it. And he said guess who that is, and he*

*goes it's his grandfather. So his grandfather was there to help him. Of course I took my Mum too and I think it was meant to be that we had to go and see [Māori healer], yeah. And he's himself compared to how he was before. He just went off track, and I'm really glad that he is himself. But I think that he may still have a touch of it, but not as much, yeah. (WH5)*

The young person also responded well to the Matakite:

*Well when [Māori healer] did tell him [he said] can you feel the heat, he actually did. So he actually, you know, he was actually surprised. That mahi that [Māori healer] did on him, he didn't actually do any mahi, he was just sitting here, [young person] was there and he was talking. You know, this is how he heals them, like he's got a tokotoko, he was going like that and talking to [Young Person's] grandfather. That's how he did it, yeah. (WH5)*

This participant also appreciated that their healing was conceptualised and practiced from a wairua (spiritual) perspective:

*Yeah, we prefer to go to our own people first [...] Yeah, coz I didn't want my son to go down that road, just in case something really bad would happen. So I said no, I need to get him that professional help. Not so much with the Pākehā system, but within Māori. (WH5)*

The participant reported that she would advise others to also seek out a Māori healer, particularly if they were unsatisfied with the support they were receiving from their clinician:

*First of all I'd just, yeah, I would, if they're Māori I would tell them to get in touch with the healer. If they find it difficult with their social workers or whoever they're with, if they're not helping enough for them, well yeah I would refer them to the Matakite. (WH5)*

Another participant also reported that they went to a Matakite to help with the young person who was unwell as her whānau had a strong belief in Māori approaches to healing. This participant reported that she was initially startled at the assessment of the

Matakite, however after some time she noticed it helped the young person to make sense of his experience:

*It was a good experience at the Matakite and it's turned out, like it's, I think [Name of young person]'s taken in what Matakite's been saying, plus what the family have been saying to him. (WH2)*

Some participants noted the importance of spiritual wellbeing especially when people are mentally unwell. One participant recounted a story of how she herself had attended seven drug and alcohol treatment centres before she was able to make a full recovery. She reported that attending a Māori programme assisted her address deeper issues related to spirituality:

*The last one I went to was a Māori one, because I had some spiritual problems [...] the other ones, you know how you pick up things and you don't sort them out, they kind of end up on a different level. So if I started from the hard stuff, the reason why I started, but it ended up being seven levels higher when I first started off. So it's kind of like you chip away each level for each treatment. Actually, one day I just got sick and tired of scraping my arse on the ground because of that. Nobody likes to admit (laugh) how sick in the head they can be, physically, mentally. You know, my moral values (laugh), I didn't even know how to be nice or say hello to people, I used to smack them over. So you try and chop all those things down. And the Māori one was last because that was my inner being. (WH11).*

Though this account was not directly related to the experience of engaging with Whirinaki, the participant recognised the importance of accessing Māori centred support for people who are mentally unwell. This participant specifically chose to engage with a Māori team because of the value placed on tikanga Māori and wairuatanga. In addition, building resources and resiliencies is also seen as a proactive strategy to assist with relapse prevention and overcoming future challenges and adversities.

**Aspirations.** At the end of the interview each participant was asked if they there were any suggestions that they could give about how the service could be improved and what advice they would give new whānau coming to CAMHS.

Many participants commented on the importance of access to collective support. Some participants expressed a desire to increase their capacities related to Māoritanga (Māori practices and beliefs), drawing on mātauranga Māori, traditional Māori knowledge and the importance of recognising pūmanawa/strengths and preferred learning styles.

**Collective support is important.** Rangatahi participants suggested that collective support, talking to others who understand and have been through the same thing helps:

*Just to meet up with each other and talk about their stuff, and how to get through it. I was talking to a person from there that has groups and stuff. That would be really helpful [...] I think that was one of the things I wanted back then, to have a group session with young people like myself. (R4)*

*...talking to people who have been through the same thing but people who understand as well. (R6)*

Many whānau participants also shared a similar desire to talk with other parents who had similar experiences of going to CAMHS:

*Well just if there are parents out there that you've interviewed and that, if they just want somebody to talk to it would be good if everyone that you're interviewed, together you could make like a circle and network eh. And then we'd be able to relate and also help one another. I'm open for that[...] I'm open to it. Once I get my papers back then I can also share this from the start to the end and give them an open, you know, on what I went through with my son. (WH5)*

*.... I think I'm better than, like, talking how I'm talking with you with other mums and that. Yeah, sometimes I feel like I could be a counsellor myself, the way I talk to others [...] I don't know, I think I'd have to be around in the group to actually [open up].... (WH3)*

The last account described how the participant thought talking with others in a group situation would enable her to share her advice as well as gain input of others who had similar experiences.

Many participants commented on the need for alternative treatments, other than medication:

*Yeah it doesn't have to be in a classroom setting. It doesn't have to be any setting as long as they can learn something from it. And if someone can come up with anything other than a pill. (WH1)*

*And we thought we've got to give it a go so we know we can say we've been there, done it and that's it. So it was that, to see what they had to offer, stay there to see what else, what else, what else, but there wasn't very much. (WH2)*

**Mātauranga Māori/Māori Knowledge.** Some participants articulated a strong desire to return to traditional Māori practises as a means of therapeutic intervention for the young person. One whānau participant who had experienced being placed in a non-Māori team drew attention to the importance of teaching tikanga Māori to young people:

*Back home, the basic stuff. You know a lot of things were, one of the things we have at home is for the youth is, they go, they take them out on a barge out to the [Name of Harbour] Parengarenga Harbour. They have to, they're there for a week, and whānau back home on the marae, oh they're well looked after. The cakes coming out, the fruit coming out, you know it's well supported. And the kids get taught to fish, to net, to read the stars, to make fire, how to light a fire when the ground is wet. (WH1)*

This participant recognised that many whānau were disconnected from their hapū and iwi and unable to access the traditional Māori ways of living and being healthy:

*....Survival. That was school camps, school holiday camps. But I understand not a lot of tamariki have that opportunity, especially if they're not connected with their iwi, you know. And so he thrived on those things. And Papa would say because he's good with [Whānau member], because he's back to basics, and I would listen to that. He may have only been young but he thrived. (WH1)*

This participant reported that her whānau believed that basic life skills which were essential for daily life in traditional times were also skills that were relevant for young people today:

*And they even wrote down you know I think we're going to do a next one would be do to kānga piro [traditional Māori food]. You know you need a flowing river and then you take the kids out to pick sometimes puha and all of that. And those are basic stuff and you know we don't need a classroom setting or a pen and paper. But he, he [Uncle] had a lot of influence on you know what was good for rangatahi and what wasn't. And he voiced a lot about how you know our kids would thrive better rather than you know. He would lead the schools, yes he would lead the schools but he also believed in back to basics stuff. (WH1)*

**Pūmanawa: Understanding unique strengths.** Whānau participants had a good understanding of their children and their strengths, personality and learning styles. Many participants indicated that their children enjoyed sports, hands-on physical activities whereas others were 'thinkers'. One participant noted these unique differences:

*... I know what they're good at. And she's a hands-on kid, you know. You know how you go to school and they expect you to do all this range of things and bloody hell, you look at it and go ugh. You know, it's not achievable in your head, but if you get them to do it with their hands it's a different story altogether. They can keep up with anybody [...] their physical appearance and mobility and all that stuff has to work or else they're nothing. That's their uniqueness. And then you've got the thinkers that think a hundred miles an hour [...] and I said it's just like that, there are some kids that are clever at some things, but I guarantee physically you can out man her, you know. So I'm just trying to make her stronger [...] yeah, [more aware] of her good techniques. I said why would you wanna try something that you already know in your head you aren't good at, but if you actually put physical play to it you can succeed in it, easy as. (WH11)*

Another participant also echoed this sentiment:

*[Name of young person's], a kinaesthetic learner. He's, you know, when you talk to him it's just like pppchung... [Name of clinician] did a lot of talking, loads of talking and he just would zone out. And, when she realised this, which was quite a long time later. Her and I both realised that it's not going in, she started practical and that's when he started becoming, took us a while to pick that up. (WH14)*

This participant recommended that clinicians explore preferred learning style and align this with the intervention offered to the young person:

*Yeah, yeah, that would be something in the beginning, try and determine, you know, their learning style. Because, he just was not getting any of it at all. (WH14)*

Similarly, other participants noted that being skilled at hands-on activities and sports was valued by whānau:

*...he's so bright, he's such a clever kid. Although he didn't have much schooling but, you know, it's more hands on and it was just them. (WH2)*

*Sports. ...I love sports. Basketball, T Ball, baseball. (R3)*

**Hopes and aspirations.** Many whānau participants mentioned that having aspirations for their children were a key attribute of their resiliency. One participant commented on how aspiring to be being role model for others encouraged her daughter to be resolute and push through her difficulties:

*Just to keep their head up and stay strong, yeah. Yeah. Because that's what I said to her when it all came about, and I knew she was going to make improvements, I said 'be an example to all your own friends, you know, let them see the positive changes in you so they can make the same steps as well. Be a role model for these other young ones that are going through it'. And that's what I mean with getting the letter from you explaining who you were, what you were about, that's why I said to her, 'this is your way of giving back, to help these other young ones, help them to understand what these young ones are going through'. And no-one wants to talk to someone that doesn't have the experience of it and I mean anybody's like that. You*

*want to hear from someone that's been through it, you want to hear what they have to say because they're speaking from experience. (WH9)*

Another participant also encouraged her daughter to focus on future aspirations as a motivation to get better/push through her difficulties:

*.. focus on your studies and achieve, and become the person that you wanna become. She said I wanna be a lawyer, a kids advocate lawyer. I said if that's your aim, to be that, then go for it. So that's what she's going to, she's doing university work right now. (WH 7)*

In summary, access to collective support was very important to participants to ensure ongoing wellbeing. Some participants expressed a desire to explore their Māoritanga. Whānau also had depth of understanding of the young person's unique pūmanawa or strengths and learning style and how to best maximise these. Aspirations for the future further enabled whānau to push forward on their pathway to wellness.



## CHAPTER FOUR: RESULTS – HE KĀKANO FOCUS STAFF GROUP

Themes from the focus group interview are presented in the following three topics: pre-engagement difficulties, ongoing engagement and barriers for whānau and for staff/practitioners. These three topics are aligned with the topic areas identified in the whānau participants' interviews in the previous chapter.

### Pre-engagement Difficulties

He Kākano practitioners interviewed articulated that initial barriers to engagement for whānau were whānau perceptions of the service and external barriers such as accessibility to the service and financial difficulties. Practitioners made an effort to intentionally address āwangawanga (concerns) and ensure that whānau [individuals and family members] felt comfortable with the process of coming to Whirinaki.

**Discrimination and stigma with mental health.** Negative perceptions associated with mental health were acknowledged by practitioners as a barrier to engagement.

*Well, the whole mental health. My kid isn't mad, the whole discrimination around mental health, it's a real challenging one. (HK10)*

Whānau found it helpful when they were able to talk to someone about He Kākano during the triage process:

*I think perception's a contributing factor. I think that sometimes people are not aware of He Kākano until [Name of Clinician's] had a talk to them. Sometimes people have heard different things about He Kākano. (HK4)*

Another complicating factor was the consent process around the referral. Practitioners reported that whānau often were coerced in to attending Whirinaki:

*... in terms of who the referrers are, I think we're about nearly 50/50 split between GPs and schools. Or schools a little bit more. And often the referrers from school are sending whānau here almost under duress. It's kind of like you have to go to Whirinaki as part of the plan, or your kid doesn't get back into school. Sometimes it's*

*a lot more subtle than that. These are the issues with your child, therefore we're making this referral, do you agree to it [...] And sometimes they'll turn up here because they had to, they don't wanna be here, they don't really want a bar of you as the assessing clinician and they certainly, sometimes, don't feel like they want to develop a relationship with you because you're an extension of the punitive system that is the school. So that's certainly a significant barrier for engagement. (HK2)*

As this practitioner member pointed out, some whānau may have been referred under duress and therefore had no intention to engage with the service. He Kākano practitioners were aware of these situations and were mindful of how they went about working with the whānau to ease some of the tensions:

*We can work with some of that stuff though. (HK7)*

*Yeah, we can, we don't have them leaving hostile. (HK10)*

*I've always found that's a priority [...] whānau walk out of here feeling like it was worth their while coming. That's always the most important thing. (HK7)*

The importance of positive perceptions of He Kākano amongst the local Māori community was expressed by practitioners:

*I think word of mouth has a really important place in minimising the barriers or the perception of barrier. And so we sort of hope now that more people have come through He Kākano, they're going to go back out there and say look, you know, it's a great service, go along and see those people at He Kākano. I think Māori certainly work by word of mouth. (HK4)*

**Socio-economic barriers.** Financial difficulties in general were cited as a reason for not being able to attend:

*Actual financial problems, trying to find the money. (HK9)*

The cost associated with going to the General Practitioner (GP) to get a referral to the service was a barrier for whānau. The importance of whānau being able to directly refer to the service was noted by practitioners:

*Connect with our service directly, rather than go through a doctor and pay fifty bucks or go to school and talk to somebody they don't like. You know, just make it easier for them to be able to make that referral. (HK7)*

Other factors were associated with the opening/operating hours of Whirinaki which were often not suited to the work hours of parents/ caregivers:

*...working parents, do you work at a time when we can come in when Dad finishes work? The answer's no. Monday to Friday Dad works eight to five [...] Or seven til seven at night. (HK10)*

**Accessibility of the service.** The formal process of referral via the GP or School was an obstacle for some whānau. Where possible, He Kākano practitioners assisted whānau to ensure they were able to access services.

*Our service, because we have a triage system now [...] it's gotten a little bit more stringent again. But certainly, I mean I've had whānau ring me up and say, you know, we want our kid seen. I'll fill out the referral form and take it up to triage. So yeah, if they ring us. (HK2)*

*I got one [referral] today that came in, and I went and saw whānau last week. We've got her grand daughter here and she's whāngai'ed (customary practice of adopting a child) another boy and she was talking to us about what the service is for, and talking about us and wanting to refer to us. So we're going back today to talk to her about it [...] She would've seen how we operate and what we do, and identified that we would be something that could be helpful, you know. (HK7)*

**Not knowing about He Kākano.** When referrals were triaged, whānau were routinely asked whether or not they wanted to be placed with the Māori team- He Kākano. Some whānau did not have a preference initially, while others worried about not being 'Māori enough' to engage with He Kākano:

*... some of them would just want whoever's best to fix my children or my child, so it doesn't matter. But once they hear a little bit about the background of He Kākano, the majority will go with He Kākano. We have a lot of intermarriage now in South*

*Auckland and if children are part Māori they have a choice in which team they go to. The understanding of some of these whānau is that I don't speak te reo (Māori language) so I don't want to be in the Māori team. So there's a problem there as to what they perceive to be part of a Māori team. (HK3)*

One practitioner reflected on an experience where He Kākano practitioners were able to work alongside a well-known community Kuia (female elder) who was apprehensive about engaging because of the concern she had that the service was ill equipped to provide a culturally safe service for her mokopuna (grandchild):

*We had a Kuia, we were privileged to be in IA (initial assessment) with this Kuia and she's well known in a community based organisation and she speaks in reo. She came in and she had certain āwangawanga (concern/distress) about coming in here because of the perception that she had of here. And being able to [converse] in the tongue that's her first language, I think, started to settle things a wee bit for her. She was coming in with her mokopuna and I think that sort of helped a wee bit. When she left to go out, when the session finished, she was really at ease, she was very calm. So I think we were able to provide a response that kind of sat well with her. So that reading the situation, as the others have talked about, I think is really important. (HK4)*

The practitioner member spoke of 'reading the situation'; this included being able to identify the importance of the status of the Kuia, and ensure that the process was carried out in line with appropriate tikanga (protocols) where she was able to voice her concerns in te reo Māori. This in turn contributed to the Kuia feeling a sense of respect which enabled her to feel/be at ease when she left the session. Another aspect of 'reading the situation' was skilfully observing the body language of the Kuia (elder) and providing support in the moment:

*This same kuia came in without her mokopuna initially and it was interesting what she was sensing from those who were at the reception. So her and I came in and I sat with her and had a kōrero (discussion), it was good. (HK9)*

This type of approach has led to an increase in access rates for Māori:

*There is certainly stats that you can access, by the way, that illustrate that the access rates for Māori to this DHB's child and adolescent mental health services have increased exponentially since the inception of He Kākano. So for this DHB the access rates for Māori to Whirinaki are just above blueprint expectations. And nowhere else in the country reaches the blueprint anywhere near. So that's not to say there's not a cause and effect here, that now that there's He Kākano that that was the answer, but certainly I'm sure we can put our hand up to have some of the impact of He Kākano be a part of that. (HK2)*

In summary, practitioners had an understanding of access barriers and tensions associated with forced referrals and negative perceptions that many whānau shared prior to engaging with the service. This awareness and ability to read the situation allowed practitioners to ameliorate some of these initial barriers. Managing tensions in a culturally appropriate way resulted in a positive foundation for the initial engagement process.

## **Initial Contact**

Practitioners talked about the importance of initial contact as it sets the scene for the engagement relationship with the whānau. The following themes were identified: initial impressions, whakawhanaungatanga (customary practice of building relationships) and the unique approach of He Kākano. These were a vital part of the engagement with whānau during the initial assessment as it demonstrated respect and genuine concern. Whakawhanaungatanga was done sensitively by practitioners to ensure that whānau felt comfortable with the process. Providing a structure for the sessions at Whirinaki also assisted whānau to feel safe during the process.

**First impressions.** Practitioners recognised the importance of the first impressions and positive experiences of initial entry into the service. One practitioner member likened it to the tomokanga (entry gateway) on the marae (traditional meeting place), where the manuhiri (visitors) are like whānau that the clinicians welcome as if they are embarking on to the marae. The experience of initial entry reflects on how people perceive the service as a whole:

*....how you come in through the tomokanga (entry gateway) and I think there's a specific process that we have. [...] to a certain extent we have to own that process*

*and make sure that it's activated [...] how you come in through the tomokanga is how the people see the whare (house/meeting house). I think that's really important.*  
**(HK4)**

Carrying out the proper processes from the outset was necessary to ensure whānau experienced the service positively. The importance of following cultural practises and protocol was also echoed by another practitioner. Waiting for whānau to respond in a way that felt comfortable to them and having flexibility with the process was also essential.

*It's about tikanga (protocol). Tikanga is them coming into your environment, you're welcoming them, you're in charge, and to give them the opportunity to reply [...] even the father wants to get up and to reply to a mihi [...] And that's part of tikanga, just to pause. He may not want to, but if he does you give him that opportunity and let him have that chance to mihi (speech/greeting) back, because that is tikanga. Having said that, there are some who don't want to go down the proper process, but it's making them feel comfortable. For example, talking about their whakapapa (geneology, descent line), sometimes they feel that is private stuff and they don't want to share that. Whatever that means to them, you don't push the issue. (HK 3)*

This practitioner highlighted the importance of a non-pressuring approach and respecting the whānau, particularly around sharing aspects of their whakapapa (geneology). Sometimes whānau arrived to the initial assessment with a support group and Kaumātua (elder) and therefore it was important that the team also had a Kaumātua present to greet them as this was a sign of respect.

*There have been times when I've worked with whānau and you come up to the waiting room and you often see that they've brought whānau support, and I've had to rally to go and get [Kaumātua]. And sometimes they'll turn up and their mum will say I've brought my Kaumātua, and [Kaumātua's] had to come into the room with me. That kōrero (discussion) has been really nice and that's a good way for the whānau, I don't know, it's about us engaging and it's about them trusting in what we have. So I think that's huge in terms of engagement for our whānau. (HK1)*

This practitioner expressed the importance of meeting the cultural needs of the whānau when they arrived as the interactions that take place initially are significant. It was helpful when clinicians were able to gather specific information about the whānau before the initial assessment took place to ensure they were able to respond appropriately to their needs.

*It's helpful to try and find out as much as you can about the whānau before they come in. Sometimes that kōrero (discussion) can happen in MDT or with people in the team around making that whānau known and how we may be able to respond appropriately to that whānau. Sometimes when we see them in the waiting room, usually if I see a nanny or koro (elder) or something, I'll get someone to help facilitate a process when I know that I can't. But sometimes we can sort of gauge what we're going into, sometimes. Or even identify who's coming in before they get here, and what do we need to prepare for. (HK7)*

Practitioners stated that during home visits their whānau were in control of, and directed the process.

*I suppose on the reverse side is the home visits, when you're going into their environment. You just don't go in, you wait for them to lead the process and then you reply in that manner. So it's the reverse to what we do here. (HK3)*

*I think for me I always thank them for letting us into their home, you know, I'm always respectful and ensure that they know that we're thankful for being there. (HK1)*

**Whakawhanaungatanga.** Practitioners recognised that some whānau felt whakamā (ashamed) during the whakawhanaungatanga process of introductions as they did not know how to speak in Māori, did not know their iwi or hapū (tribe or sub-tribe) or feel confident to say where they came from, therefore practitioners provided encouragement for whānau to do things in a way that felt natural to them:

*When we get up and do whakawhanaungatanga some of them feel really whakamā that they can't stand up and say who they are or where they're from. But yeah, we*

*kind of encourage them, you know, and it doesn't matter, just introduce themselves.*

**(HK10)**

Practitioners took a sensitive approach to whakawhanaungatanga, where they took in whānau input about what they were comfortable with:

*There's a process I think we all follow and we initiate whakawhanaungatanga with all our whānau but obviously we're aware of where whānau sits and how connected they are or comfortable or capable they feel they are in being part of that process. So we just work it out as we go and they find a way to be part of that. (HK7)*

Practitioners reported that Māori whānau placed more value on where others came from and who they were rather than their qualifications:

*And sometimes it's just gonna create a barrier. It's more about just acknowledging what I think is important, and that's about who we are and where we come from. And when you can open that sort of kōrero (discussion) up for them it gives them the idea that they know what you're acknowledging, what you hold as being important and what do you respect. (HK7)*

It was important to offer whānau the opportunity to do karakia (prayer/incantation) before the session started, where practitioners supported by leading the karakia when necessary:

*We offer, so when we're in the room with them we offer that we start with a karakia. We don't make it that they have to know one, start one, you know. We offer and support so it's very much led by us. (HK1)*

Practitioners talked about how they started off using a mihi (greeting) during the introductions and then translated from Māori to English to ensure whānau understood what was said:

*I always start with a mihi (greeting speech) to the family, I always start with a mihi to them. And that's usually starting off in Māori and finishing in English so that they can see and you make sure they get the point of what I was talking about whether they speak Māori or not. So that kind of opens the door for them to either respond*



*by standing up and doing something similar or to just go around and talk in English, however they feel comfortable. So I sort of do a mixture of that in the beginning, and it sort of sets the scene for them to participate however they feel comfortable. (HK7)*

Another practitioner talked about allowing for the engagement to be whānau-led but also the importance of clinicians providing the structure and upholding the tikanga (protocol) for whānau so that the process was predictable and safe for them:

*...part of having a process around whānaungatanga and the way that we do our assessments is providing a bit of security and safety around it, that somebody owns the process. And although very much, you know, we take our lead off the whānau as to how much reo we use, whether we get them to do a karakia or whether it's us, so we're informed by the information we're getting from whānau and yet more often than not we will still try and keep a process for that, well I see it as security. I have seen non-Māori clinicians go okay, so what are you here for today and leave it almost totally over to the whānau to guide the process. And I've seen the looks of oh my gosh, there's expectations on me and I don't know what those are. So yeah, to me, I get a real sense that we do a real balancing act of trying to provide some boundaries around a process whilst allowing for changes or modifications based on the input from the whānau.(HK2)*

Another practitioner also elaborated on the underlying intention of making connections with whānau:

*... I think we're telling them, and this is my observation again as an outsider if you like, that we're not just interested in fixing the problem. We're interested in them as people and we hope that they've got an interest in us as people as well, rather than just as clinicians. And more often than not that's the case, and then we're able to start to explore why we're all coming together and what journey needs to be looked at. (HK8)*

Practitioners reported that they purposefully focused more on the process of whakawhanaungatanga and taking time to build relationships during initial assessments rather than acquiring information from the whānau; in this way the intention was that

whānau benefitted from the interactions in that it lessened some of their concerns/problem in some way:

*...we've talked about this [initial contact] over time, I don't know who else might share in this but I'm sure we all do, in that every contact or every opportunity to make contact with whānau we see as a, I mean I use the word therapeutic because that's the word that we use, but is a therapeutic opportunity [...] you know, say I don't tick all the boxes in that first assessment, as long as they leave feeling like they've made some connection and that some of that āwangawanga (concern), hara (wrongdoing/problem) or raruraru (difficulty) was, somehow we helped in some way. Even if it was the process that helped and not directly our specific, I don't know, input. So yeah, I think that that's something that's different to a lot of our colleagues or the different teams that exist here, and that we see every contact opportunity as being a therapeutic opportunity. (HK2)*

*...we might not get all of the information that we're meant to get in a kotahi rā or an initial assessment. We might not have gotten to sleep, energy, you know, appetite, that box. But we spent time on that whanaungatanga, yeah, we sometimes like to prize, well we do, we prize that over getting all the information that you were meant to get by the end of that assessment session. (HK2)*

**Uniquely Māori approach of He Kākano.** One practitioner who had worked in other teams outside of He Kākano reported that He Kākano placed more of an emphasis ensuring whānau were at ease by offering cultural practises but also being flexible if whānau were unsure or preferred to do things differently.

*I think one of my observations since being with He Kākano as a [Clinician] into He Kākano is that whatever it takes, whatever is comfortable for the whānau is what happens [...] everybody has their own individual ways of allowing that comfort to actually take place, by offering karakia, by mihi, but sometimes there's just a feeling that it might want to go another way. And that's something that's sensed by these people and again it leads to a comfortable introduction to He Kākano as a service and to the people that are involved ....(HK8)*

The same practitioner commented that he noticed the difference in the way He Kākano opened initial assessments compared the way other clinical practices started off the initial sessions:

*I can say that as an outsider if you like, who's come to work within He Kākano [...] it is not uncommon for the clinician or clinicians or whosoever might be doing a first engagement or first assessment to ask very typically and what brings you here today. That's a very common opener. It's not a great opener, in my opinion, and I'm sure that my colleagues here would agree with me. What's unique is the approach. It's very culture sensitive, but it's very sensitive on a very personal level as well and that respectful approach, the cultural approach, the knowledgeable approach is there every time [...] it is that cultural sensitivity and respect for those people that makes it unique within He Kākano as to the approach to matters. (HK8)*

Other practitioners who had worked in other health settings also noted differences in the way they worked as Māori compared to non-Māori. One practitioner commented that greeting, using the hongi (pressing noses in greeting) was an example of this:

*...I think, like, a big difference working with Māori and non-Māori is the way you greet them, just basics. So when I work with non-Māori people I don't normally go up and kiss them or hongi them. I think that's just a simple thing that you do differently when you're with Māori and non-Māori, and I think that makes a huge difference. (HK6)*

This practitioner had an experience of working in a hospital setting. She stopped using her own cultural practises and noticed that Māori patients did not respond well to her:

*.... I was working with any nationality, any ethnicity, and I was so used to the Westernised way of working and the process. And so I completely forgot about my own culture and my own identity and when I went to Māori people I was just really clinical and Westernised. And people didn't engage with me as well. So it took for me to be able to get a kaitiaki, like a Māori culture facilitator, to come with me and help me build that engagement. He was like you've got to tell them from you're from, treat them like they're your grandparents. I was like, I know, I should've*

*thought about that. When I did that, he took me in and introduced me to them like that, and it just made things, it was a complete change the next day I saw them. So I think that's a real big, important thing to remember. They're your whānau and you treat them that way. (HK6)*

The same practitioner also talked about the importance of treating patients like she would treat her own whānau. Another practitioner also shared a similar story about how she felt that the Western clinical approach was detached and depersonalised. As one practitioner put it:

*It's almost impersonal. (HK8)*

The skill of making connections was seen as a strength that Māori clinicians utilised:

*I think mainstream tends to be very clinical focussed and they go to somebody, whether you're Māori or whatever nationality you are, and they just see what it is that you're there for. They don't bother to actually wonder where you've come from. I think that Māori do that so well. They kind of just walk in, and as soon as you make a connection whether you're from the north or even if you're just Māori, they just love to know where you're from, why you're here and it's awesome. I mean, there's very few Māori in clinical settings, and so if you're Māori and you just turn up there you already get a tick from them [...] another brown face (laughter) (HK5)*

As this practitioner alludes to, it was important for Māori clients to see Māori health professionals as there were so few Māori working in clinical settings. This practitioner also contrasted how Māori and non-Māori clinicians worked. It was important to form connections before whānau opened up to clinicians:

*.. if you can actually say I'm from here, they might say oh, I know so and so from there. You instantly have a connection, you instantly have a relationship with them that's on a different level and they're not shy of you anymore. I found, I mean, I'm new in He Kākano team but in my training I found that was huge. I worked in a Māori rōpū (team) and we visited Māori whānau in the middle of nowhere, but I just tended to know that when they had Europeans come, sorry other nationalities come, they would be there and then just expect to go straight in to whatever it is that*

*they're there for. Whereas what I've realised with Māori, you can't do that. You have to engage with them and make connections with them before they're gonna allow you to actually help them with whatever it is that's going on for them. So unless you have the ability to make connections or to find links, it's really difficult. I don't know if, in mainstream, that's explored. I don't believe that that's explored well enough for Māori anyway. (HK5)*

One practitioner summarised this approach of whakawhanaungatanga as being the key to developing good engagement and making effective changes with whānau:

*Just working with Māori whānau, unless you can do the whānaungatanga first, you don't get nowhere else after that. Unless you can actually make a connection with them, you won't get anything. I see that in mainstream, that they don't tend to get anywhere with them because they don't make that time for the connection. Yeah, sometimes you have to put off maybe half the initial assessment just to allow the time for that. But in the long run it makes the world of difference because if you can't get that connection, if you can't be with them through the journey then you're not ever gonna get to whatever they're there for anyway because they'll just shut down. (HK5)*

In summary, practitioners stated that it was important to ensure that the initial meeting was conducted in a culturally responsive manner. Practitioners discussed skills that they considered fundamental to working with Māori, these included being able to 'read the situation' and having knowledge of culturally specific nuances, providing appropriate cultural protocols to cater to a wide/diverse range of whānau, making connections by referencing where they came from as opposed to talking about their profession or academic qualifications. Using whakawhanaungatanga to establish relationships was viewed as valuable and information gathering during the initial assessment. It was also an effective strategy to enhance engagement in the long term.

## Ongoing Engagement

After the connection had been made via the process of whakawhānaungatanga, practitioners discussed the importance of continuing to build the relationship with the whānau. Practitioners commented on incorporating values that were important to whānau during their engagement. Key values included treating whānau [clients and their families] with aroha (compassion, empathy, love) and practicing humility. Practitioners were also mindful of power dynamics and made an effort to connect with whānau at their level. Throughout the engagement, it was imperative to provide a safe space for the expression of emotions, 'mai i te whatumanawa' (from within the deeper recess of consciousness) to process mamae (painful experiences) trauma and other difficulties that had brought whānau to Whirinaki. It was also important to have a safe space to express wairuatanga (spirituality).

**Values.** Practitioners talked about difference in values, where Māori whānau were less interested in the clinician's profession:

*Nobody cares that I'm [Name of clinical profession] [...] so that's certainly not an opener for me, I'm a [Name of clinical profession]. That doesn't mean shit to them.*  
**(HK7)**

Other practitioners also commented on the importance of humility and reported that whānau had little interest in qualifications and the professional title of clinicians:

*I think the humbleness that you come into that space is really important too Pikihiua. Whereas I think perhaps, and I shouldn't be too general, but our other colleagues tend to look at the tohu (qualification) they have. Whereas we're there to work alongside the whānau. I think the approach is completely different and I think that's what enables us to make those connections and build those relationships. **(HK4)***

*It reminds me of being on the marae last year, back at home, and another one of my cousins is also, she's a medical doctor, and [Name of person] is my whānaunga. And she was coming up to getting her [qualification], and we were sitting in the wharekai and she was saying to her whānaunga (relation) [...] these are our two [Clinical Professionals] already and I'm having my [qualification] next year or something like*

*that. Anyway, my aunty comes out and she goes okay [Clinical Professionals], time to get in the bloody kitchen and do the dishes (laughter) [...] Yeah, she goes our [Clinical Professionals] still need to get in there and do the bloody dishes and she came out waving her tea towels. And it was just a good laugh and yeah, we went and did the dishes. But you know, it was about values. My Aunty [Name] doesn't care who's got [degrees], she cares how clean those dishes are. (laughter) (HK2)*

A practitioner provided an example that illustrated the way that He Kākano clinicians had aroha (compassion and empathy) for the whānau and young people they were working with:

*I think a lot of what comes back to me is around just having that aroha. I was talking with some students about the way that we work in our team and working with Māori and stuff, and I was talking about how I bought one of my boys a tyre tube because he couldn't ride his bike and dad couldn't afford one. So I bought him one, and I didn't think anything of it. They were saying to me why didn't you say to him if I give you this, you have to do this for me. Or if I give you this inner tyre tube then you're gonna do this for me next week or something. And I said I never actually thought about doing that at all, and the Māori lady next to me said that's coz it's called aroha. (laughter) (HK7)*

This practitioner stated that aroha (compassion, empathy, love) was the core foundation of their work; it allowed clinicians to have empathy and positive regard for rangatahi:

*... there's ways that we understand where things come from and the way that we look at our own whānau, how we connect with them and why we connect with them, because fundamentally we do have that aroha. I don't know how many of my [clients] I say are cool and my favourites, and cute, you know. Just have all these terms that are probably not always clinically on track but you can't help but feel those things. They remind me of me and my cousins and, you know, my uncles and all sorts of people that I've got in my own life and that's where some of that comes from, some of that care. (HK7)*

This practitioner also stated he often regarded clients as being similar to members of his own whānau which assisted him to feel compassion and empathy towards them. Practitioners noted how they felt it was an honour to meet with whānau and provide support during their engagement with Whirinaki:

*Often [He Kākano Clinician's] talking to me about young people or whānau that's she's feels so privileged to have come across them and having met them. I think a lot of people may have the reverse impression, that it's their privilege to see us and it's not that at all [...] we're there for them, not the other way around [...] And we're there because of them. (HK 7)*

*Yeah, wouldn't have a job –(laughter) (HK10)*

Practitioners indicated that they were committed to (providing care) for whānau, not only was it their job but also a duty that they felt grateful/ privileged to carry.

**Awareness of power dynamics.** Practitioners commented on how whānau did not relate to clinicians using formal/complex and technical language and the importance of connecting on the level of the whānau:

*I do know working with non-Māori, , I find I'm using my bigger words [...]so yeah, that's how it works for me but I know that a lot of families in He Kākano they're just not interested in that way of using words, language, you know. (HK7)*

Another practitioner reiterated the cultural differences in values and commented on how she adapted her approach based on this:

*It makes me think about a difference of values. Like I was thinking yes, with my non-Māori clients and colleagues I talk differently. I might use bigger words, and that's not because those people deserve my bigger words, it's because that's what's important to them. You are somebody who knows something. Whereas with a lot of the whānau that we work with, they don't care how much you know and what your *tohu* (qualification) is [...] Like [Clinician] said, nobody cares what an occupational therapist is. Are you gonna be there for our whānau when we need them, that's what they care about. (HK2)*



**Safe space for expressing emotions and wairuatanga (spirituality).** Practitioners were often mindful of the importance of the therapeutic work of processing past hurts. When whānau were engaged with Whirinaki it was important to provide a safe space for the expression of emotions. Practitioners commented that often whānau may not be able to articulate their emotions in words but they express it in other ways and this was encouraged by practitioners as a way to begin healthy healing:

*They may not have the kupu (words), but they feel it. There'll be some families that'll be quite articulate about it, there'll be others that will feel it and you can see them feeling with it and not quite sure where it sits with them. Because, you know, sometimes it wasn't what they expected when they came in, and they get quite a shock that they felt it. Or they start to cry, and then try to put their tears back, and we say cry, it's really important. It's the beginning to healing. So the imagery is sometimes, yeah, quite an interesting one. (HK4)*

Practitioners reiterated that it was a privilege for them to facilitate the process of healing with whānau. It was important to recognise the importance of the role of clinicians to have the appropriate skills to manage the depth of emotions and spirituality. It was also vital that whānau [individuals and families] felt that they trusted clinicians in order for them to feel that they could release deeply held emotions and hurt:

*I think it's also about facilitating that you're there to hold it, you know, you're there to provide the room where it's going to be respected and I think that's really important that they feel safe. People use the word safe and I'm always a little bit hesitant to use the word safe because I'm not quite sure how you define it necessarily, but it's about holding the kaupapa (the important topic of discussion) you know, and if they feel that you can hold the kaupapa then I think that they just start to really release all that mamae (pain/hurt) and that pōuri (sadness, sorrow, gloom) and it's really, really a privilege. It's just wonderful, you know. (HK4)*

Another practitioner also reported that whānau accessed Matakite (Māori healers) to enable greater connection with tūpuna (ancestors) and spirituality as a means of support while they were engaged with Whirinaki. One practitioner commented that she saw her role as supporting the rangatahi with expression of their emotions throughout the process of

connecting with their taha wairua (spirituality). It was very important for rangatahi and whānau to feel safe around spiritual work:

*...I've been finding a number of whānau that I've been connecting with, there's a good percentage that are aware of whānau that have managed to matakite (prophet, seer also known as Māori healer), so definitely for me it's a huge privilege. Actually being able to walk with them as they talk about their ancestral connections. Some of them have been afraid to actually look, and helping them and supporting them to know when you're healthy and when you're not healthy, the differences. That actually takes a lot of time, there's a lot of time and at different times they want to see me here. But I've noticed that as they've gone through that they want to see me at home because as I sense it, and when they talk to me about it, it's about safety. It's not just physical safety, it's the safety of their wairua (spirit). I don't think I talk about it much, I'm just aware that it's happening, and they say that it's connecting them to their own whakapapa (geneology) and so that for me I know that I've got to make sure that they're really safe, that I reconnect them. Sometimes the whānau that they're around isn't helpful because it's seen as being mad, so we've had to talk about connecting to our elders. It's definitely us being Māori. (HK9)*

Practitioners reported that it was important to take the lead from the whānau with regards to spirituality as many whānau were still making sense of and integrating their experiences.

*I try my best, realising that it's a privilege and doing my best not to trample on their mana (status, spiritual power, charisma. supernatural force in a person) and tapu (sacredness) and always remembering that what they give is, they'll tell me anyway, what I can talk about and what I can't talk about. It's only because they're still discovering, and they're sort of trying to weigh up what's happening. It's not because they don't wanna share it. I can see them in the future doing that, but right now it's not quite ready. (HK9)*

Whānau were imbued with mana and tapu and this required a careful approach. This practitioner reported that often when whānau had shared information about spirituality

with her that they preferred to be seen at home, in their own environment as a way to ensure the safety of their kōrero (information)

**Sharing kai (food).** Practitioners also talked about the importance of sharing kai with young people as a method of engagement. One practitioner talked about doing activities such as cooking kai with his clients and also the value of eating together. Sharing kai together was seen as an activity that allowed meaningful and genuine connection:

*Food is important [...] We make butter chicken on Friday. One of my boys always wanted to make butter chicken so we got one of the natives to help them learn to make butter chicken from scratch. So we're doing some activities each week and that's what they wanted to do. But a lot of my boys will go out for lunch and stuff, and usually that comes out of my own pocket. But... there's something about being able to be on that level together, when we're eating together. It's part of our process, and just the kōrero that you can have while you're munching that Big Mac, it's real. Because you're coming together and eating together and it's a level playing field. That's what happens, and it happens sometimes without needing food. It's about what you're mindful of and how you talk to people, the language you use and how you might sit in your chair, if you're gonna cross your legs and write on your piece of paper in front of them or not, it's all conducive to that kind of relationship [...] food is helpful. (HK7)*

Of note, this practitioner observed that sharing kai together diminished potential professional-client power dynamics and facilitated a better therapeutic alliance. One practitioner reported that there were institutional barriers within the service that limited their ability to share kai with tamariki/rangatahi (clients).

*Certainly access to food and providing food for our whānau is a barrier. Like the opportunity to actually meet and share in a kai together would be huge wouldn't it. Just the opportunity to be able to do that without it having to come out of our own pocket, or wait for a consequent hui where we can take them off down to McDonalds or something you know. I mean, subway (laugh). (HK2)*

**Māori models of health.** Other practitioners reported that they also utilised Māori paradigms of health and wellbeing to aide engagement with whānau. The models used varied and the application of the models depended on the familiarity of whānau with concepts and words used in the models:

*Some of the kupu (words) in the models and frameworks sometimes explore it. It's quite variable really with the youth and how connected they are with the terms.*

**(HK7)**

Other practitioners discussed models that placed an emphasis on reflection in their clinical work with whānau:

*Āwhiowhio. (Whirlwind, whirlpool. Name of a model of practice) It's the spiral and what is the idea is that as you're going around you pause as you're doing the turn, and that energises the continuation so you're constantly going up. But what it does, the whakaaro is that when you're facing with people, that's you going up. But then you have the opportunity to reflect on your practice, and that's when you come back down. So it's an action reflection dichotomy. (HK4)*

In summary, practitioners expressed that He Kākano model of care based was based on aroha. Clients were held in high regard and treated similar to how practitioners treated their own whānau. Humility and breaking down professional-client barriers was important as it allowed whānau a safe space to engage with psychological aspects of therapy and openly express emotions. Practitioners recognised the depth of the work of processing mamae (pain) and whānau reconnecting with their whakapapa (genealogy, lineage, descent line). Some whānau also shared tapu (sacredness) information with clinicians related to the spiritual aspects of their healing. Another method of engagement discussed was sharing kai. Aspects of Māori models of health were utilised to varying degrees dependent on the familiarity of the rangatahi and whānau with the Māori terminology within those models.

## **Barriers**

Practitioners were asked if there were any barriers to engagement. Barriers that were identified for whānau associated with accessibility to services have been discussed in previous sections, other barriers for whānau [clients and families] were the lack of

appropriate resources and misunderstanding and misdiagnosis. There were also barriers for practitioners being able to provide a Māori service in a mainstream setting.

**Barriers for whānau.** Not having psychometric and cognitive assessments in Te Reo Māori was problematic:

*The cognitive assessment of kura kaupapa (Māori immersion school) kids is near impossible. I mean I've done cognitive assessments and then just translated parts of it into te reo to help them to get a better indicator of their performance than just they don't speak English that well, therefore their scores are impoverished. I wanted to get a sense of how much of some of the assessments they could do. But that's so far away from being an exact science. I mean, like, what I do in that circumstance is I will just draw upon my own clinical knowledge of the kid, my own cultural knowledge of their circumstances to try and put forward an argument as to how well or not that they're functioning in general. But yeah, it's very difficult. (HK2)*

There were significant implications of not having correct resources and psychometric/ cognitive assessment tools for these young people:

*I suspect that some of my colleagues might just put that in the too hard basket. But I suppose that that particular scenario wouldn't be too much different than a lot of other English as second language clients in this country. So yeah, it's got huge implications. (HK2)*

Another practitioner also stated that in addition to language being a cultural barrier, behaviour and communication is also misinterpreted by clinicians when they are formulating about clients:

*You know, there's so many ways that people could understand a young person by the way that they are communicating or not. I think it can be quite harmful, the way that people come across or conceptualise what they're getting back. They might not like the look of that person, they might have the wrong coloured skin or they might just be doing things their own way. (HK7)*

Practitioners commented that lack of understanding of behaviours potentially had serious implications for whānau.

**Barriers to providing a Māori service in a mainstream setting.** Practitioners commented on the imposition operating in a Westernised service. Tensions associated with prioritising process of whakawhanaungatanga over information gathering were noticed during multi-disciplinary team meetings (MDT) which in was structured to suit the Westernised approach:

*One of the things that I think we currently struggle with or battle with in terms of the pull of what's expected from us is that I believe that the clinicians in our team, when they're in the room or in the place, in the space with whānau, we prize process or relationships over information and facts. And yet when it comes to our MDTs and feeding back our formulations we've all been trained to provide facts and information, so sometimes we get a bit, we stumble over our words and the way that we communicate our formulations because we're stuck between that pull in terms of the clinicians who we are to prize process and experience and relationships over that information. And yeah, so we're just in a process of trying to work it out at the moment, because there isn't a model on which to know how we do MDT different to non-Māori services. So yeah, that's just the whakaaro that I have. (HK2)*

Practitioners reported that finding a more suitable model for MDT was an area for development.

Another difficulty practitioners encountered was negative perceptions of Māori practices in the service:

*There's almost an unwritten assumption that the way we are doing it doesn't quite make it with the clinical side. (HK9)*

This practitioner reported that she was considering transferring a client to another team however changed her mind after she had heard clinicians from the other teams making disparaging remarks about Māori practices:

*... after that experience decided that if that's happening to me I don't think it's gonna be very good for the client, so I didn't do it. It was just quiet hints that I kept thinking I can't be hearing this. (HK9)*

Another practitioner also had a similar experience of being looked down on for using Māori practices:

*... working outside of the Māori clinical team as well, one has developed broad shoulders because there are quite often not attacks, but my approach when I've talked about my approach being the approach that we in He Kākano take has been poo-pooed by a lot of clinicians. And I get quite defensive about that because they're in a dark place and not willing to see the light, whereas I've always said that I'm in a dark place where the light is being turned on for me, so it's their problem, not mine. (HK8)*

This practitioner reported that some other clinicians had an attitude of unwillingness to learn about Māori ways of working clinically:

*....it's more than a lack of awareness, I think it's a lack of willingness to understand what the approach is as it is and why it's so important. It would be terribly, terribly nice if all the other clinicians have an opportunity to open their eyes a little bit. (HK8)*

Another practitioner who also worked alongside practitioners in other teams stated that others were often fixed on a mono-cultural Westernised clinical approach of working with clients:

*A lot of those people are afraid of what's on the other side of being clinical, and I think that because we're already on that side and that's the side we're coming from it's easier for us to sort of pull in the clinical stuff when we think it's not time for it. (HK7)*

Despite this, overall the attitudes and negative perceptions of others towards the Māori team had shifted over time:

*There's been a lot of positive change within this service over the years. When we started we came up against a lot of criticism and negative feelings really, just*

*because we were different and we stood for something that was separate and it was scary for other people to feel that they didn't have something and therefore this particular service needed to be developed. So over the years that seems to have, well it hasn't gone away completely. (HK7)*

*It's evolved. (HK2)*

*It's evolved in some positive ways, but it still feels like the way that we do things is not credible, it's not valid and it's not important around what's the best practice in the eyes of the DHB. We know it is, but there's not a terrible amount of acknowledgement at any level higher than us. Our colleagues can see, in some ways. (HK7)*

Other institutional restrictions were noted as barriers by practitioners. As previously mentioned, the ability to carry out cultural practices to aided engagement such as sharing kai was limited. Practitioners also noted that there were other practices that they would like to incorporate in their practice such as providing taonga to whānau who had completed intensive programmes at Whirinaki:

*...it came to the last session and they felt that they had reached a point where they wanted to finish. And we had been using mana and some of the words as a way of trying to keep the family engaged while the therapists were doing, so we gave them each a taonga (gift) at the end, on the last session, as well as kai. That was really important because it was around the kōrero that we'd built up with this family. It was about honouring the family. Now that's really difficult because then when you put your reimbursement in they go what, this isn't part of the DHB and suddenly you're got to kōrero around taonga. So it's been really interesting from their point of view [...] culturally for us it was really important to finish that last session properly. So yeah, they've still got some work to do, absolutely. (HK4)*

The concept of engagement itself, from a Māori perspective was also adapted to suit the service. In the real world, relationships established via the process of whakawhanaungatanga were enduring, however, in the service, relationships with whānau



were ended when they were discharged and this posed a tikanga dilemma as one practitioner pointed out:

*I think there's an interesting dilemma where the DHB encourages you to engage and then you sign the case off so to speak and you discharge. It's very difficult because you've built a relationship with the family. And whilst we see the importance of discharge, it's where does the relationship begin and end and you know, if you've already done whakawhānaungatanga or you've done tūhonohono(joining, linking) there's a connection that's been made there that stands irrespective of whether the case is on your books or not. And that presents a really interesting dilemma, and I don't know that it's resolvable but it's something that I think any piece of research that talks about engagement is are you ever disengaged. (HK4)*

In summary, practitioners identified several areas of improvement delivery of services for Māori in CAMHS. Barriers were related to resources as well as institutional factors and the dismissal of mātauranga Māori and tikanga practices by non-Māori practitioners. These barriers hindered the ability of the team to carry out effective engagement practices to their full extent.

## CHAPTER FIVE: DISCUSSION

The following section provides an outline of the study and an overview of the findings from the results section. Key themes about how Māori navigate the process of engagement in CAMHS will be linked to tikanga and mātauranga Māori, Māori models of health and engagement as well as related Western engagement literature. Clinical implications for engagement in CAMHS for Māori young people and their whānau will be discussed as well as the strengths and limitations of this study. Finally, recommendations for future research will be proposed.

### Outline of Study

Meeting the mental health needs of Māori children and adolescents and their whānau in CAMHS is a priority in Aotearoa, New Zealand. Māori are vulnerable to psychological distress and disadvantage due to compounding effects of colonisation and urbanisation, economic poverty, intergenerational trauma, narrowing of traditional support networks and the loss of traditional knowledge and practises of health. The impacts of these circumstances, in conjunction with discrimination, racism and socio-economic adversity, are seen in the negative statistics around Māori health generally as well as mental ill health.

Past research has tended to highlight deficits with Māori whānau and with rangatahi, repeating negative statistics without providing socio-political analysis and or offering meaningful solutions such as investing in protective measures, positive developments or transforming services to match the needs and aspirations of Māori. Kaupapa Māori research was developed to counter these deficit approaches and shift control and tino rangatiratanga (autonomy) of research to Māori to enable and promote research that focuses on realising Māori potential and aspirations for health as affirmed in the Treaty of Waitangi. In recent times there has been more focus on engaging with mātauranga Māori (Māori knowledge) for current purposes as well as exploring, articulating and measuring Māori wellbeing (Cram, 2014; Durie, 2011; Kukutai, 2014; Palmer, 2005).

This research was undertaken with He Kākano, a Kaupapa Māori CAMHS team based in the urban city of Auckland in Manukau where the largest number of Māori reside in Aotearoa, New Zealand. Kaupapa Māori services are based on tikanga and mātauranga

Māori as well as Māori models of health that draw on these. In recent years more information has been published about the delivery and effective application of theories and practice in general Kaupapa Māori health services, however, there is still limited published research on Kaupapa Māori approaches to child and adolescent mental health services. This thesis contributes to research in the area of Kaupapa Māori mental health services, to engagement and to research on Māori experiences of CAMHS.

The aims of this thesis were firstly to capture rangatahi and whānau members' perceptions of engagement with CAMHS. Secondly, to elucidate effective engagement strategies and practices utilised by He Kākano. The final aim was to present an analysis of these perspectives of engagement and to contribute to knowledge and understanding of factors that facilitate or inhibit engagement with CAMHS and offer recommendations on how to best align services and clinical practices with needs of Māori in CAMHS.

Kaupapa Māori methodology was used to conduct semi-structured interviews with 24 service users consisting of eight rangatahi participants (aged 13-18 years old) and 10 whānau member participants (parents, caregivers and wider whānau members) who engaged with He Kākano. He Kākano perceptions of engagement were also gathered through a focus group conducted with 11 He Kākano practitioners. Qualitative methods were utilised to analyse the data and themes were developed. Presented below is a summary and discussion of the findings in relation to four key areas: The initial engagement period, ongoing engagement, barriers, and whānau pathways to wellbeing and aspirations for future services.

## Summary of Key Findings

**Initial engagement period.** Positive interactions during the initial encounter at CAMHS was vital for tamariki, rangatahi (young people) and their whānau. He Kākano practitioners were aware of the importance of the experiences and initial impressions of the service:

*....how you come in through the tomokanga (entry gateway) is how the people see the whare (house/meeting house). I think that's really important. (HK4)*

He Kākano utilised whakawhanaungatanga (process of building relationships) as the foundation for the initial assessment; this then provided the platform for ongoing engagement. Whakawhanaungatanga was used as a therapeutic tool to attend to whānau needs and address difficulties around whakamā (shame, embarrassment) as well as worries and or misconceptions about the service. Practitioners drew on their understanding of Māori psychology, tikanga and mātauranga Māori to guide the transactions during whakawhanaungatanga. The dynamic use of this process allowed a space to attend to and negotiate these issues and settle some of these initial tensions while simultaneously enabling practitioners and whānau to connect in a meaningful way. Whānau commented that the use of whakawhanaungatanga conveyed a real sense of respect and genuine care.

Tamariki, rangatahi and whānau were acknowledged as being imbued with intrinsic mana and tapu (Marsden, 2003). Viewing engagement with whānau through a lens of mana and tapu therefore has implications for how practitioners interact and care for whānau during the process of engagement. Acknowledging and respecting the mana and tapu of every whānau guides whanaungatanga and is particularly pertinent within the area of mental health. Practitioners articulated the importance of having a careful approach to engagement, providing the appropriate respect to ensure their actions enhance rather than infringe on or diminish the mana or tapu of tamariki, rangatahi or whānau during their engagement.

*I try my best, realising that it's a privilege and doing my best not to trample on their mana and tapu and always remembering that what they give is, they'll tell me anyway, what I can talk about and what I can't talk about. It's only because they're still discovering, and they're sort of trying to weigh up what's happening. It's not because they don't wanna share it. I can see them in the future doing that, but right now it's not quite ready. (HK 9)*

Tikanga contained within Te Ao Māori such as karakia (incantation, prayer), mihi (greeting) and whakawhanaungatanga enable a pathway to acknowledge the depth of mana and tapu of individuals and whānau during interactions and ongoing engagement. According to Royal (2006) "because the mana of an individual or group is measured in the thoughts of others, a mana inspired way of acting leads to relationship and connection" (p. 12). Viewing

engagement through a lens of mana and tapu is in line with the Dynamics of Whanaungatanga Framework of maintaining tapu and mana through whanaungatanga (Tate, 2010).

He Kākano practitioners emphasised that holding a structure informed by tikanga protocols was necessary during initial assessment as it provided security, safety and predictability for whānau when they came to the service. While practitioners sensitively took cues and sought information from whānau about what was important, the process of the session was explained and facilitated by the practitioners. Conversely, if sessions were held at the whānau home, whānau dictated the process. While tikanga protocols provided the structure for the initial meeting, whakawhanaungatanga was a dynamic process that was shaped by feedback from whānau in the room.

He Kākano practitioners interacted with whānau in a Māori way for example, whānau were greeted with a hongī, practitioners offered karakia (prayer/traditional incantation) at the beginning and end of session. The whakawhanaungatanga process during first contact is consistent with other approaches for Māori used in primary health settings (Lacey et al., 2011), adult mental health settings (Durie, 2007; Mental Health Commission, 2004; Milne, 2003; Wharewera-Mika, 2012), Kaupapa Māori mental health services (Manna, 2002), and CAMHS (McClintock, 2013). Embedding tikanga into psychological assessments not only has therapeutic value for Māori accessing mental health services but also ensures cultural safety, by which is meant, practices that are culturally appropriate and acceptable as determined by the clients and whānau (Lawson-Te Aho, 2013; Ramsden, 2002; Waitoki, 2012).

Karakia is a fundamental tikanga practice that was also used within the engagement practices of He Kākano. Karakia has many therapeutic benefits within mental health settings. During initial stages of engagement, He Kākano practitioners used karakia to set the purpose for the meeting by assisting whānau to feel safe, calm and at ease and relieving heightened anxieties by appropriately acknowledging and settling the wairua (spirit/soul) and mauri (life force) at the beginning of the session. Karakia is also utilised to clear space and open and close the spirual pathway of the meeting. The mauri of a karakia itself can also uplift or set the tone for positive interactions and engagement (Matua Raki, 2009).

Karakia was also used by He Kākano practitioners with whānau as a safety mechanism to provide containment for difficult emotions. Connection to Io/Te Atua (the creator), tupuna (ancestors) and to kaitiaki (guides) through karakia is outlined in the Mauri Ora Model as a way to receive guidance and enhance wellbeing (Mataira, 2011). Given the depth of the practice of karakia, understanding the tikanga (protocols) and function of karakia and connecting with the kupu (words) is essential to protect the integrity of the practice so it is not misused. Understanding tikanga around karakia is important for the spiritual safety of the practitioner and whānau/clients.

Following the karakia practitioners started off with mihimihi (structured greeting) and introduced themselves with a pepeha outlining their whakapapa links, tribal affiliations and referencing landmarks. Other research has also found that sharing relevant information and disclosure of tribal affiliation, working history and family background enabled engagement with Māori in a culturally adapted CBT programme (Bennett et al., 2014). According to Lacey et al. (2011) self-disclosure may be challenging for some clinicians who have been taught from Western psychological paradigms not to disclose information in order to maintain professional boundaries. However, these findings suggest that those assumptions should be reconsidered as sharing culturally relevant information during whakawhanaungatanga enables practitioners to facilitate engagement while also maintaining appropriate parameters.

He Kākano practitioners sensitively took their cues from whānau, reading the situation to guide them in the process with the ultimate goal of putting whānau at ease. If the initial mihi (greeting) was conducted in Māori, practitioners translated for whānau into English, offered a chance for whānau to respond to the mihi and where necessary provided a Kaumātua, Kuia or Cultural Advisor to afford respect to whānau who had brought along elders. Furthermore, He Kākano practitioners noted that Māori often placed more value on where a person came from (iwi, hapū, place where they lived or grew up) as opposed to the practitioners profession or qualification. From a Māori perspective, the interactions that occur during relationship building, rather than an individual's reputation, contributes most to a sense of respect between therapist and client (Tassel et al., 2012). Bright and colleagues (2014) also reported the importance of considering dynamics of the co-

constructed process of interactions between the client and the practitioner to facilitate greater engagement.

He Kākano engagement practices also overlap with evidence from Western literature on the effectiveness of promoting accessibility and reducing attitudinal barriers that families often have about services and practitioners in the Western literature on engagement with CAMHS (Staudt, 2007). Other research has indicated that a personalised collaborative approach to addressing engagement challenges may decrease ambivalence about attending CAMHS as it conveys respect and understandings for the difficulties of remaining engaged in the service or intervention (Miller & Rollnick, 2002). The use of whakawhānau by practitioners in this research demonstrates the effectiveness of tikanga and mātauranga Māori as a therapeutic tool to initiate and enhance engagement, increase accessibility, instill hope, align needs and goals and reduce barriers for whānau who attend CAMHS.

The ability to navigate these aspects of engagement relies on the understanding Māori cultural norms, and expression of nuanced behaviour. International research indicates that the practitioner's level of cultural fit with service users is associated with higher rates of family engagement in CAMHS (Liddle et al., 2006; Cardemil et al., 2010; Kumpfer et al., 2002; Poderefsky et al., 2001; Sue et al., 2009). Locally in Aotearoa/New Zealand there has been impetus from Māori about the need for understanding of Māori worldviews, values, beliefs and every-day life contexts in the discipline of psychology (Milne, 2005) and clinical psychology (Waitoki, 2012).

There are many challenges and complexities related to Māori identity that are able to be negotiated by practitioners who have a nuanced understanding Māori behaviours, values and beliefs. This is particularly relevant for the diverse urban Māori population which consists of a various iwi, with some whānau who have a strong understanding of their whakapapa, as well as mātauranga and tikanga and others who have had limited access to this knowledge due urbanisation and colonisation. Some whānau had misconceptions about the how 'Māori' they needed to be to be referred to the Māori team, for example some made assumptions that they needed to know how to speak Māori or know their pepeha (tribal landmarks). After whānau were provided information about He Kākano being an inclusive Māori service/team they felt more at ease. Borrell (2005) suggests that while some

urban Māori do not exhibit what would be considered traditional markers of Māori culture such as being able to speak in Māori or being versed with aspects of traditional mātauranga and tikanga Māori, it should not be assumed that they are any 'less Māori'. Durie (1999) has also talked about the substantial diversity within Māori realities which shapes the expression of identity. He Kākano were able to integrate understandings of these realities and identities to ensure services were relevant to Māori.

He Kākano practitioners also reflected on how their practice was different to commonly accepted Western based approach to initial assessments, for instance they integrated Western practices to fit within their tikanga-based engagement process. Whanaungatanga therefore provided the foundation for their clinical practice while Western clinical practices were selected and added in to this format. Taking time to build the relationship and therapeutic alliance at the beginning helped put whānau feel at ease and enabled better engagement with whānau from the in the long term.

As well as this, practical barriers such as transport and timing of appointments were addressed where possible. Most whānau had transport difficulties and reported that they appreciated He Kākano made home visits to alleviate these practical barriers. Literature also supports the importance of addressing practical barriers to enable better engagement (Kim, Munson & McKay, 2012).

Whakawhanaungatanga provided a means to develop therapeutic alliance through connection and bonding with whānau during the initial assessment and throughout the engagement. There is a significant body of international research supporting the critical influence of the therapeutic alliance as primary to success in mental health service delivery (Elvins & Green, 2008). How the intervention is delivered is of more importance than the therapeutic technique itself, emphasising the importance of establishing and maintaining the therapeutic alliance (Blow et al., 2007; Duncan et al, 2004). Similarly, other literature also indicates that families who experience a personal bond with their therapist and a collaborative relationship for developing tasks and goals of treatment are more likely to remain engaged in interventions (Thompson et al., 2007).

**Ongoing engagement.** Maintenance of engagement allows whānau to gain maximum benefit of the service and interventions. He Kākano consisted of practitioners



who were competent in appropriate tikanga for CAMHS. Cultural Advisors were particularly valued by whānau and rangatahi for their pūkenga (skills/abilities), interpersonal skills and knowledge. Cultural Advisors were 'real' and 'straight up', assisted with re-engagement for rangatahi who were difficult to engage, or alternatively provided a calming presence during difficult times, for example during a crisis. Their input was valued by whānau throughout engagement with the service. According to a report by the Mental Health Commission (2004) input from Kaumātua, Kuia or Cultural Advisors is often limited to the initial meeting and the integration of cultural input is lacking in clinical assessment/practice and the development of comprehensive care and treatment plans. Findings from this thesis suggest that Cultural Advisors not only assisted with maintaining ongoing engagement but their work was valued by rangatahi and whānau throughout the course of therapy.

Clinician/practitioner characteristics and skills that helped ongoing engagement were: empathy and compassion, awareness of professional power dynamics, and regular consistent contact. Similarly, He Kākano practitioners felt privileged to 'walk alongside' whānau to improve their wellbeing: they described treating young people and whānau like they would treat their own whānau. Aroha (compassion, love) and (hūmarietanga) humility permeated their clinical interactions with whānau; every interaction was seen as an opportunity to be therapeutic with whānau, to alleviate or assist with their difficulties. Whānau participants found it difficult to engage with practitioners who were too "clinical" or had a detached approach. Milne (2005) reviewed Māori perspectives of psychology and found that Māori experienced psychology and psychologists in some settings as being primarily concerned with "having the right questions to ask" (p. 13) and this led to a feeling that psychologists needed to convey more awhi (embrace, showing care) and aroha towards people they work with. As stated by one whānau participant in the present research, investment of aroha was the antidote for the child in her care:

*...it's love. There's not enough of it going around. A person can feel unloved, their feelings aye. (WH2)*

Of equal importance was the recognition of the importance of addressing power differentials between whānau and practitioners. Conveying respect, without imposing a professional superiority was a strong theme discussed by rangatahi and whānau. Likewise

He Kācano practitioners also asserted that humility was required when working alongside Māori. Minimising significant power imbalances that exist between professionals and clients is identified as an essential requirement for psychologists, particularly when working with indigenous populations who have a history of systematic disempowerment (Tassell et al., 2012).

Regular, consistent contact was another strong theme present in participants' talk. Both rangatahi and whānau members valued practitioners who regularly checked in either by phoning or stopping for a home visit as it demonstrated genuine care and concern for the tamaiti/rangatahi (young person). Rangatahi also appreciated having someone outside of their whānau to talk to and once they established a therapeutic relationship with the practitioner they felt supported to openly express themselves.

Intervention characteristics were also imperative for ongoing engagement. Whānau and rangatahi appreciated gaining practical coping strategies that suited a range of learning styles and strengths. Some had a preference for learning via physical modalities with hands on activities whereas others preferred to work with cognitions (CBT) or a combination of both. Whānau expressed the importance of holistic approaches to therapy Māori methods of expressing emotions, this is particularly important as Māori have high rates of emotional expression (Wirihana & Smith, 2014). In regards to wairuatanga (spirituality), some whānau also went to Matakite (healer or spiritually gifted person) based at marae settings to make sense of their mental health difficulties. Practitioners assisted with providing information to whānau and rangatahi about culturally congruent health coping strategies, where appropriate. These findings provide further support for the applicability relevance of Māori models and paradigms of health such as Te Whare Tapa Whā and The Meihana Model in contemporary Māori life-contexts and the importance of holistic conceptualisations of wellbeing (Durie, 1995; Nepe, 1991; Pitama, Huirua & Lacey, 2014).

During therapy whānau and young people experienced deep emotions while they were processing their mamae (pain, grief). Wairuatanga (spirituality) was acknowledged by whānau and practitioners as an important aspect of healing and therefore it was imperative to provide a safe space to express emotions and spirituality. While there is significant variation in Māori identity, many have written that wairua has an integral role in mental

illness and wellbeing for Māori (Ahuriri-Driscoll, 2013, Lawson-Te Aho, 2013; Taitimu, 2007; Valentine, 2009; Wharewera-Mika, 2012). The importance of the expression of emotions, *mai i te whatumanawa* (from the seat of emotions) and spirituality is captured in the following excerpt from a practitioner in He Kākano:

*They may not have the kupu (words), but they feel it. There'll be some families that'll be quite articulate about it, there'll be others that will feel it and you can see them feeling with it and not quite sure where it sits with them. Because, you know, sometimes it wasn't what they expected when they came in, and they get quite a shock that they felt it. Or they start to cry, and then try to put their tears back, and we say cry, it's really important. It's the beginning to healing...(HK 4)*

**Barriers.** The main barriers for rangatahi and whānau included the inappropriate use of language and medication. Overly technical and clinical language was a barrier for some and led to disengagement during sessions. This finding is consistent with other literature that stresses the importance of clear communication in language that is appropriate to the service-user/client (Jansen, Bacal & Crengle, 2008; Stern et al., 2014). This was also touched on by He Kākano practitioners who suggested that formal language and technical terminology often restricted engagement.

Some whānau were against the use of psychiatric medication in general whereas others found it helpful. For those that were ambivalent about medication, the decision to pursue this treatment pathway was not taken lightly. Some whānau had negative experiences where the consent process was rushed. Others experienced negative side effects of the medication or found the medication to be ineffective. Providing full information and options with regards to medication will likely assist whānau to make informed consent decisions around medication (Taitimu, 2007; Wharewera-Mika, 2012).

Challenges of operating as a Māori team within a mainstream service were expressed by He Kākano team members. Māori engagement strategies and tikanga practices were difficult to practice within the constraints of the service. For example, although whakawhanaungatanga was the fundamental basis for engagement, the current CAMHS system which utilises Multi-disciplinary team (MDT) meeting is orientated towards Western models of practice. Practitioners were required to report back to MDT meetings with

information regarding the presenting problems and symptoms, however, there was minimal capacity to document and reflect on the process of engagement or whakawhanungatanga. He Kākano practitioners also noted that there was a lack of culturally appropriate psychometric assessment measures and there was significant need to develop these for Māori.

He Kākano also discussed negative attitudes of some practitioners in other teams. Attitudes from others were slowly improving; however, some noted that there was a perception by mainstream practitioners that the Māori team and Māori practices lacked the same clinical credibility as the mainstream approaches. Practitioners in He Kākano who experienced this discrimination were reluctant to refer Māori clients to these teams as they were concerned about how they may be treated by practitioners who lacked cultural understanding.

The interface between Māori and Western knowledges and practices remains a constant challenge in research and in practice. Western knowledge is privileged over indigenous knowledge within many mental health disciplines. Mātauranga Māori is often minimised in psychology and Māori practices are viewed as less 'clinical'. However, this research demonstrates that there are many tikanga and mātauranga Māori based therapeutic processes and practices that are being utilised successfully by Māori practitioners in CAMHS. The findings of this research contain elements equivalent to effective engagement strategies identified within Western literature. Many of the effective strategies were already embedded in to the engagement approach used in He Kākano. The confluence of these different knowledge systems, where both Māori and Western knowledges are recognised as legitimate and valid provides a basis for further development and enhancement of services for Māori. It is critical in Aotearoa, New Zealand that Māori knowledge and practices for effective engagement is utilised in services to meet the needs of the the high numbers of Māori tamariki, rangatahi and whānau that suffer a high burden of mental health difficulties.

**Whānau strengths and resiliencies.** It was not the original aim in this research to explore whānau pathways to wellbeing, however, during interviews participants were forthcoming about various coping strategies they employed as a whānau to assist the young

person to get better. The discussions yielded important information about whānau strengths and resiliency. Recognising strengths enhances engagement and also provides a foundation for therapeutic intervention with young people and their whānau.

Whānau helped young people cope with their mental health difficulties by building strong whānau relationships which included showing aroha (love) and listening to young people when they needed to be heard. Whānau engaged in holistic approaches to wellbeing and parents or other significant adults shared experiential wisdom about what helped them during challenging intersections in their life. Adult whānau members reflected on how they came to learn later in life the importance of Māori identity for wellbeing, belonging and connection. The combination of these whānau practices alongside the work undertaken while engaged with He Kākano practitioners, all assisted in making changes and consequent positive outcomes for young people and their whānau. Recent literature on positive youth development for rangatahi points to the critical influence of whānau members (parents and other significant adults) in young people's health and educational choices (Simmonds, Harré & Crengle, 2014). Further to this, whanaungatanga (whānau connectedness) and Māori identity were identified as coping strategies which assisted with promoting resilience with whānau who had faced adverse life events (Waiti & Kingi, 2014). Whānau connectedness was also found to reduce risk for suicidal rangatahi (Clark et al., 2011). Investing in whānau resilience and strengths provides many benefits for the young person and their whānau during their engagement with CAMHS, while also boosting their capacity to overcome future life challenges.

**Future aspirations.** Whānau and He Kākano articulated aspirations for services in the future. Whānau suggested interventions based on the traditional ways of tūpuna (ancestors) and returning back to tūrangawaewae (original home-land) as a means to improve wellbeing and enhance engagement. Whānau and rangatahi also wanted support groups with other peers who had also accessed CAMHS.

He Kākano wanted the ability to deliver more tikanga based engagement strategies in the service, such as sitting with rangatahi to have kai (food), which helped relationship building by 'being on the same level', thus mitigating inherent professional power differences. The importance of kai as a means of bringing people together to engage in

dialogue/conversation is captured by the following whakataukī (proverb) which relates to finding spaces and opportunities to sit together and talk freely:

*He wāhi noho, he wāhi kai, he wāhi kai, he wāhi kōrero*

*Where there is a place to sit, there is a place to eat, where there is a place to eat there is a place to talk*

This method of engagement may be particularly helpful for working with young people/rangatahi (and whānau) where it takes time to build trust and rapport with practitioners before a collaborative therapeutic relationship is established.

The combined rangatahi, whānau and practitioner aspirations within the research are strongly situated within a Kaupapa Māori research approach to advance Māori aspirations. There is a growing body of literature regarding Kaupapa Maori theories and practices that assert a need for Māori to develop initiatives for change that are located within distinctly Māori frameworks (Pihama & Penehira, 2009). This is also true for mental health and psychology. There is a also scope for these considerations in the Treaty of Waitangi with respect to Tino Rangatiratanga (autonomy) over health choices for Māori for future services.

## **Clinical Implications**

**Māori methods of engagement.** Tikanga-based practices such as whakawhanaungatanga and other processes of engagement which facilitate the therapeutic alliance were considered important in the reports of rangatahi and whānau in this study. To this end, updating current practices in CAMHS to align with Māori methods of engagement is vital. In addition, there is a need for psychologists and other mental health practitioners to have an understanding of Māori psychology, tikanga and mātauranga Māori as well as clinical skills to enable effective engagement during the initial assessment period and throughout ongoing sessions. Methods of engagement taught in training programmes for mental health professionals, including clinical psychologists need to be adapted to a more culturally responsive format, which would include whakawhanaungatanga and other tikanga and mātauranga Māori based engagement approaches as key training components.

### **Clinicians and Cultural Advisors who are competent at working with Māori.**

Throughout Aotearoa there are only a small number of Kaupapa Māori CAMHS teams like He Kākano. It is recommended that there is continued investment in the Māori mental health workforce, including clinical psychologists to match the numbers of Māori in need of mental health services.

It is likely that most other CAMHS services employ Cultural Advisors, including Kaumātua and Kuia, to provide cultural support to Māori attending mainstream mental health services. Pertinent cultural considerations can be missed when clinicians have limited knowledge and experience with Te Ao Māori. It is recommended that clinicians working with Māori consistently consult with Cultural Advisors not only for ceremonious aspects of engagement (for example karakia, mihimihi, whaikōrero) but throughout engagement in line with the goals of the young person and whānau. It is important to ensure that all facets of a person's wellbeing are carefully considered from within holistic Māori frameworks and that these factors inform the psychological assessments, formulations, diagnosis, clinical planning and implementation of interventions.

It is also recommended that clinicians continue to develop their depth of knowledge and understanding of Te Ao Māori, as well as the practical application of Māori models of health in everyday contexts and interactions rather than relying solely by mono-cultural Western perspectives to inform practice.

**Therapeutic interventions.** Teaching strategies in therapy for coping with mental health difficulties is valuable for young people. The selection and application of appropriate interventions is also important for engagement. Māori children and adolescents may do better with hands-on activities, cognitive therapies or a combination of different modalities of talking and activity. Strategies need to be relevant to the young person's interests (such as music, sports, art, hobbies) and every-day life contexts to ensure they are engaging. For instance self-soothing skills, distress tolerance strategies must be accessible and suited to the young person's personal preferences. Developmental needs of children and adolescents must also be considered from Māori norms.

Awhi, aroha and manaakitanga provided a basis for whānau to engage with interventions. Whānau also wanted to incorporate traditional therapies in to services indicating a desire for more mātauranga and tikanga Māori based interventions.

**Practical help.** Whānau capacity to engage with interventions is limited when there are financial pressures. Social supports to alleviate stressors are important pre-requisite for any psychological intervention. Broadening the whānau support system by linking whānau with external support services such as social services, marae based services, Non-Government Organisation Services (NGOS) and Whānau Ora government services can help alleviate social concerns. Young people also benefit from the supportive relationship with a community support mentors.

**Pūmanawa: Recognising strengths.** Gathering information on pūmanawa or existing strengths and resiliencies of the young person and the whānau enables clinicians to match interventions with need and also has the added benefit of empowering young people by acknowledging their inherent uniqueness and abilities.

## **Strengths and Limitations of the Study**

A strength of this study was the focus on the Māori living in the urban area of Manukau. The Kaupapa Māori qualitative research design used in this study gives a depth of understanding of the experience of engagement for rangatahi and whānau. Giving rangatahi and whānau participants their own voice allowed them to provide their perceptions of engagement with a Kaupapa Māori team in CAMHS. Consulting He Kākano and Whirinaki meant that the current research could be meaningful and useful to the team and organisation. Interviewing He Kākano practitioners also provided an opportunity to describe and discuss the idiosyncrasies of engagement with Māori. Māori epistemology as a tool of analysis also allowed a depth of understanding of concepts elicited by whānau and practitioners to be interpreted within a Māori worldview, in line with the aspirations of Kaupapa Māori research. It also provided a voice to Māori participants which is often not heard in the mainstream media or captured in statistical data.

This research contributes to advancing knowledge on engagement for Māori tamariki, rangatahi and whānau by outlining the practical and contemporary application of mātauranga and tikanga in CAMHS. It also provides practical processes and potential areas



of development to assist clinicians to enhance and maintain engagement with Māori. Despite the inherent challenges of integrating Western and Māori practices, He Kākano provides an example of a comprehensive Kaupapa Māori engagement approach during assessment and throughout intervention.

Giving rangatahi and whānau the opportunity to talk about anything that they felt was important for engagement opened the dialogue and reduced limitations on the topics discussed. This made it possible to uncover topics or aspects of topics that are not covered or are not well represented in the current literature such as whānau wisdom and pathways to wellbeing.

Given the interviews were conducted while I was 7-8 months hapū (pregnant) with my third child it is possible this contributed to participants being forthcoming and supportive of the research during the interviews. It appeared that being hapū elicited feelings of joy and excitement and I certainly felt a great sense of manaakitanga from participants whom were mostly interviewed in their home environments. It is likely that this could have enhanced the engagement with participants during the interviews. The process of whakawhanaungatanga, being respectful and allowing kōrero from whānau and rangatahi to unfold during the interviews paralleled the methods of engagement outlined in the body of the thesis.

Despite the strengths of this research, the analysis should be assessed in the context of a number of limitations. Firstly, the majority of participants spoke positively about their experiences of He Kākano, this could be due to the fact that they may have seen me as a member of the team or part of the service. Alternatively, as mentioned above because I was hapū (pregnant) while conducting the interviews, rangatahi and whānau may have been more positive during interactions with me and therefore may have only wanted to talk about their positive experiences with Whirinaki. However, I did ask participants directly about barriers or areas of service improvement to counter this. Although there are patterns across participants, each participant in this study had a unique experience, both in terms of their presenting difficulties or diagnoses, as well as their perception of engagement. Furthermore, the rangatahi and whānau interviewed were urban based Māori who resided in Manukau, Auckland. Manukau has the largest Māori population in New Zealand,

however, whānau living in rural areas may experience different challenges to accessing and engaging with CAMHS. Similarly, gathering information from whānau residing in other areas in Auckland or other urban areas and cities in New Zealand may have yielded different findings.

Another factor related to the participant sample was the lack of balance representing tāne (adult male) whānau participants as all whānau participants were females (mothers, older sisters, aunties, grandmothers and female caregivers). Research about tāne Māori would aid in our understanding of the best ways to engage with all members of the whānau and gain insights and understanding into contributors to health and wellbeing for tāne Māori. Kaupapa Māori research in to Māori mens' health and wellbeing point to the influence of constructions of masculinity and the importance of relational health. According to Hokowhitu (2004) dominant discourses on physicality and Māori male constructions of masculinity, colonisation and the lack of educational opportunities have disadvantaged Māori men and led to diminished wellbeing. Recent research on factors that contribute to the health and wellbeing of Māori men highlight the importance of meaningful relationships with partners, children, colleagues, friends and communities as well as the role of cultural traditions, physical and symbolic places, and shared practices (Rua, 2015).

A final limitation of the study was the lack of access to whānau who chose not to engage in Whirinaki or had dropped out, although a few participants had unsuccessful experiences of engagement with mainstream teams. Exploring the perspectives of those who did not engage would have added significantly to further understanding about recruitment, retention and overall engagement issues for Māori in CAMHS.

## **Future Research**

The current study offers a broad and initial overview of the perspectives of Māori whānau engagement in a Kaupapa Māori CAMHS team in an urban area. Future research of a similar nature would benefit from a larger sample of rangatahi and younger participants, tamariki under the age of 13 to provide information about important factors to consider when engaging with these groups. Gathering the views of tāne (male) whānau members would also enrich and enhance the reach of this type of research to a broader range of whānau.

Future research could aim to recruit a cohort of participants, at the point at which they enter CAMHS, then interviewing them at later stages of engagement. This would provide a more comprehensive, detailed examination of whānau engagement, including examination of factors that contribute to disengagement with services. Recruiting a cohort of whānau clients, as in a group of successive referrals, would also assist to counter issues of selection bias; although it is acknowledged that there would be a portion of whānau who would decline involvement in such research.

It would also be useful to explore the effectiveness of programmes with regard to both short- and long-term outcomes for whānau. This study explored experiences and perceptions of engagement, however, this was not specifically an 'outcomes' study. Exploring outcomes for whānau in more detail, including what maintains positive changes within whānau following discharge from CAMHS, could provide useful information for intervention development, delivery and follow up, and well as for understanding the contributors to positive whānau development and whānau ora. In this regard, future research may consider recruiting whānau clients into a follow-up study in order to create opportunities to better develop this understanding.

A Māori model of engagement in CAMHS could be developed based on the principles and methods outlined in this study. Continuing to develop these practice approaches may offer further opportunities for development of improved engagement for whānau. Also important would be research which examines the efficacy of such approaches. Trialling the Māori models of engagement will require outcome studies such as randomised control trials to using Māori wellbeing measures determine usefulness. Future research could also measure quality of engagement in current services by measuring attendance rates, drop-out rates using culturally appropriate outcome measures.

## **Conclusion**

In summary, the concept of the whakataukī, and title of this research He Kācano ahau i ruia mai i Rangīātea, provides a basis for us to understand fundamental components of engagement for Māori. Engagement is effective when CAMHS deliver a service that involves, acknowledges and encourages whānau while nurturing existing strengths, wisdom and resiliencies and supporting aspiration for the wellbeing of tamariki and rangatahi. Like

kākano (seeds), tamariki (children), rangatahi (youth) and whānau have capability for growth and expansion with the investment of these services and other supports systems.

This thesis demonstrates the effectiveness of tikanga and mātauranga as a tool for engagement with tamariki, rangatahi and whānau in mental health services. Findings from this research further support Māori models of health and the importance of the continued development of Kaupapa Māori approaches and services. This research could also inform policy guidelines, teaching and educative resources, and training for clinicians working in CAMHS. The key to the improving mental health outcomes whānau lies in the confluence of effective engagement practices that enable the *kākano* to develop and blossom to the fullest potential.

# APPENDICES

## Appendix A

### Participant Information Sheet: Parent

## Information Sheet for Potential Participants for Whānau/Caregiver(s)

### He Kākano ahau i ruia mai i Rangiātea: engaging Māori in Child and Adolescent Mental Health Services

Tēnā koe, my name is Pikihuia Pomare. I am of *Ngapuhi, Ngai te rangi* descent. I am studying towards a Doctor of Clinical Psychology at the University of Auckland. I am doing this research for the purpose of my thesis. You are invited to take part in study investigating the best ways to support Māori children and their whanau in child and adolescent mental health services (CAMHS). I want to find out what would be useful for whānau involved in these services so that a ‘best-practice’ model can be developed. Taking part in this study is your choice, and you have the right to not participate. It is also hoped that this information will enhance services provided for Maori involved in child and adolescent mental health services.

### Who will benefit from this study?

We would like to learn from you what things have been helpful and what you think could be improved. This information will provide valuable feedback to the Whirinaki staff and will assist in identifying things that work well and things that could improve their service. It is hoped that whānau will benefit from this research by having their ideas heard about the support needed at child and adolescent mental health services. It is also includes ideas based on your experience at Whirinaki. Your thoughts and feelings may relate to general ideas about this topic, specific cultural factors, specific clinical factors, or any combination of these. The interview should take between one to two hours, but this will depend on how much information you wish to share with me. You do not have to answer all the questions and can stop the interview at any time, either for a break or to finish completely. I need to take a few notes and audio-tape the

interview, to be sure that I have a correct record of what you tell me. Please feel reassured that anything you say will be confidential and private.



### **Where will it be done?**

The interview will be held Whirinaki or the University of Auckland in a place where we can talk with privacy. I will provide petrol vouchers to pay for your travel to the interview and as a koha for your participation. You are more than welcome to have whānau or friends present for support.



### **What will happen at the end of the study?**

After our interview I will write-up the main themes from the audio-tape. You will have a chance to check the record of your interview. This will be a few weeks after the interview. You can take out, change or add to anything that you said in the interview. I would like to report the final results back to you and if you are interested, discuss them with you. No material that could personally identify you will be used in the write-up of the study. The university requires that the information you give me is kept in secure storage after the completion of the study until your child's age of majority (16years old) plus 10 years. After this time the tapes and notes will be destroyed. No one except me and my two research supervisors will have access to this information.



### **What are your rights as a participant?**

If you do agree to take part, you can choose to withdraw from the study after the transcripts are sent to you. This also includes the right to withdraw the information you have given me. You would not have to give a reason for withdrawing from the research. You can contact either me, or one of my supervisors, with any questions or concerns that you may have at any for withdrawing from the research. You can contact either me, or one of my supervisors, with any questions or concerns that you may have at any stage of the study. My supervisors are Fred Seymour from the Psychology Department of the University of Auckland, and Ainsleigh Cribb-Su'a (*Ngati Maniapoto / Ngati Kauwhata*), Clinical Psychologist/Team Leader, He Kākano Whirinaki (CAMHS) Counties Manukau DHB. Their contact details are given on the back page. If you have any queries or concerns regarding your rights as a participant in this study, you may

wish to contact an independent health and disability advocate. Their contact details are also given on the back page. If you want to make a complaint, you can address it to me or my supervisors, or the National Ethics Committee at the address given on the back page.



### **Are there any risks involved?**

It is possible that you may become upset during the interviews if there are particular ongoing issues from your time at Whirinaki. If you think the risk of becoming upset may be a problem for you, we can begin and then stop if you feel uncomfortable. You can have a break and then continue, or stop altogether. If necessary, I can help you to access support you might require. You are also welcome to discuss these issues with me. If any issues arise that suggest your safety or someone else's safety may be at risk, I will need to talk about this with someone that I think can help reduce this risk.



### **Where can I get more information about the study?**

You can contact me by the phone number supplied below, leave a message for me and I will call you back as soon as I can. By replying, you are not committing yourself to the research. What you are agreeing to is giving me your contact details and allowing me to contact you to discuss whether you may like to participate. I would be very grateful if you could take the time to reply to me as soon as you have had enough time to think about this. Thank you for taking the time to read this information sheet and considering sharing your valuable knowledge with me. I hope I will hear from you soon.

Ngā manaakitanga,

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Health and disability advocate: Free phone: 0800 555 050

Email: [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)



## **Appendix B**

### **Participant Information Sheet: Rangatahi**

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[Ainsleigh.Cribb@middlemore.co.nz](mailto:Ainsleigh.Cribb@middlemore.co.nz)  
Clinical Psychologist/Team Leader  
Whirinaki (CAMHS)  
Counties Manukau DHB

**Other contact details:**

If you have any questions or concerns regarding your rights as a participant in this study, you may wish to contact an independent health and disability advocate:

Free phone: 0800 555 050  
Free fax: 0800 2 SUPPORT (0800 2787 7678)  
Email: [advocacy@hdc.org.nz](mailto:advocacy@hdc.org.nz)

**This study has received ethical approval from the Northern X Ethics Committee, ethics reference number NXT/10/07/063**

**He Kākano ahau i ruia mai i Rangiatāea: engaging Māori in Child and Adolescent Mental Health Services**

**Information Sheet for Potential Participants for adolescents**

Tēnā koe,  
My name is Pikihua Pomare. I am from *Ngapuhi* and *Ngai te rangi*. I am studying towards a Doctor of Clinical Psychology at the University of Auckland and I am doing this research for my degree. You are invited to take part in a study to give your ideas about the best ways to support young Māori and their whānau in child and adolescent mental health services (CAMHS). We are looking at how best to help young people who are attending these services and because you are attending right now, we would like to hear what you think. We would like to learn from you about what things are helpful and what you think could be done better. By talking to you we hope to learn how to help you and other young people in similar situations. Taking part in this study is your choice, and you have the right to not participate.

**Who will benefit from this study?**

It is hoped that young Māori like yourself will benefit from this research by having their ideas heard about the support needed at child and adolescent mental health services. It is also hoped that mental health and social services will benefit by learning from the recommendations that will result from this study about the best ways to help whānau and tamariki in child and adolescent mental health services.

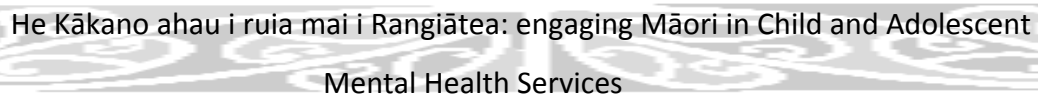
**What does the study involve?**

Whirinaki staff members, providers and experts in the field of child and adolescent mental health, and whanau who have attended Whirinaki will be invited to participate in this phase of the study. I hope to interview about 30 people altogether. During the interview you will be asked to talk about your thoughts and feelings on what young Māori need in child and

<p>adolescent mental health services. This includes ideas based on your experience at Whirinaki. Your thoughts and feelings may relate to general ideas about this topic, about cultural ideas, about clinical ideas, or any combination of these. The interview should take between one to two hours, but this will depend on how much information you want to share with me. You do not have to answer all the questions and can stop the interview at any time, either for a break or to finish completely. I need to take a few notes and audio-tape the interview, to be sure that I have a correct record of what you tell me. Please feel reassured that anything you say will be private and confidential, I will not be talking about your information with other people other than my supervisors at the University.</p>	<p>one of my supervisors, with any questions or concerns that you may have. My supervisors are Fred Seymour from the Psychology Department of the University of Auckland, and Ainsleigh Cribb-Su'a (<i>Ngati Maniapoto / Ngati Kawwhata</i>), Clinical Psychologist/Team Leader, He Kakano Whirinaki (CAMHS) Counties Manukau DHB. If you have any questions or concerns about your rights as a participant in this study and you do not want to ask me or my supervisors, you can contact a Health and Disability Consumer Advocate. All of the contact details are given on the back page. If you want to make a complaint, you can address it to me or my supervisors, or the National Ethics Committee at the address given on the back page.</p>
<p><b>Where will it be done?</b></p> <p>The interview will be held at your home, the University of Auckland in a place where we can talk with privacy. I will provide petrol vouchers to pay for your travel to the interview. You are more than welcome to have whānau or friends present for support.</p>	<p><b>Are there any risks involved?</b></p> <p>It is possible that you may become upset during the interviews if there are particular ongoing issues from your time at Whirinaki. If you think the risk of becoming upset may be a problem for you, we can begin and then stop if you feel uncomfortable. You can have a break and then continue, or stop altogether. If necessary, I can help you to access support you might require. You are also welcome to discuss these issues with me. If any issues arise that suggest your safety or someone else's safety may be at risk, I will need to talk about this with someone that I think can help reduce this risk.</p>
<p><b>What will happen at the end of the study?</b></p> <p>After our interview I will write-up the main themes from the tape. You can check the record of your interview if you want. You can take out, change or add to anything that you said in the interview. I would like to report the final results back to you and if you are interested, discuss them with you. Your name and any other personal information about you will not be used in the write-up of the study. The information you give me is locked away in a filing cabinet at the university until after the study is finished. No one except me and my research supervisors will have access to this information.</p>	<p><b>Where can I get more information about the study?</b></p> <p>You can contact me by the phone number supplied below, leave a message for me and I will call you back as soon as I can. By replying, you are not committing yourself to the research. What you are agreeing to is giving me your contact details and allowing me to contact you to discuss whether you may like to participate. I would be very grateful if you could take the time to reply to me as soon as you have had enough time to think about this.</p>
<p><b>What are your rights as a participant?</b></p> <p>If you do agree to take part, you can choose to withdraw or pull out from the study after the transcripts are sent to you. This also includes the right to withdraw the information you have given me. You would not have to give a reason for withdrawing from the research. You can contact either me, or</p>	<p>Thank you for taking the time to read this information sheet and considering sharing your valuable knowledge with me. I hope I will hear from you soon.</p> <p>Ngā manaakitanga, Pikihua Pomare</p>

## **Appendix C**

### **Participant Information Sheet: He Kākano**



He Kākano ahau i ruia mai i Rangiātea: engaging Māori in Child and Adolescent  
Mental Health Services

**Information Sheet for Potential Participants for Staff**

Tena koe,

My name is Pikihuia Pomare. I am of *Ngapuhi, Ngai te rangi* descent. I am studying towards a Doctor of Clinical Psychology at the University of Auckland. I am doing this research for the purpose of my thesis. You are invited to take part in study investigating the best ways to engage Māori whānau in child and adolescent mental health services (CAMHS). I want to find out what would be useful for whānau involved in these services so that a framework/model of best practice can be developed. Taking part in this study is your choice, and you have the right to not participate. It is also hoped that this information will enhance services provided for Māori involved in child and adolescent mental health services.



**Who will benefit from this study?**

As someone who works at Whirinaki in He Kākano, I would like to talk to you about the ways you engage Māori whānau in your services. This information will then be used to improve the services offered to Māori clients and their whānau/caregivers. It is hoped that mental health and social services will benefit by learning from the recommendations that will result from this study about the best ways to engage whānau in child and adolescent mental health services.



**What does the study involve?**

Whirinaki staff members, key informants (providers and experts) in the field of child and adolescent mental health, and whānau of clients at Whirinaki will be invited to participate in this phase of the study. I hope to interview about 30 people altogether. I will be conducting face-to-face interviews and will be asking you about your views of the process of engaging whānau. As mentioned above, I am interested in finding out about your ideas on engagement strategies based on your work experience in He Kākano. Your thoughts and feelings may relate to general ideas about this topic, specific cultural factors, specific clinical factors, or any combination of these. The interview should take between one to two hours, but this will depend on how much information you wish to share with me. You do not have to answer all the questions and can stop the interview at any time, either for a break or to finish completely. I need to take a few notes and audio-tape the interview, to be sure that I have a correct record of what you tell me. Please feel reassured that anything you say will be confidential and private.



**Where will it be done?**

The interview will be held Whirinaki, in a place where we can talk with privacy.



**What will happen at the end of the study?**

After our interview I will write-up the main themes from the audio-tape. You will have a chance to check the record of your interview. This will be a few weeks after the interview. You can take out, change or add to anything that you said in the interview. I would like to report the final results back to you and if you are interested, discuss them with you. No material that could personally identify you will be used in the write-up of the study. The university requires that the information you give me is kept in secure

storage after the completion of the study period of 10 years. After this time the tapes and notes will be destroyed. No one except me and my research supervisor Professor Fred Seymour will have access to this information.



**What are your rights as a participant?**

If you do agree to take part, you can choose to withdraw from the study after the transcripts are sent to you. This also includes the right to withdraw the information you have given me. You would not have to give a reason for withdrawing from the research. You can contact either me, or one of my supervisors, with any questions or concerns that you may have at any stage of the study. My supervisors are Fred Seymour from the Psychology Department of the University of Auckland, and Ainsleigh Cribb-Su'a (*Ngati Maniapoto / Ngati Kauwhata*), Clinical Psychologist/Team Leader, He Kākano Whirinaki (CAMHS) Counties Manukau DHB. Their contact details are given on the back page. If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organisation. If you want to make a complaint, you can address it to me or my supervisors.



**Are there any risks involved?**

It is not anticipated that there will be any major risks involved with this research; however, you are welcome to discuss any issues you may have with me. If any issues arise that suggest your safety or someone else's safety may be at risk, I will need to talk about this with someone that I think can help reduce this risk.



**Where can I get more information about the study?**

You can contact me by the phone number supplied below, leave a message for me and I will call you back as soon as I can. By replying, you are not committing yourself to the research. What you are agreeing to is giving me your contact details and allowing me to contact you to discuss whether you may like to participate. I would be very grateful if you could take the time to reply to me as soon as you have had enough time to think about this.

Thank you for taking the time to read this information sheet and considering sharing your valuable knowledge with me. I hope I will hear from you soon.

Ngā manaakitanga,

Pikihuia Pomare

Pikihuia Pomare

(09) 373-7999, extn. 87198

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Auckland 1142

This study has received ethical approval from the Northern X Ethics Committee, ethics reference number NXT/10/07/063

## **Appendix D**

### **Consent Form: Parent**



DEPARTMENT OF PSYCHOLOGY  
 Faculty of Science  
 Human Sciences Building  
 10 Symonds St  
 The University of Auckland  
 Private Bag 92019  
 Auckland, New Zealand

**CONSENT FORM**

**(This consent form will be stored until age of majority plus ten years)**

**Project Title:** He Kākano ahau i ruia mai i Rangīātea: engaging Māori in Child and Adolescent Mental Health Services

**Principal Investigator:** Pikihuia Pomare

Māori	E hiahia ana ahau ki tētahi kaiwhaka Māori/kaiwhaka Pākeha kōrero	Ae	Kao
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I have read and understood the Participant Information Sheet dated 3/8/2010 for this project for volunteers taking part in the study designed to investigate the best ways to support Māori children and their whānau engage in child and adolescent mental health services.

I have had the opportunity to discuss this study, ask questions and have them answered.

I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study, and have been given time to consider whether to take part.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without giving a reason and this will in no way affect my future health care/continuing health care. I understand that my participation in this study is

confidential and that no material which could identify me will be used in any reports on this study.

I understand that my interview will be audio-taped and that I have the right to turn off the tape at any time. I understand that I can request the tape be returned to me after transcription has taken place (after the words on the tape have been listened to and written down) by contacting the Principal Investigator.

I understand that this consent form will be stored separately to any other data related to me. These will be stored until age of majority plus 10 years (until your child is aged 16 plus 10 years) in a locked filing cabinet in Professor Fred Seymour's office at the University of Auckland.

NAME:

SIGNED:

DATE:

This study has received ethical approval from the Northern X Ethics Committee, ethics reference number NXT/10/07/063

## **Appendix E**

**Consent form: Rangatahi**

## CONSENT FORM FOR ADOLESCENTS

(This consent form will be stored until age of majority plus ten years)

**Project Title:** He Kākano ahau i ruia mai i Rangiatea: engaging Māori in Child and Adolescent Mental Health Services

**Principal Investigator:** Pikihuia Pomare

Māori	E hiahia ana ahau ki tētahi kaiwhaka Māori/kaiwhaka Pākeha kōrero	Ae	Kao
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I have read and understood the Participant Information Sheet dated 5/4/2011 for this project for volunteers taking part in the study designed to investigate the best ways to support young Māori and their whānau engage in child and adolescent mental health services.

I have had the chance to talk about this study, ask questions and have them answered.

I have had the chance to use whānau support or a friend to help me ask questions and understand the study, and have been given time to think about whether to take part.

I understand that taking part in this study is voluntary (my choice) and that I can withdraw or pull out from the study at any time without giving a reason and this will in no way affect my future health care/continuing health care at Whirinaki. I understand that my participation in this study is private confidential and that no material which could identify me will be used in any reports on this study.

I understand that my interview will be audio-taped and that I have the right to turn off the tape at any time. I understand that I can request the tape be returned to me after the words on the tape have been listened to and written down by contacting the Principal Investigator Pikihuia Pomare.

I understand that this consent form will be stored separately to any other data or information related to me. These will be stored until age of majority plus 10 years (until you are 16 plus 10 years) in a locked filing cabinet in Professor Fred Seymour's office at the University of Auckland.

NAME:

SIGNED:

DATE:

This study has received ethical approval from the Northern X Ethics Committee, ethics reference number NXT/10/07/063

## **Appendix F**

**Consent form: He Kākano staff**



DEPARTMENT OF PSYCHOLOGY  
 Faculty of Science  
 Human Sciences Building  
 10 Symonds St  
 The University of Auckland  
 Private Bag 92019  
 Auckland, New Zealand

**CONSENT FORM**

**(This consent form will be stored until age of majority plus ten years)**

**Project Title:** He Kākano ahau i ruia mai i Rangīātea: engaging Māori in Child and Adolescent Mental Health Services

**Principal Investigator:** Pikihuia Pomare

Māori	E hiahia ana ahau ki tētahi kaiwhaka Māori/kaiwhaka Pākeha kōrero	Ae	Kao
-------	---	----	-----

I have read and understood the Participant Information Sheet dated 3/8/2010 for this

project for volunteers taking part in the study designed to investigate the best ways to support Māori children and their whanau engage in child and adolescent mental health services.

I have had the opportunity to discuss this study, ask questions and have them answered.

I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study, and have been given time to consider whether to take part.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without giving a reason and this will in no way affect my future health care/continuing health care. I understand that my participation in this study is

confidential and that no material which could identify me will be used in any reports on this study.

I understand that my interview will be audio-taped and that I have the right to turn off the tape at any time. I understand that I can request the tape be returned to me after

transcription has taken place (after the words on the tape have been listened to and written down) by contacting the Principal Investigator.

I understand that this consent form will be stored separately to any other data related to me. These will be stored until age of majority plus 10 years (until your child is aged 16 plus 10 years) in a locked filing cabinet in Professor Fred Seymour's office at the University of Auckland.

NAME:

SIGNED:

DATE:

This study has received ethical approval from the Northern X Ethics Committee, ethics reference number NXT/10/07/063

## **Appendix G**

### **Participant Interview Schedules**

## **Rangatahi and whānau members semi-structured interview questions**

How did your whānau come to be involved with Whirinaki/CAMHS?

Whānau engagement at Whirinaki- what did they do at the first session(s)?

What did they do throughout your time there to ensure you got the best service?

What do you think contributes to good whānau engagement for Māori?

What do you think is the impact of referral? (on them as individuals? on the whānau?)

Why might some whānau have difficulties with engagement and not others?

How can barriers be reduced or avoided?

What type(s) of support could be provided to whānau?

What type(s) of current intervention(s) have you found to be helpful/unhelpful for helping.....(young person)?

## **He Kākano staff/practitioners focus group interview questions**

Defining whānau engagement: what is it?

What contributes to good engagement?

Why might some whānau have difficulties with engagement?

How does your service engage with whānau?

How does your service meet the needs of the whānau and cultural needs?

What type(s) of practices have you found to be helpful/unhelpful for engagement?

What are the strengths and weaknesses of service provision for Māori in CAMHS?

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