

**EFFECTIVE INTERVENTIONS FOR
MĀORI WITH BIPOLAR DISORDER: A
QUALITATIVE STUDY**

Cassandra Staps

Te Aitanga-a-Hauiti / Ngapuhi

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ABSTRACT

This study explores the perspectives of clinicians and others knowledgeable in Hauora Māori in describing effective interventions when caring for Māori diagnosed with bipolar disorder. Māori, who are the indigenous people of New Zealand, experience higher rates of mental disorder in comparison to non-Māori, and the focus on bipolar disorder was chosen because of the prevalence within Māori.

A kaupapa Māori research and qualitative research methodology was utilised for this study. Participants were sampled from Otautahi (Canterbury), and one other participant lived in Te Whanga-nui-a-Tara (Wellington). Data collection was gathered by way of individual interviews and focus groups. Transcriptions were thematically analysed for the individual interviews, and nominal group technique was used to collate data from the two focus groups.

Three themes were identified through thematic analysis: Māori worldview (te ao Māori), tikanga Māori and whānau. Nominal group technique consensus further identified whakawhanaungatanga, Māori models of care, identity of tangata whaiora, whakarongo, powhiri process, open communication and clear boundaries.

This study identified that interventions for Māori with bipolar disorder need to incorporate Māori world view, tikanga Māori and whānau. The process of providing these interventions needs to involve whakawhanaungatanga, Māori models of care, identity of tangata whaiora, whakarongo, powhiri process, open communication and clear boundaries.

This study emphasises the importance of clinicians having an understanding of the relevance of te ao Māori, tikanga Māori, and whānau for Māori diagnosed with bipolar disorder.

Key words: Māori, bipolar disorder, kaupapa Māori, Māori worldview, whakawhanaungatanga.

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“E hara taku toa I te toa takitahi engari he toa takimano

My strength is not that of an individual but that of the collective.”

(Māori whakatauki)

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LIST OF ABBREVIATIONS

CBT:	Cognitive Behavioural Therapy
CDHB:	Canterbury District Health Board
DHB:	District Health Board
DSM:	The Diagnostic & Statistical Manual of Mental Disorders
FFT:	Family Focused Therapy
IPSRT:	Interpersonal Social Rhythms Therapy
MOH:	Ministry of Health
NCNZ:	Nursing Council of New Zealand
NGO:	Non-Government Organisation
NGT:	Nominal Group Technique
OT:	Occupational Therapist
SMHS:	Specialist Mental Health Services
WHO:	World Health Organisation

GLOSSARY OF MĀORI TERMS

Aotearoa:	New Zealand
Hapū:	sub-tribe/s
Hauora:	health
Hinengaro:	mental
Hongi:	pressing of one's nose and forehead (traditional Māori greeting)
Hui:	meeting
Iwi:	tribal group/s
Kai:	food
Kaiarahi:	Māori health worker
Kaihaumanu:	Māori health worker
Kanohi ki te kanohi:	face to face
Karakia:	prayer
Kaumātua:	respected elder/s
Kaupapa:	philosophy/ strategy or theme
Kite:	basket
Korero:	talk or speak
Ko wai koe:	who are you
Ko wai te iwi:	what is your tribe
Ko wai te waka:	what is your waka
Ko wai to ingoa:	what is your name
Mate Māori:	illness for which there are no physical causes
Mana:	integrity or prestige
Māori tangata whaiora:	Māori with experience of mental illness
Māoritanga:	Māori culture, traditions, way of life
Marae:	traditional meeting place/s of whānau, hapū or iwi
Matauranga Māori:	a Māori way of being and engaging in the world
Mihi:	greeting/introduction
Mokopuna:	grandchild/ren
Mōteatea:	tribal chant/s
No hea koe:	where are you from

Noa:	something that is free from tapu, something which is not forbidden, restricted, confidential or sacred
Otautahi:	Christchurch
Oriori:	a waiata/song
Paepae:	group of speakers in a Māori meeting house
Powhiri:	a Māori welcoming ceremony
Pukenga Atawhai:	Māori health worker/cultural practitioner
Rangatiratanga:	self determination
Rongoa:	traditional Māori medicine
Tangata Whaiora:	person with experience of mental illness
Tapu:	sacred or sacredness, or something/things which is/are forbidden, restricted or confidential
Tauparapara:	ritual/chant
Te Ao Māori:	Māori World
Tika:	doing things right
Tikanga:	custom or meaning
Tikanga Māori:	Māori custom/Māori traditional values
Tinana:	physical
Tino Rangatiratanga:	unconditional sovereignty
Tipuna:	ancestor, grandparent, grandfather, grandmother
Turangawaiwai:	individual's home ground. Considered a place where one is able to stand and identify with particular iwi, hapū, and marae
Waiata:	song/singing
Wairua:	spirit/spiritual
Whakama:	shame, embarrassment or loss of mana
Whakarongo:	listen
Whakapapa:	genealogy or ancestry
Whakatauki:	proverb
Whakawatea:	choreographed exit from stage when performing
Whakawhanaungatanga:	getting to know one another
Whānau:	family
Whanaungatanga:	concept of building relationships

CHAPTER ONE: INTRODUCTION

Māori and bipolar disorder

Mental health disorders are common in Aotearoa, and for Māori bipolar disorder is particularly common, with one in nine Māori being at risk of developing bipolar disorder during some time in their life (Baxter, 2008). Having cared for many Māori tangata whaiora with this diagnosis who have struggled within western practices of care, the writer has chosen to explore what effective interventions are available by speaking with clinicians and those expert in hauora Māori, with a view to being able to share this information for all clinicians caring for Māori with bipolar disorder.

Personal experience

As a Māori nurse working in the mental health field for the past 19 years there have been many instances where I have worked with and alongside colleagues who have been responsible for caring and looking after Māori tangata whaiora. Through these experiences I have witnessed some stressful situations where Māori tangata whaiora and their whānau felt unheard as well as unsupported by the treating teams, and as a consequence became quite withdrawn or oppositional in any discussions regarding treatment and recovery.

I observed Māori being given medications to calm them, but this produced the opposite effect, particularly when they needed to be restrained to receive an intramuscular injection. Worst of all was hearing discussions from staff about managing Māori tangata whaiora, based on their historical high-risk presentations and not their current presentation. When I challenged this approach I was reminded quite

clearly that I was new in this area, and therefore did not know how difficult some Māori tangata whaiora could become.

At the time my position gave me the authority to advise the staff members that while I appreciated their historical experience with Māori tangata whaiora, we would assess the situation when they arrived and have further discussion if necessary. When the Māori tangata whaiora arrived for example, their presentation did not warrant being placed in a secure area. The Māori tangata whaiora was admitted into an open ward, where they were able to engage with other patients.

This issue clearly demonstrated to me the importance of my role as a Māori nurse and the potential for being able to create opportunities of sharing knowledge about my understanding of being Māori, which in turn may provide improved pathways to work in partnership with Māori tangata whaiora diagnosed with bipolar disorder and their whānau.

Māori mental health inequalities

Māori represent 15.8% of the population and are over-represented within the mental health system (Harris, Waitoki, & Nikora, 2015; Te Rau Matatini, 2015a) by accounting for 27% of mental health users (Ministry of Health (MOH), 2017). The most common disorders Māori experience over a lifetime are identified as anxiety disorders (31.3%), substance disorders (26.5%) and mood disorders (24.3%) (Oakley-Browne, Wells, & Scott, 2006).

Whilst Māori are admitted into acute psychiatric wards more frequently than non-Māori but at a later stage (Wharewera-Mika, 2012), questions need to be asked regarding the barriers preventing Māori from seeking earlier treatment prior to

requiring hospitalisation. The question arises whether this discrepancy is driven by differential access to resources such as access to healthcare (Robson, 2009).

Although, the Ministry of Health, (2017) mental health annual report indicates that Māori had an increase in accessing services in comparison to other groups within Aotearoa, the same report identifies the likelihood of these increased rates being due to higher rates of Māori being placed under compulsory treatment orders (MOH, 2017). Elder and Tapsell (2013) assert the need for greater understanding around Māori tangata whaiora and their experiences under the Mental Health Act, and Māori receiving differential treatment in comparison to non-Māori.

Given the differences between western models of care and indigenous models of care, how are inequalities between Māori and non-Māori to be improved? To address the over-representation of Māori requires effective treatment interventions and provision of culturally appropriate and culturally competent care (Durie & Kingi, 1997; Pitama, Huria, & Lacey, 2014), with the expectation of moving Māori tangata whaiora forward in their recovery. Treatment of Māori tangata whaiora continues to be a long-standing issue and requires much thought around making significant and effective changes to address this disparity. This study of Māori tangata whaiora with bipolar disorder seeks to explore effective strategies for improving mental health disorders.

Bipolar Disorder

Māori who are diagnosed with bipolar disorder experience a variety of symptoms. To better understand the mechanisms of bipolar disorder and how this impacts on all tangata whaiora as well as Māori, this section will present a detailed outline of this disorder.

Bipolar disorder is a mood related disorder (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: DSM-5, 2013) which causes major shifts in mood, activity, functioning ability and energy. This disorder is a chronic condition with extreme highs and lows, and creates significant interference which affects individuals and the lives of their whānau (Crowe et al., 2010; McPherson, Dore, Loan, & Romans, 1992; Reinares, Sanchez-Moreno, & Fountoulakis, 2014).

Bipolar disorder is also known as manic-depressive illness (Goodwin & Jamison, 2007), which is a serious psychiatric disorder and has multiple ramifications for Māori tangata whaiora as well as their whānau (Dore & Romans, 2001; Perlick et al., 2007). These can include, but are not limited to, financial difficulties (due to impulsive spending whilst experiencing a manic episode), marital relationship difficulties (due to being disinhibited and having extramarital affair/s), social relationship breakdowns (due to the illness phase of their bipolar disorder and not being able to manage social situations), as well as non-compliance with medication regimes (Crowe et al., 2012).

There are various subtypes of bipolar disorder listed by the DSM-5 (2013) as follows:

Bipolar I disorder is characterised by symptoms of both mania and depression (mixed episodes). A person would experience one or more manic or mixed episodes on a daily basis for at least one week, and one or possibly more depressive episodes.

Bipolar II disorder is characterized by high episodes of euphoria and low episodes of depression (known as hypomania). Mood episodes are intense, and whether it is euphoria or depression, this occurs for distinct periods of time.

Cyclothymic disorder is characterized by mood swings from mild depression to emotional highs, and these occur for at least a two-year period.

Substance/medication-induced bipolar and related disorder is characterised by depressive symptoms, which appear following the use/abuse of substances, prescribed medication for other ailments, intoxication or withdrawal as evidenced by presentation or confirmed by laboratory results.

Bipolar and related disorder due to another medical condition refers to medical conditions that can lead to states of depression.

Other specified bipolar and related disorder is characterized by patients who experience abnormal moods and do not meet criteria for being diagnosed with bipolar I or II due to insufficient symptoms or insufficient duration.

Unspecified bipolar and related disorder is characterised by symptoms similar to bipolar disorder, which cause clinically significant impairment and/or distress in areas of a patient's functioning ability, but those symptoms do not meet the full criteria (DSM-5, 2013).

Co-morbidity

The onset of bipolar disorder has been identified from age 15–19, with 75% of patients having an onset prior to 18 years of age (Inder et al., 2008). Co-occurring mental disorders are common, and those who have a diagnosis of Bipolar I Disorder have high rates of serious or untreated medical conditions and can meet criteria for an alcohol use disorder (Baxter, Kingi, Tapsell & Durie, 2006a)

Bipolar disorder is highly prevalent, heterogeneous and among the most disabling psychiatric conditions and its increasing complexity is often caused by the presence of comorbid conditions (Ghouse, Sanches, Zunta-Soares, Swann, & Soares, 2013). These can include alcohol and drug problems and anxiety disorders, which cover a variety of subtypes; some of these are social phobia, generalised anxiety and obsessive-compulsive disorder (Malhi et al., 2015). However, of all the subtypes the one with the highest comorbidity risk is panic disorder (Perugi et al., 2012; Sagman & Tohen, 2009).

Approximately 60% of individuals diagnosed with Bipolar II Disorder have three or more co-occurring mental disorders (DSM-5, 2013). Māori have high levels of lifetime comorbidity, which include 19.7% with one disorder, 13.8% with two disorders and 17.1% with three or more disorders (Baxter et al., 2006a).

Research development and objectives

Following discussion with a respected researcher, the writer was influenced to undertake research around Māori tangata whaiora diagnosed with bipolar disorder. Commencing research for the benefit of Māori has always been a goal, and linking this with bipolar disorder was a new concept for the writer. However, after discussion with the researcher and reflecting on experiences of caring for Māori tangata whaiora with bipolar disorder, the writer decided to explore the perspectives of clinicians and experts in hauora Māori and their shared knowledge regarding effective interventions they use when working with Māori diagnosed with bipolar disorder.

Thesis Structure

Chapter Two

Chapter two discusses relevant literature pertaining to clinical diagnosis of bipolar disorder in indigenous populations and Māori (indigenous people of Aotearoa). This chapter explores the impact bipolar disorder has on Māori and their whanau, and identifies relevant treatment options that can be utilised. The chapter also discusses colonisation and its implications for Māori and their physical and mental health.

Chapter Three

Chapter three discusses the research methodology utilised in this study, which incorporates a kaupapa Māori research and qualitative research approach with the use of thematic analysis and nominal group technique in gaining data for this research. This chapter covers information relating to consent, confidentiality, ethical and local approval in being able to complete this research as well as documenting the research questions and the recruitment of clinicians and pukenga atawhai to participate in individual interviews and focus groups.

Chapter Four

Chapter four reports on the findings that emerged from the data. This chapter covers the individual interviews which were undertaken as part of this research and identified themes and also reports on the findings, and comments on data gathered from the two focus groups, pukenga atawhai and clinicians.

Chapter Five

Chapter Five discusses the data that emerged from the findings of this research, and compares these findings to existing literature. This chapter also discusses the key findings critical for clinicians wanting further insight and knowledge in working with Māori tangata whaiora diagnosed with bipolar disorder, and their whānau.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The World Health Organisation (WHO) has identified grave concerns from a public health and racial inequality perspective in relation to indigenous populations (WHO, 2013a). This chapter looks at the literature pertaining to indigenous populations, and more specifically Māori, during and following colonisation. The chapter discusses the consequences and implications of colonisation on Māori and their physical and mental health. While this is not a new topic, it is an area of significant importance, as it gives context and understanding around Māori tangata whaiora, helpful for mental health clinicians. This chapter also describes Māori diagnosed with bipolar disorder in the broader context of colonisation. The implications of bipolar disorder for Māori and other indigenous populations is emphasised, together with the extent to which Western treatments are effective for Māori and other indigenous peoples.

Māori health is examined from a national perspective, and factors contributing towards ongoing disparities are explored. He Korowai Oranga, the Māori health strategy (2014) will be briefly discussed together with its connection to Te Tiriti o Waitangi, regarding the protection and wellbeing of Māori (Ellison-Loschmann & Pearce, 2006, MOH, 2014a).

Colonisation

Prior to the arrival of Europeans, whānau independently cared for themselves as a collective within their whanau, hapū and iwi (Panelli & Tipa, 2007). These hapū chose to stay in specific areas based on their relationship to the land, which provided

food resources as well as protection (Harmsworth & Awatere, 2013). Within these hapū there were political and economic structures which were followed by these groups. Each hapū was led by a chief, recognised by the mana they exuded (Te Puna Kokiri, 2007) and together they formed a larger collective of iwi.

However, once the European settlers arrived in Aotearoa they introduced infectious diseases (Durie, 2004a; Kingi, 2007) which led to severe epidemics and starvation. Once a thriving population, Māori numbers reduced significantly, resulting from a number of factors, including musket warfare and the loss of land (Kingi, 2006a; Pool 2011). These declining numbers contributed to poverty as well as lack of access to the resources that Māori depended on for their wellbeing (Durie, 1997a). It was believed by the late nineteenth century that Māori would become extinct; however, in the early twentieth century, Māori leaders Apirana Ngata, Maui Pomare and Peter Buck worked to address and improve Māori health (Durie 1998; Kingi 2006b), and numbers began to stabilise and increase (Pool & Kukutai, 2011).

It is imperative to understand the changes Māori have been exposed to as a result of colonisation when considering changes to the differential treatment that created inequalities between Māori and non-Māori. Colonisation promoted oppression and devalued the colonised (Strong, 2009) by ensuring that the indigenous worldview was undermined and undervalued by those who believed they were superior (Cunneen & Rowe, 2014).

For Māori, this meant the kaupapa of what they once knew, living their lives successfully socially, economically and politically, changed as a consequence of colonisation, assimilation and acculturation (Durie, 2004a; Pool, 2011; Zambas & Wright, 2016). Colonisation has made significant imprints on the lives of indigenous

peoples and their worldviews; however, the introduction of legislation like the acts for example, The Native Land Acts (1862 and 1865) and the Tohunga Suppression Act (1907), severely disadvantaged Māori (Durie, 2004b) and has been one of the worst uses of power for the purpose of ensuring socio-economic and political growth for non-indigenous people (Cunneen, 2010; Wirihana & Smith, 2014).

The use of legislation, while deemed to be in place to ensure fairness for indigenous people and their culture, in practice legitimizes the actions of the European settlers and disregards indigenous people and their worldview (Durie, 2004c). There is no doubt that legislation was implemented for the purpose of destroying indigenous cultures and their worldviews (Cunneen, 2010), and furthering their assimilation into European culture. This resulted in Māori being marginalised, isolated from their traditions and alienated from their lands, hapū and iwi. Māori experienced loss of cultural and spiritual traditions in healing which ultimately left them feeling displaced and undervalued (Durie, 1997a; Harry, 2009; Stephens, Porter, Nettleton, & Willis, 2006), and eliminated tino rangatiratanga (Williams, 2001)

The legacy of colonisation for Māori has been widely discussed, including the cultural legitimacy of Māori traditional values being extensively devalued (Walsh-Tapiata, 2008). However, Māori are a resilient population and their efforts and revitalisation of core values, which are underpinned in tikanga Māori are offering a way forward to improve their socio-economic position in contemporary Aotearoa.

Urbanisation and migration

By 1936, 10% of Māori lived in urban areas of Aotearoa (New Zealand Official Year Book, 1973), and by 1971 the proportion of Māori living in urban areas had significantly increased to 70% (Barcham, 2004; New Zealand Official Yearbook,

1995). Migration occurred on this level for the purpose of Māori seeking work (Paul, 2005), which led to Māori being fragmented from their whanau, and the very essence of Māoridom and collectivism being destroyed (Durie, 2003a; Mikaere, 2002).

Māori life expectancy in the late 1700s was higher than life expectancy in Britain, with Māori having a life expectancy of more than 30 years in comparison to British subjects in lower socio-economic groups having a life expectancy of under 30 years (Pool, 2011). However, following European contact, there was a decline in estimated life expectancy for Māori with Māori men expecting to live to 25 years and Māori women expected to live until 23 years of age (Kingi, 2007).

Current Māori population and life expectancy

Today, Māori are almost 15% of the population in Aotearoa, with 598,605 people identifying as Māori according to the 2013 census, which is an almost 40% increase from 1991 (Statistics New Zealand, 2013). Information also retrieved from the 2013 census indicates that Māori are a young population with 33.1% of their population being under 15 years (Statistics New Zealand, 2013).

Māori population and age differences in comparison to non-Māori were discussed in the 2006 census, when one in every seven people was Māori. Māori make up a greater proportion of younger age groups, with one in every four children under ten years (24%) and one in every five (21%) youths between ten and 19 years being Māori. However, the proportion of the population who are Māori decreases in older age groups, and only one in 20 (5.3%) of all people 60 years and over are Māori (Baxter, 2008).

Māori life expectancy, whilst the gap has reduced, remains lower than that of non-Māori, with Māori men having an average life span of 73 years compared to other New Zealand men, with an average life span of 80 years. Similarly, Māori women have an average life span of 77 years in comparison with other New Zealand women who average 83 years of age (Becares, Cormack, & Harris, 2013).

Leading causes of Māori mortality

The main causes of death currently for Māori men and women include lung cancer, ischaemic heart disease and diabetes (MOH, 2016). Māori are also identified as being the highest population in Aotearoa who smoke tobacco (38.1%) in comparison to European and Other (15.1%). Health risks associated with this include cardiovascular disease and cancer, with smoking also being linked with adverse child health outcomes (MOH, 2016; Ministry of Social Development, 2016).

Yon and Crimmins (2014) completed research on comparative mortality trends of Māori and non-Māori, and believe that there are links associated with early life exposure to infectious diseases. Evidence suggests that the older non-Māori population continue to experience better health outcomes and lower mortality (MOH, 2011) in comparison to Māori.

Māori rate high in hazardous drinking, and the risks associated with this include deterioration in physical and mental health, and suicide. Domestic violence and vehicle accidents leading to either injury or death are also high risks (MOH, 2016). Suicide and motor vehicle accidents are in the top five causes of death for Māori men (MOH, 2017).

Socio-economic

Socio-economic factors are widely acknowledged as important determinants of health and social outcomes. Compared with non-Māori, Māori are socio-economically disadvantaged and more deprived in relation to unemployment (Durie, 2004a; Robson, Cormack, & Cram, 2007). Māori have lower income, less education (Kingi, 2005) and tend to live in overcrowded and substandard living conditions which are cold, damp and mouldy (Gillespie-Bennett, Keall, Howden-Chapman & Baker, 2013; Canterbury District Health Board, 2014).

Furthermore, Māori are identified as living in the highest areas of deprivation, with two-thirds living in deprivation deciles ranging from seven to ten, with decile ten being the highest deprivation decile (Baxter, 2008). Although socio-economic status is a contributor towards mental health issues in Māori, and 40% of Māori living in the lowest income areas had a mental health disorder within a 12-month period, one in six Māori living in higher income areas also experienced mental health disorders. So, while there is evidence that socio-economic determinants contribute towards ethnic differences, socio-economic factors do not necessarily explain all differences (Becares et al., 2013). There is, however, clear evidence that indigenous health inequalities occur from socioeconomic factors combined with cultural and historic factors, particularly for those who have experienced colonisation (King, Smith, & Gracey, 2009).

For Māori, Te Tiriti o Waitangi offers a mechanism for pursuing their rights as indigenous people of Aotearoa (Ellison-Loschmann & Pearce, 2006). However, there continues to be much debate around the relevance and legitimacy of Te Tiriti in today's context (Hickey & Wilson, 2017; O'Malley, Stirling, & Penetito, 2013).

Te Tiriti O Waitangi

In Aotearoa, Te Tiriti o Waitangi continues to have a platform within health and social policy (Oh, 2005). The text itself is not regarded as law because the English and Māori versions do not have exactly the same meaning. However, there is some recognition in legislation, and Te Tiriti has been referred to as the principles of the Treaty since 1975 (Hayward, 2012).

Te Tiriti principles include partnership, participation and protection (Kingi, 2007), which frame policy around the Māori health strategy He Korowai Oranga (MOH, 2014). These principles look at the cultural concepts and values that are derived from Māori culture, relevant to informing their level of health (Kingi, 2007).

Furthermore, the Māori health strategy reflects the agreement by the government that working together in partnership with Māori will improve services and outcomes for Māori (MOH, 2002). This involves working with Māori at all levels regarding decision making and delivery of care, with an emphasis on Māori having the same level of health as other New Zealanders.

Māori Health as a National and Local Health Priority

He Korowai Oranga (MOH, 2014) provides a framework for the public sector by informing non-Māori organisations, and developing culturally safe and culturally appropriate services. In addition to this, He Korowai Oranga also assists Māori providers and organisations in their strategic planning. This policy was originally implemented in 2002, and reviewed and updated in June 2014, to ensure it continues to provide a strong platform for Māori health in the future. The purpose of this strategy is to affirm Māori approaches with the intention of improving Māori health outcomes.

Nationally and locally there is a drive to reduce the inequalities between Māori and non-Māori. At a local level the CDHB has committed to improving Māori health workforce development. This allows the Māori workforce to implement their cultural knowledge and offer a greater awareness of cultural understanding to health workers employed in primary and mental health who are non-Māori (CDHB, 2016).

One such intervention is demonstrated by the pukenga atawhai who work in the Specialist Mental Health Service within multidisciplinary teams. Their role is to provide cultural assessments and ensure cultural aspects of care are provided to Māori tangata whaiora and their whānau (Johnston, 2018). Whilst this is a positive service, and staff are encouraged to collaborate with pukenga atawhai, particularly at the beginning of an engagement process with Māori tangata whaiora, this does not always occur. It is, however, a prerequisite for Māori who have not utilised the mental health services previously to have a pukenga atawhai present to ensure that Māori tangata whaiora feel culturally safe. This practice also has the added bonus of having a cultural practitioner who is expert in this area.

Another critical area of improvement for best health outcomes for Māori at a local level was initiated in 2013, following discussions and a common desire to have a coordinated approach in Otago. Canterbury health service providers created the Canterbury Māori Health Framework to guide service providers in reaching the best health outcomes for Māori and their whānau (CDHB, 2016).

Whilst there are strategies being put in place on a local and national level for improvement in reducing inequalities for Māori, the question must be asked whether these are being collaboratively addressed within diverse social services. It is evident

that there are a variety of factors which contribute towards Māori mental health disparities, and for change to be effected, services are required to work collaboratively.

Furthermore, exploring the interventions which have been discussed and implemented requires a review of their efficacy, with measurement of what improvements, if any, have occurred for Māori tangata whaiora. To date, these concerns have not been measured.

Current Māori Mental Health Profile

Māori constantly feature disproportionately across poor health statistics amongst ethnic groups in Aotearoa (Baxter, 2008; Oakley-Browne et al., 2006), and mental health continues to be a major concern (Bacal & Jansen, 2006; Baxter 2007; Kingi, 2006b). Baxter (2008) completed a comprehensive review of Māori mental health and determined that Māori are 1.7 times as likely to develop a mental health disorder as non-Māori. Additionally, in this same research Baxter (2008) identified concerns for Māori aged 15-35 years, as this group had the highest prevalence rate in Aotearoa.

Māori admitted into psychiatric units were proportionately fewer than non-Māori before the 1970s. However, a change occurred during the 1980s and 1990s which reflected an increase in psychiatric admissions for Māori (Jansen, Bacal, & Crengle, 2009; Kingi, 2005), particularly for those diagnosed with schizophrenia, bipolar disorder and substance use disorders (Baxter et al. 2006a; Sachdev, 1990).

The literature identified changes in social, cultural and demographic areas as being the main indicators for the increases in hospital admissions (Durie, 2003a; Sachdev, 1990). These indicators included loss of whānau support, increased binge

drinking associated with other social problems, and admissions through the justice system (Baxter, 2007; Durie, 2003a; Hirini, 1997; Kingi, 2005).

There are multiple gaps in the literature regarding Māori mental health. High rates of suicidality among young Māori males, and psychological distress for Māori females (Clark et al., 2011) are clear indicators for further exploration of Māori mental health issues. In 2011, the non-Māori suicide rate was 1.8 times lower than Māori (MOH, 2014b), with the youth rate being 2.8 times lower than Māori, which is a major concern given the Māori population is a young one as detailed earlier. Furthermore, suicide rates for indigenous populations around the world are at a higher rate than those of non-indigenous groups (Clifford, Doran, & Tsey, 2013).

While non-Māori experience lower rates of mental illness in comparison to Māori (Statistics New Zealand, 2013), ongoing new strategies, Māori health models, frameworks and policies are being implemented, with the purpose of reducing inequalities. It must be noted that while there continue to be inequalities between Māori and non-Māori, there has been an identified trend where Māori use of mental health services has been on the rise (MOH, 2014b).

Te Rau Hinengaro: The New Zealand Mental Health Survey (2006), surveyed 2,595 Māori participants and found that Māori with bipolar disorder had all aspects of life impacted on to a high level (Baxter et al., 2006a). Bipolar disorder is more common than previously believed, and it is evident that the psycho social impact on Māori with this diagnosis is significant (Waitoki, Nikora, Harris & Levy, 2014).

As previously discussed, Māori are a young population (Statistics New Zealand, 2013), and given mood disturbance is the first noticeable sign in people with bipolar disorder, which generally occurs during their adolescence (Moor, Crowe, Luty, Carter

& Joyce, 2012), it is critical to ensure appropriate interventions are in place to educate and support Māori who may suffer from mood disorders.

According to Baxter (2008), one in four (23.8%) Māori between the ages of 16 and 24 years experience bipolar disorder; over one in four (27.8%) Māori between the ages of 25 and 44 years experience this disorder; and one in thirteen (7.8%) Māori over 65 years experience bipolar disorder. Baxter further suggests that findings would indicate younger Māori living today are more likely to experience mental disorders in comparison to previous Māori generations.

Meeting the needs of Māori diagnosed with bipolar disorder therefore requires serious consideration of what strategies and interventions are most effective in improved management for Māori tangata whaiora (Baxter, 2008). However, there continues to be a lack of research about effective treatment for Māori diagnosed with bipolar disorder (Baxter and Tapsell, & Wheeler, 2010).

Kaupapa Māori perspective

Historically, Māori have struggled to have their concerns heard and rarely been in positions of influence to effect change (Chaplow, Chaplow & Maniapoto, 1993). However, in the past four decades Māori intellectuals and academics have promoted change by challenging Western models of knowledge (Eketone, 2008; Racine, 2003). Kaupapa Māori research is research conceived and developed by Māori with the intention of the outcome benefiting Māori (Henry & Pene, 2001; Walker, Eketone & Gibbs, 2006).

Kaupapa Māori research relates to being Māori, implementing cultural beliefs and systems, and having the autonomy to govern one's own life as well as cultural well-

being (Walker et al., 2006). Kaupapa Māori is essentially about tino rangatiratanga (Cram, Smith, and Johnstone, 2003; Wolfgramm, 2008) and is viewed in the context of te ao Māori (Toki, 2017).

The use of traditional Māori approaches has been discussed in the literature and shared as effective healing practices, which include rongoa Māori (Ahuriri-Driscoll, 2012; Mark & Lyons, 2010), wairua (Valentine, Tassell-Mataamua, & Flett, 2017) and engagement with traditional Māori healers (Bush & NiaNia, 2012; Durie, 1997b). Kaupapa Māori aligns itself explicitly with Māori philosophy, ways of knowing and experiences.

NiaNia, Bush and Epton (2017) researched indigenous mental health issues and offers four perspectives: indigenous tangata whaiora, whanau, psychiatrist and Māori healer. This research recognises the value of Māori traditional healing practices when working within a variety of settings. NiaNia, Bush and Epton offer insight into the ability to transform practice when colleagues from diverse worlds are able to work in a manner which identifies best practice outcomes for Māori.

Māori tangata whaiora who identify with their culture have proven to be responsive to treatment and interventions that underpin their worldview. Having the opportunity to utilise traditional Māori approaches, as well as work through their experience of mental health, can only enhance their recovery. Whilst traditional Māori healing is currently limited in terms of evidence of outcomes, it is clear that integrating evidence such as that detailed by NiaNia, Bush and Epton (2017) would promote evidence-based practice and ultimately endorse the use of traditional Māori approaches (Ahuriri-Driscoll, Hudson, Bishara, Milne, & Stewart, 2012; Rada, Ratima, & Howden-Chapman, 1999).

Recovery perspective

While there are a number of definitions around the recovery model there are two main streams that are recognised. One derives from the medical model, which concentrates on the clinical picture and emphasises tangata whaiora returning to a state of wellness following medication and possibly hospitalisation (Field & Reed, 2016). The other stream of recovery derives from tangata whaiora/consumers/Māori tangata whaiora movements, which concentrate on tangata whaiora as a person rather than the symptoms they may be experiencing (Jacob, 2015). Although biomedical interventions play an important role for some, the recovery model challenges the biomedical model approaches, particularly when they take priority over the individual's rights in determining what recovery means for them (Strand, Gammon, & Ruland, 2017). Walsh-Tapiata (2008) asserts that using Western theory approaches effectively silences indigenous approaches to informing and transforming practice.

Piat et al. (2009) study of consumers' perspectives of recovery findings identified two contrasting meanings. The first definition included returning to a previous state of wellness or experiencing better health as well as linking recovery to illness. The second definition of recovery included self-determination and actively participating in transforming oneself. The latter definition aligns with kaupapa Māori research in the context that within indigenous cultures, the emphasis is on the collective perspective on self-determination (Walsh-Tapiata, 2008).

Field and Reed (2016) assert the recovery model entails mental health service providers allowing tangata whaiora to identify what works for them, and as health providers making this happen by supporting tangata whaiora in their self-determination. Similarly, other researchers agree that working from a kaupapa Māori

and recovery perspective will greatly elevate positive outcomes for Māori tangata whaiora, particularly for Māori who are connected to their cultural identity and whānau (Durie, 1997a; Krieble, 2003).

Māori and the causes of bipolar disorder

While there is no clear evidence of what causes bipolar disorder, there is agreement that it is underpinned by a biological component and is inherited (Post et al., 2010; Wheeler, 2014). Other possible factors associated with the onset of this illness are environmental issues, illness, and other stressful life situations (Johnston-Wilson et al., 2000; Miklowitz, & Johnson, 2009).

A study by Waitoki et al. (2014) identified a variety of areas contributing towards high rates of Māori with bipolar disorder, which included diagnostic reliability (whether the person was diagnosed correctly) and the effects of intergenerational family mental illness. Waitoki et al. (2014) also recognized family violence, environmental stressors and drug and alcohol issues being high risk and extensive and intergenerational factors.

When considering the plight of Māori with the suppression of their traditions and culture, no longer living within extended whānau (Barcham, 2004), but living in nuclear whānau, it is no wonder this major social shift has contributed towards psychological distress as well as mental illness (Byrant, Knights, & Salerno, 2006).

Treatment of bipolar disorder

Treatment of bipolar disorder primarily focuses on stabilisation from mania and depression to a euthymic state (Geddes & Miklowitz, 2013). The complexities here involve monitoring to ensure the medication and treatment offered does not place the

individual in a rapid cyclic of depressive or hypomanic state (Geddes & Miklowitz, 2013).

Some Māori and tangata whaiora diagnosed with bipolar disorder continue to have residual features such as anxiety and social phobia, which impacts on their ability to function socially (Deckersbach et al., 2014). Additionally, as previously discussed, there is also a high proportion of Māori tangata whaiora who misuse illicit substances as well as find it difficult to adhere to medication regimes (Healey, Peters, Kinderman, McCracken, & Morriss, 2009). Among Māori with a mood disorder, 20.6% had a substance disorder (Baxter, 2008). There is substantial evidence which links substance abuse to poor mental and physical health (Ebbet & Clarke, 2010; Baxter et al., 2006a; Huriwai, Robertson, Armstrong, Kingi & Huata, 2001). Furthermore some Māori tangata whaiora struggle with medication compliance which is underpinned by a biomedical approach, compared to looking at working holistically with Māori and engaging with them in their everyday problems (Drury & Munro, 2008).

Pharmacotherapy is primarily the first line of treatment for Māori and tangata whaiora hospitalised with bipolar disorder; however, evidence suggests that psychosocial interventions in addition to pharmacotherapy could be beneficial for Māori and tangata whaiora (Crowe, Beaglehole, Wells & Porter, 2015a).

Developments in psychological therapies for bipolar disorder are aimed at improving psychosocial functioning, assisting the client to understand and accept their illness, preventing or reducing the incidence of relapse and alleviating symptoms (Geddes & Miklowitz, 2013). There are a few psychosocial therapy techniques used in bipolar disorder, which include interpersonal and social-rhythm therapy (IPSRT), cognitive behaviour therapy (CBT) and psychoeducation and family-focused therapies

(Crowe, Beaglehole & Inder, 2016; Crowe et al., 2010; Miklowitz & Johnson, 2009). Each of these psychotherapies has demonstrated efficacy; however, in a recent study it was found that CBT showed no overall improvement, unless it was used on those with bipolar disorder who had experienced fewer than ten episodes (Scott et al., 2006). This research indicates the importance of early detection and intervention.

Kaupapa Māori View on treating mental health

The DSM–5 (2013) mental health diagnostic criteria conflict with the kaupapa Māori worldview (Bennett, 2009) which clearly results in challenges when attempting to diagnose and treat Māori tangata whaiora. Furthermore, the DSM-5 limits the opportunity for cultural input when looking at treatment options for those experiencing mental illness (Wratten-Stone, 2016).

Bennett (2009) has offered recommendations to successfully assess Māori suffering from psychiatric illness. He has identified some steps in addressing Māori by determining the cultural identity of the tangata whaiora, as well as understanding their insights into ill health from the perspective of their whānau and their own understanding. Furthermore, Bennett also encourages staff to ensure Māori tangata whaiora have a whānau member or support person with them when they are being assessed, for the benefit of Māori feeling safe within this environment. Whakawhanaungatanga is another component of positively getting to know Māori tangata whaiora, and Bennett discusses the importance of clinicians sharing information about themselves as well.

In recent years the literature has suggested that health professionals can be more effective in treating indigenous populations, including Māori, by implementing a

cultural approach (Durie, 2001; Hurawai, Sellman, & Potiki, 2000; Lacey, Huria, Beckert, Giles & Pitama, 2011; Pitama et al., 2014). In contrast using mainstream modalities and treatments for Māori and other indigenous populations has been said to perpetuate colonial oppression (Sherwood & Edward, 2006; Walsh-Tapiata, 2008).

The literature indicates indigenous populations struggling to engage in treatment that undervalues their understanding of health and wellbeing (King et al., 2009). The Indigenous Health Framework (Pitama et al., 2014) is a model that was created by the University of Otago researchers and includes the Hui process and the Meihana model, tools that can be used in everyday practice by any health professional. The framework is a unique and valuable tool for any clinician working with Māori as it lays out quite effectively how to extend one's clinical assessment skills and engage effectively with Māori and whānau. This framework was created for the purpose of demonstrating to health professionals how to incorporate being culturally competent within their own clinical practice, primarily with the view of improving health outcomes for indigenous populations (Al-busaidi, Huria, Pitama & Lacey, 2018).

The Framework (Pitama et al., 2014) clearly represents innovation in being able to capture an awareness of tikanga Māori for clinicians who require further education and support in being able to deliver appropriate clinical assessment and understanding Māori in the broader context. Furthermore, this model addresses the concept of flourishing Māori, which according to Durie (2018) works comparatively better than deficit-based notions when addressing health care for Māori and their whānau.

The literature offers research on a number of effective treatment modalities for bipolar disorder (Crowe & Inder, 2018; Geddes & Miklowitz, 2013; Crowe et al., 2012; Nusslock & Frank, 2012) and further research could explain how these may be

adapted to encompass te ao Māori. To date there is one study (Bennett, Flett, & Babbage, 2008) which describes modifications to CBT for Māori with depressive disorders. The adapted programme encompasses five stages and these include whakawhanaungatanga (developing a positive therapeutic alliance), ngā māramatanga (building a cognitive conceptualisation), whanoga pai (encouraging positive behaviours), whakairo pai (encourage positive thinking) and finally ora pai (staying well long-term).

CBT was adapted for the purpose of exploring the benefits for Māori from a kaupapa Māori paradigm, following concerns about the lack of relevance this modality had for Māori (Bennett et al., 2008). Given the high level of need in working effectively with Māori diagnosed with bipolar disorder (Baxter, 2008), there is no doubt that interventions need to be assertively explored, as demonstrated by Bennett et al. (2008) whose study recognised positive outcomes for Māori from using a kaupapa Māori approach (Bennett et al. 2014).

The potential to adapt and modify other existing psychosocial models to implement cultural perspectives has promising possibilities. The need for this to be further explored remains a priority.

International perspectives on mental health interventions for indigenous populations

Pomerville, Burrage and Gone (2016)'s systematic review of empirical psychotherapy research with indigenous populations found 44 studies from New Zealand, Australia, Canada and the United States. The majority of these studies largely focused on substance use disorders, and other serious mental health diagnoses were excluded. Given the high rates of mental health concerns within indigenous

populations, it was surprising that there were not more studies focused on mood disorders.

Pomerville et al. (2016) review found some information that supported adapting western models by implementing cultural practices. Fisher, Lankford and Galea (1996), for example, presented a model for Alaska Natives, where group therapy was less confrontational, the number of meetings was decreased, groups were facilitated by native counsellors, and cultural awareness activities were implemented into treatment. These activities included subsistence hunting trips, production of traditional crafts and food, drum and dance groups, attendance and involvement in cultural community events, and education on traditional practices.

In addition, in Fisher et al's (1996) model indigenous clients were not only orientated to the treatment centre they would be staying at, they were also orientated to the urban environment in which the treatment centre was located. It was reported that following these changes there was improvement in the retention of Alaskan natives at this centre. Fisher et al's research clearly demonstrates the understanding of indigenous populations having a different perspective of health, and acknowledges the relationship between indigenous people and the land, which is seen as an important factor of wellness (Byrant, et al., 2006).

Pomerville et al. (2016) found seven studies which reported on clinicians' perspectives on effective treatment for indigenous populations. It was evident that clinicians recognised the importance of adapting therapeutic methods to the cultural values and needs of the specific indigenous groups to reflect the indigenous population worldview.

Some studies found that indigenous clinicians were not happy with current evidence-based practices, which were reflective of Western style treatments, being applied to indigenous populations (Goodkind et al., 2011; Wendt and Gone, 2016). Indigenous mental health professionals, having a clear knowledge of what worked effectively in their communities, proposed that traditional healing be accorded legitimacy in clinical contexts (Wendt and Gone, 2016).

Another study was completed in Native American communities, where 19 programmes were evaluated by Del Grosso, Kleinman, Espos, Martin and Paulsell (2014). The research was unable to establish how effective these programmes were, although they were able to identify lessons about evidence-based practice in tribal communities. Del Grossa et al. (2014) identified the need for tribal leaders to contribute towards the adaption of evidence-based practice, and the cultural sensitivity and competence of staff, recognising the importance of building upon the cultural strengths and customs of the community.

Del Grossa et al's review (2014) found one fundamental theme, which bears directly on Native Americans' health, was the value and connection they place on nature, animals and land (King et al., 2009; Mark & Lyons, 2010; Neville, Oyama, Huggins & Odunewu, 2014; Panelli & Tipa, 2007). Spirituality was another area identified as a fundamental strength for Native Americans and their worldview (Greaves, Houkamau & Sibley, 2015). It is clear that culture, as an intervention, is able to strengthen individuals, whānau and communities.

Aotearoa perspectives on mental health interventions for indigenous populations

In Aotearoa, clinicians are accustomed to having Māori tangata whaiora in their care and should be familiar with a Māori worldview, which is reflected in He Korowai Oranga (2014). This national strategy is clear about Māori receiving equitable health through access to high-quality health and disability services responsive to Māori aspirations and Māori needs (MOH, 2014a). However, there continue to be high numbers of clinicians working in mental health who remain ignorant of the cultural perspectives of those they are employed to care for (Bradley & DeSouza, 2013; Johnston & Read, 2000; Mark & Chamberlain, 2012).

In an Aotearoa survey of aspects of Māori mental health conducted in the late 1980s, 75% of psychologists who participated in this survey acknowledged they had inadequate knowledge of taha Māori to work in an effective manner with Māori. Yet in the same survey, when asked if it was necessary to have compulsory courses to gain knowledge and an understanding of their Māori patients and the profile of Māori, fewer than half of the participants agreed (Sawrey, 1993).

In a follow-up survey in Aotearoa by Johnstone and Read (2000), looking at improving bicultural training and Māori mental health services, the survey received favourable responses on incorporating taha Māori overall. However, some negative and racist comments were received from a few psychiatrists, which raised concerns particularly as they are respected psychiatrists within the mental health institutions where they work (Wratten-Stone, 2016).

Racism in the health arena is clearly problematic for Māori, and the experiences of institutional racism on Māori tangata whaiora can have damaging effects (Barnes,

Taiapa, Borell & McCreanor, 2013). Racism is a key determinant of health, and the Meihana model encourages health practitioners to explore any experiences Māori tangata whaiora have been exposed to in the context of being discriminated against (Pitama et al. 2014) when engaging with services. Use of this model is intended to ensure that ongoing racism does not continue or at the very least is reduced for Māori.

It is important when working within the health arena to refrain from making assumptions, when working with Māori, as there has been clear evidence that Māori vary within their worldviews (Harmsworth & Awatere, 2013). Further, whilst having an understanding of Māori is important, it is also vital for health professionals to have an understanding of the health culture in which they work. This is particularly important as the majority of practices and frameworks are designed by and for the dominant culture, and therefore work to the detriment of many Māori and other indigenous populations (Hirini, 1997).

The provision of competent and effective mental health therapy for Māori is a complex task (Wratten-Stone, 2016), which requires mental health workers to have a knowledge of cultural interventions, with the ability to provide these when caring for Māori tangata whaiora.

However, whilst research clearly identifies Māori as having high mental health needs (Oakley-Browne et al., 2006), and many Māori looking at ways to improve and promote mental health (Harris, Cormack & Stanley, 2013), these ideas and concepts are not always put into practice, but rather discussed in theory only where they remain (Muriwai, Houkamau, & Sibley, 2015; Walsh-Tapiata, 2008).

Summary

The prevalence of bipolar disorder among Māori is high, and it is reported that Māori experience the greatest level of interference in their life because of this (Baxter, 2008). Māori have been recognised as a young population, and the onset of bipolar disorder occurs prior to the age of eighteen years. Therefore, the need for effective interventions when working with Māori tangata whaiora diagnosed with bipolar disorder is critical in considering prevention and intervention strategies.

There is limited research to date on best treatment interventions and outcomes for Māori with bipolar disorder, and indeed on Māori and indigenous mental health generally. However, there seems to be more literature on clinicians and health professionals in working with indigenous populations experiencing mental disorder in the context of their clinical practice.

Given the lack of literature on effective interventions when working with Māori diagnosed with bipolar disorder, there is clearly a need for more knowledge around effective interventions being delivered by experts in clinical and cultural practices. It is with this in mind, that the present study strives to answer the question “What is required to provide effective care for Māori with bipolar disorder?”

CHAPTER THREE: METHODOLOGY

Introduction

The purpose of this thesis is to explore clinicians' perspectives of what works effectively when working with Māori diagnosed with bipolar disorder. This thesis uses kaupapa Māori methodology and qualitative methods with the use of in-depth interviews and focus groups. Kaupapa Māori and qualitative methodology were chosen due to aligning with the research question and with transforming outcomes for Māori in healthcare.

Kaupapa Māori Research

'Kaupapa Māori research is an attempt to retrieve space for Māori voices and perspectives, methodologies, and analysis, whereby Māori realities are seen as legitimate' (Cram, McCreanor, Smith, Nairn & Johnstone, 2006, p. 50).

Kaupapa Māori research emerged following the influence of developments including greater international recognition of the need for indigenous populations to have improved self-determination over land, language and culture, and closer collaboration between Māori and non-Māori following a greater commitment to the intentions of te Tiriti o Waitangi in recent years. The renaissance of kohanga reo and kura kuapapa schools (which teach Māori language as well as Māori customs) and the creation of Māori models of health have (Jahnke & Taiapa, 2003; Pihama & Gardiner, 2005; Waikeri, 2011), contributed towards Māori creating their own processes for research (Walker et al., 2006).

Kaupapa Māori methodology has developed over recent decades and has become quite influential within the health and social sectors. As a research strategy it represents the philosophical orientation that expresses a Māori worldview (Ruwhiu & Wolfgramm, 2006). Kaupapa Māori research has been described as being Māori and having a connection to Māori philosophy and its principles (Harmsworth & Awatere, 2013; Smith, L. 1999; Walker et al., 2006). It acknowledges the importance of Māori language and Māori culture with an emphasis of ensuring Māori have sovereignty over their own cultural wellbeing (Pere, 2006; Smith, G. 1997). Kaupapa Māori research is also collectivistic and aims to benefit research participants, defining and acknowledging Māori aspirations for research (Bishop, 1999a).

Research involving Māori has been predominantly undertaken by ethnocentric researchers, and information regarding Māori reality has been misrepresented by the analysis and findings (Bishop, 1999b; Mahuika, 2008), which has distorted ideas of what it means to be Māori (Smith, L. 2012). Dissatisfaction with these past experiences of Western research has led Māori to look at what methodologies, if any, can be used to truly reflect their experiences, which have ultimately led to Māori using their own epistemology (Smith, L. 2012).

The literature emphasises the importance of Māori practitioners sharing their experience for the purpose of Māori knowledge in the health and social sectors being strengthened (Walsh-Tapiata, 2003; Eruera, 2005; Hollis-English, 2015; Moyle, 2014). Kaupapa Māori is the overall framework which was chosen for this research for the purpose of privileging the Māori world viewpoint. For this to occur this research is undertaken by Māori for Māori, with the confidence of developing positive pathways for clinicians when working with Māori in their mental health journey.

Kaupapa Māori research is popular amongst Māori academics from a variety of disciplines (Dyall et al., 2014; Smith, Puke, & Temara, 2016). Irwin (1994) believes this is because these approaches are able to acknowledge te ao Māori. To understand Kaupapa Māori research, one must understand that this is more than beliefs and knowledge within a Māori context, it is being able to understand ideas and practices and examine how Māori think about these things and how Māori live (Mahuika, 2008). Smith (1998) states: “When indigenous peoples become the researcher and not merely the researched the activity of research is transformed” (Smith, L. 1998, p.193).

Kaupapa Māori research is guided by a number of principles which include the following:

- Aroha ki te tangata (a respect for people)
- Kanohi kitea (the seen face, present yourself face-to- face)
- Titiro, whakarongo ...korero (look, listen ... speak)
- Manaaki ki te tangata (share and host people, be generous)
- Kia tupato (be cautious)
- Kaua e takahia te mana o te tangata (do not trample over the mana of the people)
- Kaua e mahaki (do not flaunt your knowledge). (Cram, 2009; Smith, L. 1999).

Prior to commencement of this study Māori consultation was undertaken where recommendations were suggested and followed, which included liaising with Te Korowai Atawhai (Māori Mental Health Unit, Specialist Mental Health Services, Canterbury District Health Board). Having met with the manager of Te Korowai Atawhai to discuss this research and enquire about the possibility of speaking with

staff regarding their participation, a decision was made to send through an email to him, he would then discuss this with the staff, and following this send names through of those who were interested. The manager felt this would be the most effective way as some staff had not worked with Māori diagnosed with bipolar disorder. Names were subsequently sent through and all staff spoken to were agreeable to participate.

In addition to this, another recommendation following Māori consultation was to engage with hauora Māori community workers to ensure that tikanga Māori frameworks were considered and integrated into this study. An NGO service was contacted in Otautahi and staff were spoken to, including a Māori clinician who engaged in both the individual interview and clinical focus group. Furthermore, a Māori clinician who has worked in mental health for many years and currently works in the development for Māori health workforce was also invited and agreed to participate in the individual interview.

A significant aspect of kaupapa Māori research is utilising important Māori concepts, which ensure Māori protocols are maintained (Hollis-English, 2015). Whakawhanaungatanga, which is an integral Māori concept, was utilised throughout the research process and during engagement with participants. This allowed for maintaining and/or forming new relationships, which allowed for trust to be built as well as ongoing rapport.

Following the individual interviews participants were invited to have some kai and drink, which those who did not have other commitments accepted. The clinical focus group, whilst not offered food, had water and sweets available to them during and after completion of the focus group; once again, due to their commitments it was difficult to extend their time further to go out and eat or have kai supplied.

Pihama (2001) emphasises there are multiple and diverse realities for Māori, therefore there will never be a consensus on what kaupapa Māori research is. Nevertheless, kaupapa Māori research provides a platform for Māori to reflect who Māori are and speak our truth according to our life experience. It offers empowerment and strength by the mere virtue of knowing Māori ways of being, and accommodates Māori within an approach that remains academically rigorous (Irwin, 1994).

Kaupapa Māori research, however, is about moving away from managing adversity to looking at solutions for the benefit of Māori within the environments in which we live (Hall, 2015), which also has benefits for the wider community.

Kaupapa Māori research methodology in practice

From the commencement of this study, the writer was aware of the importance of having a kaumatua to whom she could turn to discuss issues around her chosen topic and also receive mentorship. Dr Terry Ryan (affiliates/connects to Ngāti Maniapoto/Kai Tahu, and is proud of his Celtic, Scottish, Irish and Canadian First Nations whakapapa) agreed to support me in this study. His expertise and love of whakapapa is clearly evident from his commitment to his role within Kai Tahu over the past 50 years. Whakapapa is an integral part of Kaupapa Māori, which is reflected in whanaungatanga and exists as part of Māori identity and culture (Smith & Reid, 2000).

Dr Terry Ryan shared the importance of whakapapa and the connection this has for Māori in terms of their physical and mental wellbeing. He shared the significance of Māori being a product of their landscape, but more importantly connecting to their turangawaiwai, which creates stability in knowing where you belong and where you fit in. Engaging with a kaumatua provided guidance and ensured cultural practices were acknowledged and underpinned this research.

Rigour

Utilising kaupapa Māori research ensured engagement was *kanohi ki te kanohi*, which is the preferred way Māori wish to engage with one another and others (Walker et al., 2006). *Whakawhanaungatanga*, which is another important aspect of kaupapa Māori, was utilised in the recruitment of participants which allowed for parties to be transparent with one another and built on previous or new connections.

Kaupapa Māori research directed my analysis by focusing on the narratives and validating the voices of the participants. The narratives are shared with the intention of benefiting the care of Māori in the delivery of mental health services, which is the cornerstone of this thesis.

Qualitative Research

Qualitative research is primarily exploratory and can be described as natural and interpretive work from the perspective of the researcher who is interviewing the participant(s) who respond within their context (Flick, 2009; Tong, Morton, & Webster, 2016). Qualitative research can be described as exploring people's experiences by listening to their explanation of how they view the world in which they live (Crowe, Inder, & Porter, 2015b; Holloway & Wheeler, 2015).

Qualitative research has been known to be the preferred method for subjects where little is known (Strauss & Corbin, 1990), which fits with this study. Given there is minimal literature on working effectively with Māori diagnosed with bipolar disorder, it was felt this methodology was appropriate and would be effective in gaining information around this subject.

Whilst qualitative research is based on the evidence that participants are the best in sharing their feelings (Denzin & Lincoln, 2011) we are reminded as researchers to have an understanding of our participants' shared information without actually imposing one's own perspective. It was felt due to the exploratory nature of qualitative research that this approach would also fit well within this study.

Utilising the findings of qualitative research helps inform practice, which ultimately strengthens the reliability of qualitative research (Leung, 2015), as well as provides evidence for clinical decision-making. It is anticipated that this research will better inform clinicians working with Māori diagnosed with bipolar disorder in providing effective interventions. This being said, the goal is to expand clinicians' clinical knowledge as well as increase their confidence in working successfully with Māori.

Observational methods, interviews and focus groups are identified as qualitative research. These include one on one interaction, in-depth interviews, interactions between group members and detailed observation of people as well as observation of behaviours (Curry, Nembhard & Bradley, 2009; Gill, Stewart, Treasure & Chadwick, 2008).

The main purpose of using a qualitative method in this study is the ability to step into the world of the participant/s and view the world from their perspective, with the purpose of contributing to the development of empirical knowledge (Corbin & Strauss, 2015; Ormston, Spencer, Barnard & Snape, 2013).

Another advantage of qualitative research is the capacity to gather rich descriptions (Braun & Clarke, 2006), given by the participant(s), which contribute towards new knowledge, particularly if the subject is unknown or unfamiliar (Denzin

& Lincoln, 2011). Importantly, the objective of qualitative research is not the amount of information retrieved, but the progress and growth of understanding about phenomena of concern (Miller, 2010).

This research explores the perspectives of Māori and non-Māori practitioners delivering psychosocial interventions and support to Māori tangata whaiora, followed up by mental health services. However, it was evident from the onset that there were other important factors to consider before the practitioners were able to explore what psychosocial interventions they used or considered as effective. The study therefore examined what clinicians, and those expert in hauora Māori, believed was important, as precursors to working with Māori tangata whaiora diagnosed with bipolar disorder.

Qualitative data was collected from both individual and group interviews for the purpose of ascertaining what the practitioners believed were important factors when working with Māori. This ensured the best collaborative approach as well as recovery focused outcomes for Māori and their whānau.

Method

Aim

This project was carried out by interviewing purposively selected clinicians and pukenga atawhais who work with Māori tangata whaiora with bipolar disorder. The study was designed to capture clinicians' and pukenga atawhai descriptions in individual interviews and focus group settings.

Design

This study used a kaupapa Māori and qualitative research methodology to explore clinicians' and pukenga atawhais experiences when working with Māori tangata whaiora diagnosed with bipolar disorder and also touched on the use of psychotherapy.

This project began in August 2015, when discussions with mentors took place around recruitment, and an opportunity to discuss this project with peers and colleagues arose. Subsequently, staff were approached who work specifically with Māori diagnosed with bipolar disorder as it was critical that the participants were able to relate to the questions and have an understanding of Māori tangata whaiora.

Staff were therefore contacted via email or phone, with the opportunity of meeting face to face prior to the actual interview or focus group session. This allowed for questions to be asked and answered and ensured participants felt they met the criteria in being able to contribute towards this research. All staff interviewed either work currently with or had worked previously with Māori tangata whaiora diagnosed with bipolar disorder.

Recruitment

Participants were purposefully recruited, which is commonly associated with qualitative descriptive research (Sandelowski, 2000), based on their cultural and clinical expertise. The participants were homogenous in they all worked in mental health, and were committed to improving mental health outcomes for Māori tangata whaiora. Demographic detail of the participants is listed in Table

3.1

A) Individual Interviews

Six participants were recruited for individual interviews to explore their responses in relation to the research questions. These participants all work within mental health and the majority work for the CDHB with the exception of two participants, one of whom works in a kaupapa Māori based Non-Government Organisation in Otautahi, and the other who works for a Māori workforce development service based in Te Whanga-nui-a-Tara.

The sample ranged in age from 45 years to 70 years and included three males and three females. A range of six clinicians made up the participant group and this included a consultant (n=1), consumer advisor (n=1), NGO clinician (n=2) and CDHB nurses (n=2).

The individual interviews provided a range of responses from the participants and based on the themes that came through, helped contribute towards the question posed for the focus groups.

B) Focus Groups

Fourteen participants were recruited to participate in two focus groups, and these participants were made up of practitioners who were clinical and/or experts in hauora Māori. The practitioners were divided into a clinical focus group and a cultural focus group. The clinicians all reside within Otautahi and work for the CDHB, with the exception of one, who works for a NGO.

All participants were different from those interviewed in section A (individual interviews), with the exception of one who was invited back to participate within the focus groups, due to her cultural expertise and clarity

around promoting best practice for the benefit of Māori. Unfortunately, due to the nature of the areas participants work within, on the actual days of the focus group sessions some staff were unable to attend, which reduced the numbers from 14 to 11.

The cultural focus group sample, pukenga atawhai (n=6) ranged in age from 45 to 65 and included one male and five females. The clinical focus group sample ranged in age from 25 years to 65 years and included one male and four females. Clinicians included in this focus group were a consultant (n=1), an NGO clinician (n=1) and CDHB nurses (n=3).

The participants were selected for individual interviews and focus groups based on their expertise of cultural knowledge and/or clinical knowledge. For those who were chosen based on their clinical knowledge, a requirement was having worked with Māori diagnosed with bipolar disorder and recognising the value of working effectively with Māori tangata whaiora.

The focus groups were slightly different in the sense that they were divided into a cultural and a clinical focus group. A decision had been made to include an expert in cultural knowledge from an NGO service to participate within the clinical focus group, due to their expertise within mental health and their vast experience from having worked within the CDHB for many years and now working within a kaupapa Māori service.

Once participants were contacted (by phone or email) a time was arranged to meet *kanohi ki te kanohi*, as is preferred within Māori kaupapa approaches. Information was given on a one on one basis or some participants chose to meet in twos or threes. This occurred for the benefit of

discussing the context of the research, and clarified participants' contribution to this project. All participants signed their consent forms either at this time, or prior to the commencement of the focus groups.

Data Collection

This research project utilised semi-structured interviews which allowed for both the interviewer and participants to expand on information they felt was important, and particularly allowed for the participants to share information that the writer had not considered (Gill et al., 2008).

A) Individual Interviews

The individual interviews were conducted by the writer and occurred with clinicians on a day they chose. The venue was generally at their workplace at a time that fitted in with their schedules. With the exception of one, all the interviews were *kanohi ki te kanohi*. Whilst a day had been arranged to interview the clinician from Te Whanga-nui-a-Tara (on a day they were visiting Otautahi) this did not occur due to illness. This interview however, went ahead a few weeks later via telephone.

The questions for the individual interviews were sent to the participants via email prior to the individual interview, to allow for familiarisation with these questions as well as give the participants an opportunity to consider their responses. It was also felt prior knowledge of the questions would be an advantage, given there was a time frame of 45 minutes for these interviews. The questions asked are listed below.

1. What do you understand about mental health care needs for Māori with bipolar disorder?
2. What do you understand about bipolar disorder and Māori?
3. What is your understanding of what Māori with bipolar disorder may need from psychosocial interventions?
4. What aspects of Māori culture could be integrated into psychosocial interventions for Māori with bipolar disorder?

All interviews were audio recorded for the purpose of being able to have these transcribed, which allowed the writer to capture an accurate summary of the interview, as well as utilise relevant quotations from the interviews. Audio recording has been a method used since the 1970s, which allows researchers the opportunity to analyse, report and interpret a participant's own words (Markle, West, & Rich, 2011). This method is useful compared to having others collect data and/or read material without physically being present, and having to gain insight from information gathered by others.

All participants who took part in the individual interviews were previously known to the writer and selected for their knowledge and expertise of how to work more effectively with Māori. Nevertheless, conducting research that includes peers and colleagues can create challenges, and ensuring there is a balance between researcher and participants remains important (McDermid, Peters, Jackson & Daly, 2014).

To ensure the participants were comfortable in this process we had discussed their contribution towards this research beforehand via phone and/or email, and again at the time of their interview. It was felt that having a working

relationship with the majority of the participants was in fact an advantage: it not only contributed towards a seamless interview process but also supported the use of an important Māori concept within kaupapa Māori research, whakawhanaungatanga.

Advantages are seen in the writer and participants all having clinical backgrounds and therefore have an understanding of complex clinical situations, which can possibly give an edge and insight into information shared (Taylor, 2011). Furthermore, some would argue that having a relationship/friendship with participants enhances the value of interviews, leading to an open and frank discussion during the interview process (Blichfeldt & Heldbjerg, 2011).

B) Focus Groups

Pukenga Atawhai

The focus group consisting of six pukenga atawhai advised they meet each Thursday for ongoing education and work development. They all agreed that this would be the best time to meet as they are together on this day, and further, that it would prevent them having to be pulled out of their clinical areas outside of this time. Following discussion with their manager, it was agreed that they could leave for the proposed one and a half hours that had been requested.

Day of focus group with pukenga atawhai

The focus group met following their whakawhanaungatanga morning at Te Korowai Atawhai, which allows for staff working within the CDHB and any

other health agencies in Otautahi to meet with pukenga atawhai and share their own mihi amongst the staff, as well as other visitors who may have been invited to attend. Te Korowai Atawhai is part of the CDHB specialist mental health service, and consists of pukenga atawhai who are also members of the multidisciplinary teams threaded throughout the specialist mental health service, providing cultural expertise for clinicians. The purpose of whakawhanaungatanga day is to share with clinicians and services the value of understanding Māori frameworks and recognising the benefit of teams working together for the purpose of strengthening Māori in their recovery process.

Whakawhanaungatanga days are held once a month (every third Thursday) and offer an important experience for those who may be less familiar with karakia, waiata and other cultural aspects. This is an opportunity for clinicians to experience an insight into Māoridom within health, and gain confidence in working in partnership with Māori tangata whaiora and their whānau. Additionally, these days offer an opportunity for all clinicians to introduce themselves in Māori if they feel comfortable, and be supported by pukenga atawhai within their work areas by singing a waiata following each service's mihi.

Following attendance at Te Korowai Atawhai and having participated in whakawhanaungatanga morning everyone enjoyed a shared lunch prior to the focus group meeting together. It was decided by all to forgo repeating our mihis as these had just been shared together a few hours earlier.

Clinical Staff

The clinical staff focus group were offered several meeting options to find a time that suited the majority. Due to the acuity of the inpatient ward and sickness on the day of the focus group, three participants who had previously agreed to attend were unable to come, which reduced the numbers from eight participants to five.

When utilising the nominal group technique, the recommendation is using between five and nine participants for the purpose of allowing diversity within the participants' responses.

The focus groups which were facilitated by the writer ran on two separate days. The majority of participants were known to the writer; however, other names were provided by those who had been previously interviewed and invited to participate in this research. There was nil conflict of interest, and the participants who contributed to this research all had vested interests in sharing information for the purpose of improving recovery pathways for Māori diagnosed with bipolar disorder.

The participants within these focus groups had been advised of the research question a couple of weeks prior to their focus group meeting to allow for consideration of their responses. Participants had an opportunity to ask questions around the research beforehand and these questions had been responded to by the researcher. However, another opportunity was offered at the start of the meeting to ensure the participants were comfortable with engaging in this process.

Generation of ideas

The participants were asked to listen as the process of nominal group technique was explained as some were familiar with the process and others were not. Participants were advised to state their idea rather than write their idea on paper. This adaptation was implemented to allow the participants to state their ideas verbally, which is a process that follows tikanga Māori of working together collectively rather than individually. This approach still allowed for individual ideas to be generated and identified, but was done openly in front of the group.

Once this process was explained, the participants shared their responses in a round robin style as requested. There were times when participants passed, but on the next round were able to come back in and share another response as reflected in the nominal group technique process. This process continued until no further responses were given.

The participants were asked not to engage in conversation during the round robin, but were advised there would be an opportunity later in the day for further clarification and discussion around ideas expressed. Whilst there were occasional comments made during the round robin, overall the participants followed the instructions very well and were able to refrain from speaking at this time.

As the participants spoke, the ideas were written on the board by the writer as well as being audio recorded. Once all ideas were identified and there

were no other responses this gave an opportunity for discussion and further clarification of the ideas presented. The participants in the first focus group seemed to be similar in the way they were thinking and their responses reflected this. They generated 22 ideas (Table 4.5) all of which were discussed in an interactive manner during the discussion phase.

The clinicians responded with a combination of answers to the focus group question, “What is required to provide effective care for Māori with bipolar disorder”? and whilst there were some similarities with the responses from the previous focus group, there were additional responses in the context of physical and mental wellbeing as well as spiritual and cultural diversity.

The clinician focus group identified 26 responses initially (Table 4.8). However, during the discussion phase they engaged in a lengthy discussion, having recognised similarities between some responses, and collectively made a decision to combine these, which reduced their overall generated ideas to 14 (Table 4.9). The participants were able to demonstrate why they felt they could cluster similar themes together and why they felt some ideas were more important and needed to stand alone.

During discussion the writer posed questions for clarity around responses but did not contribute towards decision making. Ideas were discussed in the context of meaning but also offered opportunities for others to be able to add to the description. Responses given by the participants were written on the whiteboard, and all information recorded and discussed came from the consensus of these focus groups.

There was some robust discussion and education around some of the more tikanga Māori generated ideas from the second focus group, particularly around tapu and noa, and whakama. One of the participants, who is not from Aotearoa and not familiar with tapu and noa, was given an explanation by another participant within the group. Following this explanation, the participant was better informed and appreciative of this new knowledge.

It must be noted that one of the participants (P4) who has extended clinical and cultural knowledge encouraged a depth of discussion around tikanga Māori components that may not have occurred if this participant was not present. However, it is unknown whether other participants would not have produced the same responses, albeit less in-depth.

Whilst it was important earlier for participants to identify ideas without any conversation, the ability to discuss ideas in greater detail occurred at this point. There did not, however, seem to be any pressing disagreements within these focus groups regarding ideas presented; in fact, quite the opposite, in that other participants were sharing their understanding of ideas provided by others.

Ranking

The final step in the process of nominal group technique for the participants was ranking their chosen ideas in order of importance. Participants in the first focus group identified 22 responses and were asked to choose their top 11 responses (Table 4.6). Additionally, the second focus group identified 14 generated ideas and were asked to select their top seven in order of importance.

The pukenga atawhai focus group participants were given a piece of paper to rank each idea (Table 4.7) from one to eleven, with eleven being the most important and the clinician focus group ranked their chosen ideas (Table 4.10) from one to seven with seven being the most important. This was done in silence so the participants were not influenced by each other. Once participants had completed this task their sheets were handed to the writer who collated their scores and the outcome was shared with the group.

Table 3.1 Participant demographic information

Participant	Gender	Age	Iwi / Ethnicity	Health Profession	Experience/Years
P1	M	50 - 55	Ngapuhi / Ngai Tahu	Nurse	20+
P2	M	50 - 55	Ngati Porou / Ngati Hei	Cultural	10+
P3	F	45 - 50	NZ European	Consultant	15+
P4	F	60 - 64	Ngati Tuwharetoa	Kaihaumanu	15+
P5	M	50 - 55	Te Ati Haunui-a-Paparangi / Ngati Whatua, Rongowhakaata	Cultural	2
P6	F	70 - 71	Ngapuhi	Kaiarahi	40
P7	M	55 - 60	NZ European	Nurse	20+
P8	F	60 - 65	Waitaha / Ngati Mamoe / Ngai Tahu	Cultural	15+
P9	M	60 - 65	Te Whakatohea / Te Ati Awa / Tainui	Cultural	20
P10	F	45 - 50	Te Ati Haunui a Paparangi	Cultural	3.5
P11	F	50 - 55	Te Arawa	Cultural	4.6
P12	F	45 - 50	Tuhoe / Ngati Manawa / Ngati Whare / Ngati Tuwharetoa / Ngati Porou	Cultural	2
P13	F	25 - 30	Ngati Manawa, Tainui, Tuhoe, Kai Tahu	Nurse	3
P14	M	55 - 60	Ngati Pakeha / Scottish	Nurse	20+
P15	F	55 - 60	NZ European	Nurse	38
P16	F	45 - 50	German	Consultant	18

Analysis

Thematic Analysis

Thematic analysis was used for the individual interviews as it is seen as foundational for qualitative analysis. This tool, which can be used across a variety of methods (Boyatzis, 1998) provides flexibility and delivers rich, yet complex data (Braun, & Clarke, 2006). One of the reasons for using this method is its flexibility as a research tool, as well as its ability to identify key themes through identified patterns.

Braun and Clarke's (2012) method of thematic analysis, consisting of six phases of analysis was used to analyse the individual interviews. These phases are:

1. Familiarisation with the data
2. Coding
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Writing up

To ensure confidentiality of the participants, when referring to and using data information (direct transcription), P1–P6 will be referred to at the end of each narrative, which will reflect the individual participants and their contribution towards this study.

Familiarisation with the data

Thematic analysis generally involves interviewing individuals as well as groups. The purpose of this project was interviewing individuals with a set of questions and

then analysing data which had been shared. This was completed by listening to audio tapes of those interviewed, as well as reading and transcribing each interview from the participants.

Coding, searching for themes and reviewing themes

Following the thematic analysis, the writer, along with her two supervisors, read through data from the individual interviews and identified codes and categories, then searched for themes within these. Having completed this separately, the writer and her supervisors then met to discuss the findings. After discussion and some moderating, a consensus was able to be established and the themes identified.

Defining and naming themes

Thematic analysis is a process which analyses, identifies and reports patterns within data. This method helps researchers understand meanings within collected data (Braun & Clarke, 2006). It also provides the researcher with a tool for interpreting qualitative data and being able to analyse the similarities and differences that are shared by the participants (Crowe et al., 2015b).

Nominal Group Technique

Nominal group technique (NGT) is a procedure which has been proven to be effective in eliciting healthcare priorities (McMillan, King, & Tully, 2016). This method was used to analyse the focus groups and has been chosen for the purpose of obtaining qualitative information from participants in a focus group setting. NGT allows individuals to express their views and encourages participation from everyone within the group with the purpose of recognising areas of consensus amongst the

group, and looking at establishing priorities for change by finding solutions to problems (Perry & Linsley, 2006).

NGT was originally developed in the 1960s within social psychological research, with the purpose of being able to generate effective decision making (Harvey & Holmes, 2012; Van de Ven & Delbecq, 1972). The benefits of utilising NGT include meeting face to face and having a group of experts within a field together at the same time with extensive knowledge. NGT also allows information to be shared within a short time, completion of discussion ensured and decisions better understood as discussed and accepted by group members (Lunenborg, 2011).

One of the advantages of NGT is that outcomes are generated within the focus group and do not require a separate method of analysis after this group process. This allows for problem identification, the development of solutions and the establishment of priorities for action. Time efficiency is an additional advantage, which is particularly practical for health professionals working in the health arena (Harvey & Holmes, 2012).

Interviewing participants within a focus group not only enables a collective approach but is also compatible with kaupapa Māori which resonates within the worldview of Māoridom (Brannelly, Boulton, & Te Hiini, 2013). Usually in the true form of NGT the style is for each participant to be given paper to record their responses, and then these are handed in to the facilitator to transcribe them for all to see. However, this procedure was adapted to allow pukenga atawhai and clinicians to state their ideas verbally, which remained consistent with kaupapa Māori's concept of collective approach (Kumar, Dean, Smith & Mellsop, 2012).

Furthermore, there is significant research which clearly indicates that having consensus decisions within groups of participants ranging from five or more outweighs individual voting (Foote, Matson, Weiss & Wenger, 2002; Robinson & Schroeder, 2004; Johnson & Hollenbeck, 2007). The very nature of NGT works with the purpose of giving the participant ownership of the research, and is likely to influence clinical practice and policy (Harvey & Holmes, 2012).

Ethical Considerations

This research received ethical approval (Ethics approval number 15/141), from the University of Otago Human Ethics Committee (see Appendix One) and Specialist Mental Health Service Research Committee (see Appendix Two). In addition, Māori consultation also took place as discussed previously in this chapter.

Information sheets were provided for all the participants (see Appendix Three), via email, and questions for the individual interviews and focus groups were also sent via email (see Appendix Four). Once all participants had been met, paper copies of the information sheet, demographic information required (see Appendix Five) and consent form (see Appendix Six) were distributed on the day of the interview or focus group, and signed by all participants. Informed consent included the ability to withdraw from the study at any time, without any disadvantage to the individuals. The digital data from audio recordings were stored on the writer's computer under a secure file and paper copies made for analysis purposes were locked away.

Rigour

Qualitative rigour has been described by Kock (2006) as being credibility, transferability and dependability. Credibility relates to the way in which data are

interpreted. A consensus occurred amongst the research team in the context of the individual interviews, and the focus groups utilised a form of consensus also, as previously discussed. This approach is supported by Crowe et al. (2015b) who acknowledge the value of having the interpretation validated by participants or adopting consensus among the research team increases the credibility.

Transferability involves providing the reader with adequate information in order for them to assess similarities or differences between the context in which the study was conducted and their own clinical practice setting. Finally, dependability includes providing sufficient information on both the data collection and data analysis process to enable the decision-making trail to be followed (Crowe et al, 2015b; Kock, 2006).

The context in which this study has been conducted has been discussed and the methods used have also been provided. The inclusion of data by the participants offers the opportunity for others to evaluate the procedures and findings for the purpose of applying these in other settings.

CHAPTER FOUR: RESULTS

Individual Interviews

Introduction

The results of this study are presented in the following chapter and detail the data collected from individual interviews and focus groups separately as different forms of analysis were used for these two participant groups.

All participants' demographic data was provided in chapter Three (see Table 3.1), which also details the pukenga atawhai and clinicians' length of cultural and clinical experience in the health field. This does not take into consideration participants' lived experience in tikanga Māori.

The purpose of having two focus groups was to explore their responses to the question, "What is required to provide effective care for Māori with bipolar disorder," with the intention of being able to understand both the cultural and clinical component of treating this cohort, given the participants varied expertise in working with Māori tangata whaiora.

The first focus group, group A, are the pukenga atawhai who work specifically with Māori and additionally work in supporting clinicians in working collaboratively with Māori tangata whaiora and their whānau. The second focus group, group B, are clinicians working within the SMHS and a Māori clinician working from a kaupapa Māori NGO in the Otago region.

This chapter focuses on how data was obtained from the individual interviews and discusses the process involved in finding patterns. The raw data was collated and

placed into codes, which were then categorised, and finally three themes were identified. These themes are, the importance of Māori worldview, tikanga Māori and understanding the whānau context.

The data obtained from the focus groups is also discussed which has been underpinned by utilising the nominal group technique, which was developed in 1968, and conceptualised by Delbecq and Van de Ven (McMillan et al., 2014).

Obtaining data

The purpose of interviewing participants' about their practice when working with Māori tangata whaiora was to gain an insight into how clinicians think about the needs of Māori diagnosed with bipolar disorder. It was evident that most of the participants were familiar with certain aspects of tikanga Māori, and those who were less familiar acknowledged the value of utilising pukenga atawhai for cultural support.

“The pukenga atawhai are and have been very instrumental in bridging the gap between staff, who some Māori patients do not affiliate with, because they prefer to deal with Māori or rapport better with Māori, whether this is Māori nursing staff or pukenga atawhai.” [P6]

Whilst the participants were asked the same questions, their responses were quite varied based on the participants' knowledge and understanding of treatment and recovery for Māori diagnosed with bipolar disorder. It was evident that Māori clinicians offered a more comprehensive tikanga Māori aspect in their responses; however, this being said, there were also a number of non-Māori who contributed widely in the context of understanding the importance of utilising Māori models of health.

Having interviewed, transcribed and read through all the individual interviews, it was evident these participants held strong views around their understanding of what works well for Māori tangata whaiora diagnosed with bipolar disorder.

“I occasionally have called upon a Kaumatua to come in and assist, particularly if there are issues in relation to the spiritual, and I guess that might be of relevance with the situation of te mate Māori. Te mate Māori, isn’t it? With perhaps some breach of tapu that has led to a manifestation of physical illness that in fact mirrors spiritual mediator, so I guess it’s being open to that consideration. And as clinicians we’ve not always been, or certainly when I went through medical school it wasn’t something ingrained in us, to be open to. But as time has gone on and certainly in registrar training I think we’re much more made aware of.” [P3]

The process of recognising patterns within the data seemed quite clear, possibly due to responses from the interview questions. All data that identified any aspect of being Māori and relating to Māori was highlighted to be explored further. This encompassed a broad view initially, but was further refined later in the analysis. Once similar data were identified in the individual interviews these were collated together into meaningful groups which were then generated into codes.

Table 4.1 Illustration of coding, example one

Tension between western frameworks [P1]	<u>Code one</u> Different worldview perspectives
Māori worldview [P2]	
Māori framework holistic [P3]	

Table 4.2 Illustration of coding, example two

Iwi identity, cultural history [P1]	<u>Code four</u> Colonisation
Cultural alienation [P3]	
Losing traditional healing processes [P5]	

Seven codes were identified within the data, and these were then categorised by being placed with other codes that were similarly positioned. This contributed towards informing an overarching theme.

Table 4.3 Example of categorising and identifying a theme

Code one – Different worldview perspectives	<u>Theme</u> Importance of Māori worldview
Code four - Colonisation	

The categories were then placed into themes which reflected the participants' combined raw material, and demonstrated the values the participants stated were important components when working with Māori diagnosed with bipolar disorder. The remainder of this chapter will discuss the three themes that have been identified, and will be supported by direct transcription to demonstrate these themes.

Theme One: Importance of the Māori Worldview

Working effectively with Māori requires an understanding of te ao Māori that encompasses the beliefs and assumptions which Māori live within. This theme represents the importance of a Māori worldview from the perspective and understanding of the participants in this research study.

This theme demonstrates the impact colonisation has had on Māori and includes socio-economic constraints that underpin their choices, and the implications of this for their mental wellbeing. Participants discuss their viewpoints when working with Māori tangata whaiora, and their experience and familiarity with different worldview perspectives. Interwoven in this theme is acknowledgement of the need for indigenous models of health, and more specifically the need for the integration of Māori health models into treatment for the purpose of positive health outcomes for Māori tangata whaiora. Bipolar disorder is also discussed within the context of treatment interventions.

Te ao Māori

The impact of colonisation on the health of Māori has been widely discussed by participants within this study. Inequalities were acknowledged where Māori have experienced social and economic lifestyle differences in comparison to non-Māori, with the implications for their physical and mental health.

“Sadly, I know when I was going through medical school, the health disparities between Māori and non-Māori was highlighted and something that was really drummed home and sadly I don’t think there’s been much in the way of, you know advances in terms of closing that gap.... Looking at the socio-economic status of the individual concerned, because so sadly,

again due to the disparities that we know so much about. Poverty and the like, and inability to both attain and sustain employment can have a significant bearing.

So, I guess what I'm trying to say is that all of these things need to be taken into consideration as far as sort of the current mental health care needs of an individual is concerned.” [P3]

Another participant shared:

“It's not always about life style choices or the fact that people don't want to work or those sorts of simplistic kind of explanations. Sometimes it's about what type of access did people have to education, you know, and input and what sorts of, you know, how have they been able to work out what sorts of occupations they've had access to. You know it's quite evident that if you've got a good job and you're living in a house which is clean and you've got access to, you know, power and water and all those kind of essentials, well then both your physical and your mental health should be, you've got a much better chance of having a reasonable standard of health, but if you're not, if you don't have those advantages, then it's more likely that you will be susceptible to illness, whether it's physical or mental.” [P1]

Whilst these narratives suggest an awareness of inequalities for Māori, participants touched on specific areas of concern with far reaching implications for Māori on their physical and mental health. This included the ability to provide shelter and protection for one's whanau as well as being able to financially provide for them.

Participant P2 suggests when working with Māori it is important to take into consideration what they believe is of value to them, and the importance of understanding te ao Māori in the context of being able to work effectively with Māori tangata whaiora:

“I believe in listening to them and being respectful of their cultural needs, so it’s being able to understand their values and their belief system, and that ties in quite a lot with the experience of bipolar disorder, and it is necessary in order for them to have that understanding from a cultural perspective because sometimes they believe it’s a cultural phenomenon impeding on some of this around the bipolar experiences that they have. But if they start digging I believe that for the clinician they really need to understand the values and beliefs. They really need to understand te ao Maori.” [P2]

Another participant spoke of the importance of kapa haka (Māori expression through performing and singing Māori songs and doing Māori actions through the haka and poi) and the role this can play in the lives of tangata whaiora experiencing bipolar disorder:

“I said those ones do well, you know, the haka that they did, I’d say look at him, it might be six minutes for the haka and he’s at his best he’s normal.” [P5]

Another participant speaks about the importance of having a cultural perspective:

“I believe that there can be a tension between western frameworks, and when you’re imposing those sorts of frameworks on people from ethnicities

that are not mainstream European.... The reason why I'm kinda emphasizing that is because of, I think that if you're working with a cultural population like Māori that there are some really specific aspects that you have to take into consideration when you're working with that particular group." [P1]

These participants highlighted valid cultural points around Māori they were working with, and discussed possible tensions with not understanding their perspectives. There was acknowledgement for the need to incorporate a Māori perspective and to value Māori tangata whaiora's histories.

It was evident from listening to participants, and hearing their responses regarding the importance of working collaboratively with Māori tangata whaiora, that they were determined to move Māori forward by supporting them in their recovery and mental wellness and for this purpose were open to sharing their experiences.

"Maori language again is something that is very important and to be fostered in this respect, if we're looking at cultural tradition and how this might bolster I guess the individual's wellbeing and sense of identity and all of that, which undoubtedly contributes to mental wellness. Because without all of that, you know that leads to pathways of un-wellness." [P3]

This participant recognised the value of Māori language, which is an important component of kaupapa Māori and holds significance for Māori tangata whaiora. The participant also suggests language legitimizes who Māori are, and allows them to korero accordingly, to those who have the ability to speak in te reo if this is what they choose.

This following quotation provides an interesting perspective from this participant, who shares the division of being Māori in a Pakeha world and not knowing where one fits into that world.

“So, from my perspective in terms of them being Māori, if they’ve been raised Māori, although not necessarily had a lot to do with Māori, then the reaction to the way things happen to them in the world can have quite marked mood swings. And that’s just been my observation, you know. I’ve had a long period of time, like 15 years, in the community trying to keep people out of hospital...and it’s like this is one extreme, so that might be your Māori worldview, and the other extreme is this European worldview that you’ve got to accept. And so, the pendulum that swings between is often full of conflict but is extreme. So, there are huge mood reactions in there. Until we get to the place where they learn more about themselves and that might be if they don’t know much about their Māori side. But there is something that happens for them as a Māori person if we can help them explore their whakapapa, or encourage them to do a course that gives them more information, then, ummm, I find those extremes lessen.” [P4]

The importance of identity is strongly discussed here and participants recognise the conflict that can be so clearly evident with Māori tangata whaiora who may struggle with living in two worlds. Having the ability to know who you are, and where you belong, gives stability and strength in the context of one’s physical and mental wellbeing, as alluded to in this transcription.

Understanding mental illness and interventions for bipolar disorder from a Māori worldview perspective

The complexity of mental illness

Through the following narratives participants share their thoughts on some Māori tangata whaiora who struggle with their symptoms, and these narratives also indicate the complexities involved.

“A lot of them say to me, when’s it going to stop, it keeps coming back, it’s causing a lot of chaos in my life and a lot of havoc, why do I experience a lot of mood changes? And sometimes they’re quite extreme and this is what Māori tangata whaiora are saying to me, the ones I’m working with. It comes out of the blue, I lose touch of reality and I don’t know what’s going on....” [P2]

Another participant shared:

“This is a serious and debilitating mental disorder for so many, and for many it’s unrecognised and untreated until which stage, you know there’s been so much damage and that’s been accrued and it’s trying to kind of repair that.... Māori due to the health disparities that I’ve mentioned have higher rates of mental illness and addiction problems in particular.... We know that indeed Māori have higher rates of schizophrenia and bipolar, and the addiction disorders, the co-morbidity, I guess that’s so important...it’s not a single disorder that one needs to be addressing.” [P3]

It was suggested through these narratives that participants associated bipolar disorder with high levels of co-morbidity, with Māori having the highest rates of co-

morbidity. A common thread through various narratives of the participants was their understanding of what bipolar meant to Māori tangata whaiora, and how they presented during active episodes of elevation or depression. A couple of participants shared their thoughts on this:

“So, if it comes to the bipolar, you know, being part of their life, then what happens is I will see them more often, but we will work with strategies that are aimed at them being able to have insight and control over that disorder. So, it’s not about them not taking their medication, because that would be contrary to what we do as, you know, supporting the mental health system. However, medication is not my first thought. What is it that this person is still capable of doing even though they may be on a roll on into their bipolar, you know, taking control of their life.” [P4]

This participant described the importance of acknowledging other factors of Māori tangata whaiora that contribute towards what makes up who they are, without feeling their diagnosis is taking over who they are.

However, in contrast to this another participant shared some potential risks associated with bipolar disorder:

“Some people with bipolar tend to have elevated periods most of the time and just occasionally they may get depressed. On the other side there are those who just experience depressed episodes with the occasional elevated episode. It is very dangerous as it affects people’s relationships. So even people with bipolar, over time their partners get burnt out by it. It could be they’re constantly spending all their savings when they’re in an elevated

state. Because that's what people do when they're elevated in mood or in a depressed state, the partners can't cope with it over time.” [P6]

Participants demonstrated their understanding of the diagnosis of bipolar disorder and perceived it as a destructive illness. The complexity of co-morbidities further complicated the picture, and indeed adds additional pressure for Māori and their whānau.

Interventions for bipolar disorder

The participants acknowledged the need for effective psychosocial interventions:

“We now know that the kind of more enduring psychodynamic kind of orientated talking therapies are not necessarily, just in my personal opinion, as helpful with some of these major mental illnesses. Perhaps more sort of focused therapies, in particular with bipolar disorder, there's, you know, a number of therapies that now look at life style factors and sleep, wake cycles and all these kinds of things that kind of get incorporated into it, so it's practical I think, more so than it is necessarily dynamic. And that can be really, sort of the interpersonal sort of, therapies and the likes are much more sort of yeah, meaningful because it also looks at the finer integration if you like.” [P3]

Another participant spoke about the importance of implementing kaupapa Māori into treatment for Māori tangata whaiora:

“When I started reading and listening to other people around the country, I thought bloody hell, we're losing the traditional healing processes that we

always use. And it just seems that we're getting more into the medical terms and technology actually. So, what's Māori in that. Now you tell me where you can find that medication in the Māori world, or you tell me where we shut our people up, you know all of that. And they look at me and I say, well come on. It's something that we're promoting now about professional kaupapa Māori processes. Ah, I mean we know the medication will help, but you also have to talk to our whaiora....” [P5]

The participants acknowledged the importance of utilising Māori models of health or practices, which reflect te ao Māori, to demonstrate their ability in moving Māori tangata whaiora forward.

“A broad-spectrum approach of a number of different kinds of interventions would be helpful, then I'd say ok, we're just going to use medication and we're not going to use anything else, or we're just going to do interpersonal therapy of some sort. You know there's, even if you look at your interventions, like, let's say the use of medication. I think that there is, if you're using Western medications, there may still be a place for complementary medicine so there may be some things that you can use in combination with things... there could be some kind of complementary medicine that you could use that could have a more cultural base as well.” [P1]

Participants suggested being open to other options for the benefit of Māori tangata whaiora, and whilst they did not name specific interventions, they did acknowledge the benefit of exploring cultural options.

Having an awareness of what is available in psychosocial interventions, and being responsive to Māori tangata whaiora through their journey process, is an important factor as discussed by these participants.

Models of health

Models of health support participants in their clinical practice, but also require an understanding of how these models work effectively when working with ethnic groups, in this case Māori tangata whaiora. The participants acknowledged the importance of knowing about models of health, and more specifically understanding how these models impact on Māori tangata whaiora they care for. Each of the following participants was able to share what they believe is instrumental in working with Māori.

“...from a non-Māori, I think it’s drawing upon the health model which I think is a really good model, the Māori health model the tapa wha health model, the four dimensions, the cornerstones of health. So, I think that’s also a guide, isn’t it, to considering the mental health care needs. So, it’s not just the physical, the mental, the mind, it’s also considering spiritual and whānau and really just emphasizing that....” [P3]

This statement suggests that this participant was aware of the importance of a Māori health model, but more importantly acknowledged the wider implications it had for Māori tangata whaiora, by acknowledging the full complement of what makes up some Māori tangata whaiora beyond a diagnosis.

Another participant shared:

“You know the Tapa Wha? If you utilise this properly things will come out of that.” [P5]

This statement suggested that when a Māori health model was utilised correctly some positive outcomes could be expected. In addition to being able to implement culturally specific health models, participants also described the importance of the simplicity of listening and being present:

“I believe in listening to them [Māori] and being respectful of their cultural needs, so it’s being able to understand their values and their belief system.... I believe clinicians really need to understand the values and beliefs. They really need to understand te ao Māori. So, what do I mean by that? The Māori worldview and matauranga Māori, so understanding things Māori in a cultural contextual point of view.” [P2]

Participants exhibited an awareness that some Māori are not responsive to Western models of health, and they described what they have done within their clinical practice to address this. It was quite evident that these participants acknowledged the important role they played as professionals, and they indicated the importance of knowing about other health models that are more reflective of the culture with which Māori tangata whaiora affiliate.

Most participants were clear, when discussing working in partnership with Māori tangata whaiora, that their (clinical) expectation of having a cultural awareness and understanding of what contributed towards a Māori worldview was reflected in their capacity to work alongside Māori tangata whaiora and their whānau.

However, some participants, who were less familiar with cultural practices, and Māori cultural frameworks, acknowledged the need to be better informed and broaden their cultural gaze. One participant shared:

“I would always do a little research of my own just to try to better understand culturally appropriate practices because it is so different for different ethnicities. So, I do think the training has some part to play, but unfortunately medical school itself wasn’t a focus. It was my own personal experiences.” [P3]

This participant described the importance of thoughtful clinical practice, when working with Māori, in order to gain a perspective that they were not familiar with, as they recognised the value this would bring to their own ability to work in partnership with Māori.

Biomedical Model and Psychosocial Model

Most participants thought about Bipolar Disorder from a biomedical perspective:

“I guess bipolar sits with the DSM-IV or DSM-5, but my perception of bipolar is that someone’s given a diagnosis and that’s their view of it, but what I’m interested in, and because we practice much differently, is I want to know the things that the person does well in their lives and the things that they need either strengthening or need help with, or things they don’t do well.” [P4]

Some participants identified that classification systems such as DSM may not always be suitable in the context of Aotearoa:

“Look I’m not an expert in terms of how those diagnostic tools were formulated, but I hazard a guess, particularly if you look at something like the DSM model, that there’s not a lot in terms of context to that model to be able to place it within a framework that reflects New Zealand society. Now I know that actually when you look at the DSM, well certainly the older manual, because I am more familiar with the DSM-IV than with the 5 version...there is an element which looks at cultural things but it’s kinda a generic basis.” [P1]

Participants described the importance of utilising psychosocial interventions, and also acknowledged the need for holistic models of health that are inclusive, as opposed to reductionist, such as the biomedical model:

“...psychological interventions become so much more relevant and I guess that’s where it needs to be, both not only relevant but also culturally appropriate, and that’s where sometimes I think we’ve fallen down in the past. But since the introduction of kaupapa Māori services and the pukenga atawhai in particular, I think we’ve come a long way, ummm, with regards to that.” [P3]

One participant shared the effects of medication on some Māori:

“I think that I’ve come to realize because of the psychogenetic, in fact, Māori overall possibly are more sensitive to psychotropic medications and

particularly to adverse effects, so if anything, this shifted my practice as such that I'm using lower doses.” [P3]

Many Māori have not felt heard until they have gone to a kaupapa Māori based service and shared their concerns around the side effects they experience, as shared by this participant.

Additionally, the following participant suggests that listening to what tangata whaiora are expressing validates they have a voice and a right to share what is occurring for them in their treatment:

“My vested interest in people coming here is that the quality of life that they have is the highest that I can possibly help them attain to. For them to keep control and recognise what is happening. What I have recognised is that a lot of times when they've begun to speak out for themselves is that doctors refute what they say. Doctors do not necessarily want to hear what they have to say. Whereas I have learned that they are my greatest teachers. They are the ones that tell me what the medication does.” [P4]

This response was quite powerful as the participant acknowledges not having all the relevant knowledge, but rather refers to the Māori tangata whaiora in question as knowing how well the treatment is working because they are experiencing it, they are living it.

Another participant suggested the importance of being aware of what treatment options were available, and the possibility of being able to combine these:

“...there may be the capacity to, you know, obviously using lithium, but as long as you're looking at something where it's not contra indicated, if

you're using lithium there could be some kind of complementary medicine that you could use that could have a more cultural basis as well.” [P1]

Psychosocial interventions have been proven to work effectively in addition to pharmacotherapy, and one participant shared:

“So, therapy focused around that it may not necessarily be just individual kind of talking therapies, it may be looking at sort of family focused whānau focused therapeutic interventions. But I don't know of many that necessarily exist in that sphere. I mean individual therapies are happening and we have got, fortunately now, at least some more culturally relevant and Māori led services that can provide that sort of therapy, but it's sometimes going outside of the public health sector and looking at the NGOs, but I'm not sure we necessarily do or provide a great service in that respect.” [P3]

This participant shares the importance of information and education around psychosocial interventions that allow for discussion around what they mean and how they can benefit Māori tangata whaiora. Furthermore, there is discussion around working in a collaborative manner for Māori tangata whaiora:

“Education is paramount for the tangata whaiora and the whānau, and the benefits from psychosocial interventions, and so it would be wise and recommended to talk to the tangata whaiora and their whānau about psychosocial interventions and what that means. And actually, breaking that right down with regards to how that would benefit their recovery.” [P2]

These interviews identified the need for understanding Māori within their worldview and endorsed the need for holistic models of care when working in partnership with Māori and their whānau.

Summary

This theme described the importance of Māori worldview by sharing extracts from raw data to demonstrate participants' understanding of Māori they work with diagnosed with bipolar disorder. The implications of colonisation for Māori health were explored, and the need for incorporating Māori cultural perspectives when working with Māori was suggested.

Effective interventions were discussed for Māori, together with the positive outcomes that can occur when using culturally appropriate models of health. Bipolar disorder was also discussed in the context of its classification by the DSM-5, and how ineffective the recommended treatment is when measured against a Māori worldview.

Theme Two: Tikanga Māori

The second theme discusses the value of whakawhanaungatanga and recognises tikanga Māori as being instrumental when working with Māori diagnosed with bipolar disorder. Additionally, this theme also explores the intricacies of working with Māori tangata whaiora and those close to them in helping with their understanding of their diagnosis.

Tikanga Māori is described as customs and traditions that have been influential and fundamental in the lives of Māori and underpin a Māori worldview. These encompass core values and practices that governed Māori life before

colonisation took place and continue to be evident in the lives of many Māori today, albeit at a variety of different levels and understanding.

Whakawhanaungatanga

When engaging with Māori tangata whaiora there is usually a process that Māori are able to relate to and this is called a powhiri process. A powhiri process involves two parties which consist of tangata whenua (hosts) and manuhiri (visitors). Traditionally tangata whenua await the manuhiri, and when they arrive call them on to the host marae. There are times when the hosts and manuhiri are unsure of one another; however, they are able to gauge each other through korero, which is another component of the powhiri process. It is during this process (korero) that the two parties are hopeful of forming a connection.

These two parties can be likened to participants (hosts) and Māori tangata whaiora with their whānau (visitors). The powhiri process demonstrates the way Māori engage, and it can be utilised when meeting Māori and their whānau to establish familiarity. Furthermore, this process also recognises the unease that could be occurring between both parties and the need to korero to ensure both parties are feeling safe as well as informed. Following the powhiri process, kai is shared, which indicates the end of formalities and is an indication that both parties are feeling safe with one another. In a healthcare setting there may be some time constraints placed around this process, particularly for those not working within a kaupapa Māori service.

Participants talked about the importance of whakawhanaungatanga and how this can extend across boundaries, particularly when working with Māori who may feel vulnerable or threatened by entering services or receiving treatment that is new to them.

“Some people want more what I suppose we would refer to as traditional type of engagement process where you might have an Elder or someone with cultural authority to actually formalize that process and speak in te reo. And kind of introduce the clinicians as a group, and there would be a kind of protocol, a cultural protocol that would be adhered to.” [P1]

Another participant describes the importance of being authentic:

“...if you form again, a genuine relationship and that requires face to face contact, then you talk about what it is that they’re looking for to see whether or not that’s what you could offer up. And I see it as a guidance role because people come with their own knowledge, their own life experiences, and I really don’t want to spend too much time teaching them that their life experiences aren’t relevant in the room. Whereas a lot of disciplines say no, you must keep all that that’s your personal stuff out of the room. But how can you be in a genuine relationship with another human being if you’re not fully present? You must be fully present.” [P4]

Another participant suggests the importance of knowing how to engage with Māori to ensure this leads to positive experiences, as negative experiences can create future barriers for both Māori tangata whaiora and their whānau.

“My clinical experience is that if at first the engagement process doesn’t go well, naturally for those people [there needs to be] input more than once on a recurring basis. If you don’t get the first one right sometimes it can take years for them to get beyond that to a point where you are engaging with them in a really therapeutic way. And people have in the past said to me look you know the first time I came into hospital, the first time I had anything

to do with someone in the mental health service it went really badly, and I've never forgotten it, and so therefore I don't like the environment for a start or I get uncomfortable and anxious when people start talking about, well you may have to come in to hospital and so you know in my own experience, it's very much about making sure that the engagement process is done correctly.” [P1]

Another participant described establishing trust as an essential part of their role:

“So, for me whakawhanaungatanga, the building of relationships, you can't do that here within this hospital, you've actually got to go to their place of their turangawaewae, their standing place. Go to a place where they feel safe and comfortable, and go to a place where they feel supported by the staff that are around them, because new people, when they come onto the scene they're a bit inquisitive as anyone would be.” [P2]

Another participant shared:

“I have an hour and a half to two hours if I'm meeting someone for the first time. But that two hours is about me learning about them but reciprocally them learning about me, the person that they're talking to. Who am I? Where am I from? Who do I belong to, that's ko wai koe korero. Ko wai koe, no hea koe? Which for me is absolutely important. And it's not until you start to unpack who they are, and that's without even sort of really getting to where they're from, it's huge. Ko wai koe? Can mean like I'm Mary Brown, but when I say, who are you, I want to know who your grandparents are, who your parents are, where they grew up. What do you remember about them? When you look in the mirror, who gave you your eyes, who gave you

your face, who gave you your hair? All of those things make up the person. And that's not discounting the fact that they've come here because they have a mental health disorder. This is about unpacking the person and how that person even got close to having a diagnosis. So, if you don't do the whānau, whanui stuff, and that's all packed into who are you well you're floundering." [P4]

This participant demonstrates the use of tikanga Māori by exploring the identity of a Māori tangata whaiora not from an individual stance but around their whakapapa and their collective identity which is also a component of kaupapa Māori research. P5 also described the importance of creating opportunities to make connections when thinking of Māori tangata whaiora and what may improve their treatment options for recovery.

The previous participants all talked about whakawhanaungatanga, and through their narratives suggested the value of sharing of information and being respectful towards each other, which again underpins kaupapa Māori practice.

Karakia is another form of connecting for Māori tangata whaiora, and participants have shared some Māori utilise karakia in their recovery process.

Karakia

Participants described particular cultural practices that they have found helpful and inclusive for Māori tangata whaiora when meeting and wanting to generate a feeling of ease.

"I guess you know if we were to go, or endeavour to re-introduce cultural traditions [of] pre-colonized Māori, it wouldn't they wouldn't necessarily

be welcome in the here and now, but I think there are indeed some practices that are absolutely imperative. So, I know for my own practice and from working with pukenga atawhai this is where karakia, for example, you know, is so meaningful and so important in terms of building trust and fostering the therapeutic alliance, it's invaluable without a doubt." [P3]

The importance of karakia was also described by this participant:

"A lot of tangata whaiora that I know that experience bipolar, especially when they're in hospital, karakia. Karakia appears to have a really calming effect for them and although still acutely unwell they seem to be able to respond to that. I'm not saying in all cases, but I'm saying in some cases it's what works for that Māori tangata whaiora." [P2]

Participants talked of a variety of pathways of being able to connect when working with Māori. Some spoke of utilising karakia as being instrumental in progressing Māori tangata whaiora in their recovery, which suggested participants were broadening their clinical gaze and actively looking at ways of making Māori feel safe in the assessment process.

Kai wairua

Another important aspect for Māori is being one with the land, which creates an environment for safety, as demonstrated by this narrative shared by one of the participants:

"A couple of guys that I work with that have bipolar, we went and picked some watercress and man did I get a wealth of information from them, because what it does it is reminiscent of what they use to do with their

grandfather or their parents. It's something that they can gather and maybe blanche in terms of having a feed of watercress for Monday through to Sunday. And obviously there's benefits for eating watercress, but it's kinda putting them in an environment where they're so relaxed that they just start opening up, and the thing is you're not doing it as a strict guide to review, you're doing it conversationally, that's the key." [P2]

The role of kai in Māori culture and healing was emphasized by another participant:

"Our service is very well resourced, and we have great staff including occupational therapists who will work with patients to progress them forward, and our occupational therapists are aware of the importance of food for Māori, and so we will have a boil up and invite family, in so that patients can spend time with their family as well as share food with them that they have prepared." [P6]

The ability to share kai is a ritual for Māori, and these participants have demonstrated the positive effects that can occur from this simple act. Additionally, kai is also used as a means of removing tapu and making it noa.

Tapu and noa

Tapu and noa were the health codes Māori followed prior to colonisation. These codes encompassed social conduct as well as political purposes for the purpose of keeping safe and avoiding harm. Whilst there are a variety of meanings, tapu is a force that touches many facets of Māori life. In its simplest meaning tapu means sacred, and noa means ordinary or safe.

During the interviews participants talked about their understanding of tapu and noa as demonstrated by the following narratives:

“Well there was one young man, and I got a really nasty vibe off him, you know, and I thought, oh, I wonder what’s going on with this guy. Anyhow we went through the powhiri process and I went to hongi him, and you know what, that vibe had gone, and I’m thinking we talk about the mate Māori, mata kite stuff, ah, and we talk about tipuna, tapu and noa. You know all of those things, and I’m thinking, my gosh it’s gone. Whatever I felt the first time I met this young man is gone. After we had done this process, and I’m thinking, argh well, it must be his tipuna who were there at the time. You know you hadn’t greeted my boy in the way he should be greeted and he was fine after that.” [P5]

Another participant shared:

“...if you’re talking to a Māori person that transgression of tapu is certainly something you could be working with.” [P4]

The level of understanding by these participants suggests there is an awareness of the value of implementing cultural perspectives when working with Māori tangata whaiora. Furthermore, they have demonstrated confidence in being able to work from a different value base from that in which they were brought up, as well from the way they were taught in their training.

Summary

This theme has discussed tikanga Māori values which have helped participants understand the significance of culture in the life of Māori tangata whaiora. Their

understanding, which has been demonstrated through their narratives, gives a strong indication of culturally appropriate and culturally sensitive practice being present in mental health services that are not kaupapa Māori based. However, this being said, the data is a reflection only of the areas the participants work in, and cannot be generalised to other services.

In the delivery of treatment, inclusion of Māori participants from NGOs as well as pukenga atawhai and kaimahi, along with Māori models of health, have contributed towards a more culturally appropriate environment as evidenced by the narratives shared by these participants. The use of kai wairua was discussed in the context of bringing together whānau and Māori tangata whaiora, as well as creating opportunities for discussion with participants.

Theme Three: Understanding the whānau context

This theme explores the importance of a collective identity of Māori tangata whaiora and their whānau or whoever they deem their whānau to be. Some Māori may be estranged from their whakapapa whānau, or live in different cities or countries, so have chosen other important people in their lives as their whānau.

Māori who are hospitalised can at times feel vulnerable and may require cultural support during this time. Participants discussed the importance of involving cultural experts in working collaboratively with Māori tangata whaiora and their whānau.

During the interview process the participants shared their perspectives and understandings of Māori tangata whaiora they care, for and also shared personal stories which demonstrated meanings around Māori contextual experiences.

“Working with Māori patients in general I’ve always learned that family are extremely important, and that culture is extremely important to people. So, it’s always involving family in their care and encouraging them to be there. It’s involving the patient and the family in each step.” [P6]

Participants identified that when working with Māori tangata whaiora and their whānau it is important to create an environment in which Māori are able to feel comfortable. This can include sharing information about themselves that they are comfortable in sharing, which demonstrates to Māori and their whānau that they are open in sharing their information with them.

“I talk about my whānau, I talk about my mokopuna, just because it keeps me real, it doesn’t put me in a place of being all authority.” [P4]

This participant demonstrated the importance of creating trust and building confidence, which can lead to positive experiences being shared by both whānau and clinicians. This suggests that being able to share important information, particularly about one’s own whānau and whakapapa, establishes an open communication and interest that creates common ground.

“I was talking to a friend of mine the other day and we were thinking about, what it was like on the marae when I was younger, and we were talking about some people who use to be there, and when he was describing the behaviour, he was basically saying, well, you know if these people were behaving like that, in European society then they would be admitted into a mental hospital because of the behaviour they exhibited. But because it was in a marae setting he seemed to feel that there was more of a sense of tolerance I suppose.”

And yeah, when he mentioned it, I thought you're right because everyone has their place on a marae. Not everyone has to be up on the paepae speaking, we also need people to be out the back helping cooking with the food, and some of the people that I remember who, you know, would probably, yeah were definitely diagnosed with having some kind of a mental disorder, they were able to function on a marae because it was ok for people, as long as they weren't hurting themselves or others. It was ok. We were kinda tolerant, you know, people might go into the corner and talk to themselves a wee bit, but, you know, as long as they weren't harming anyone else, that was fine. They could help set the table or something like that. You know, it didn't matter how small the task was as long as you had a task that contributed, you were part of the wider community environment, and that was ok." [P1]

This excerpt discusses the participant's understanding of the strength of collective identity within a whānau concept. They describe providing care that was not judgmental or belittling, and acknowledged the significance of the marae setting in the lives of some Māori.

Another participant emphasized the importance of whānau for Māori tangata whaiora in their treatment within mental health services, and shared:

"Some Māori people are disconnected from their family, and so, involving pukenga atawhai if they don't have family here. This is a loss and so that's why it's important to have pukenga atawhai that's sort of like a substitute family, but they also help patients reconnect which is a great part of their role.... Some people through attending the waiata group have been able to

build trust with the pukenga atawhai over time. Initially, I know one particular person didn't want anything to do with her family when she first came in, and over a year refused visits. But through the staff and the pukenga atawhai and through spending time with her she developed trust, and she eventually allowed the pukenga atawhai to make contact with her family, and so she now has visits from her family.” [P6]

The importance of the pukenga atawhai in establishing relationships with whānau was described by these participants, and demonstrated the collaborative partnerships between them in being effective for both Māori tangata whaiora and their whānau.

“I can't speak highly enough of the role of the pukenga atawhai just broaching a pathway, to kind of developing some sort of collaboration with the patient and their whānau. So again, from my experience you can't work with the individual in isolation, you have to involve the whānau as best as you can and even when they're estranged. This is why I call in the pukenga atawhai, to try and bridge the divisions....” [P3]

Another participant shared the importance of whānau in a broader context:

“The other thing that I probably haven't stressed too much is that the approach will often be about identifying not just the individual and working with them, but it's the individual and working with them and their extended family. And families really have a broader meaning than what it did in traditional Māori culture. So, it isn't necessarily just the extended family where there is the blood relationship. In today's world you know it is often thinking again. In the area where I work in people have often been

mistreated by their blood family, and abused in various ways to the point where they don't actually want to have anything to do with their blood family because that's actually been a component where it has exacerbated their un-wellness. Even in that environment, amongst those people, so they will sort of adopt friends maybe, or more distant relatives and refer to them as my Mum or my Uncle or my Aunty, but they might not necessarily be an Uncle or Aunty by blood, but it's by the fact that they've entered into a really close relationship with that person, and they trust them, and they get a positive, you know, positive sort of feeling from them. So, they're kind of a surrogate relative or family member." [P1]

Another participant suggested engaging with experts in hauora Māori for the benefit of Māori tangata whaiora:

"It's been my experience that those people who work with Māori and want to be genuine in their relationship with Māori will always engage with someone like myself or other clinicians so they have someone who can guide them in their practice." [P4]

These participants demonstrated the importance of whānau in the lives of Māori tangata whaiora experiencing bipolar disorder as well as being supported by pukenga atawhai and other Māori health workers. The participants discussed creative interventions they initiated that Māori were responsive to, and incorporated practices which were familiar to Māori tangata whaiora, creating opportunities for Māori to be able to relate and share information.

Summary

This last theme identified the importance of collective identity, which is a key component for many Māori, and has been demonstrated by the participants who shared their perspectives of working with Māori tangata whaiora. The specialised roles of pukenga atawhai in assisting participants when working with Māori were identified on numerous occasions as being highly valued.

Focus Groups

Introduction

This section presents results from two focus groups, one of six pukenga atawhai and the other of five clinicians. The focus groups were asked to respond to the question, “What is required to provide effective care to Māori with bipolar disorder?”

Discussion following outcome

The outcomes were presented to the focus groups once all scores were collated, which is one of the advantages of using nominal group technique. The outcome was clear and succinct with regards to what the participants felt was required for effective care for Māori tangata whaiora diagnosed with bipolar disorder.

The outcome of the focus groups as confirmed within this section revealed participants top responses from their ideas which demonstrates the value of cultural awareness and cultural knowledge in their clinical and cultural practices. The following table identifies the top five responses chosen from each of the focus groups (Table 4.10).

Table 4.4 Illustrates the top five responses identified within the focus groups

Pukenga atawhai	Clinicians
1. Whakawhanaungatanga	Whakawhanaungatanga/powhiri process
2. Powhiri Process	Effective treatment
3. Whakarongo	Identification based on cultural identity
4. Communication	Open to cultural diversity
5. Clear boundaries	Whakarongo

Pukenga atawhai focus group

In this focus group, 22 ideas were generated (Table 4.5) and the pukenga atawhai selected their top 11 (Table 4.6) with their five top choices (Table 4.7) being: whakawhanaungatanga, powhiri process, whakarongo, communication and clear boundaries. Once the results were available the participants spoke at length around their responses and their surprise that their choices, while selected individually were similar to those of their colleagues. They spoke about their choices being about Māoritanga, and recognised their roles as being culturally specific and culturally directed. The participants all recognised that the choices they made reflected the kaupapa of what they do in their working life as well as in their private lives.

Table 4.5 Ideas generated from the pukenga atawhai focus group

Focus group one: Pukenga atawhai – ideas generated

1. Whakawhanaungatanga – removing barriers
2. Engagement
3. Whakarongo – restating same questions/not being listened to
4. Whānau tautoko – importance of whānau being supported as well as Māori tangata whaiora
5. Roll with it – adapt to presentation of tangata whaiora
6. Powhiri process
 - hongī
 - ko wai to ingoa
 - ko wai te iwi
 - ko wai te waka
7. Relationship with whānau – connection
8. Matauranga
 - educating the whānau re community resources
 - educating clinicians how to work with Māori and their whanau
9. Communication
 - Māori tangata whaiora
 - whānau
 - clinician
 - pukenga atawhai role to ensure tangata whaiora understood responses or information shared by clinicians
 - not misinterpreting
10. Clear boundaries – re roles and responsibilities of pukenga atawhai and clinicians
11. Utilizing expertise and strengths of colleagues in CDHB, community, national influence

Table 4.5 Ideas generated from the pukenga atawhai focus group continued

Focus group one: Pukenga atawhai – ideas generated	
12.	Kai – after powhiri process
13.	Consistency in duty of care – pukenga atawhai, C/M and clinical team.
14.	Not personal – all involved in care (sometimes, when unwell, Māori tangata whaiora refuse to meet or engage)
15.	Discharge back to GP – normalizing life, working in collaboration with C/M – GP – independence
16.	Self-empowerment (being in control of their treatment) for Māori tangata whaiora – mana enhancing practice
17.	Allowing/accepting tangata whaiora in their current state
18.	Tangata whaiora – visual very powerful (connecting dots) Therapy/treatment – making it meaningful, understanding principles/process to apply in life
19.	Karakia – whakawatea (clears/prepares the way) – could be stressors, negative energy, focus on here and now. Shifting from clinical/sterile environment and creating a culturally safe place
20.	Discrimination – recognize Māori tangata whaiora and tino rangatiratanga
21.	Western models/white way not always the right way
22.	Māori tangata whaiora understanding and recognizing triggers/looking at interventions, strategies for relapse

Table 4.6 Individual ranking of ideas by pukenga atawhai focus group

*Ideas listed in
Table 4.5*

Participants A - F

	A	B	C	D	E	F
1.	10	11	10	09	10	10
2.		10	09			
3.		09	07	08	09	09
4.	08		08	04		08
5.						
6.	11		11	10	11	11
7.		06				
8.		05	05	07		07
9.	07	03	06	06	08	06
10.	06	08		05	07	05
11.			04	01		04
12.						
13.	05	02	03		04	02
14.			02			
15.						
16.	01	07	01	03	06	03
17.		01			03	
18.	03					
19.	09			11	02	
20.	04				05	
21.	02				01	01
22.		04		02		

Table 4.7 Collective ranking of ideas by order of importance from pukenga atawhai focus group

*Ideas listed
in table 4.5*

Participants A - F

	A	B	C	D	E	F	Total
1.	10	11	10	09	10	10	60
6.	11		11	10	11	11	54
3.		09	07	08	09	09	42
9.	07	03	06	06	08	06	36
10.	06	08		05	07	05	31
4.	08		08	04		08	28
8.		05	05	07		07	24
19.	09		11	02			22
16.	01	07	01	03	06	03	21
2.		10	09				19
13.	05	02	03		04	02	16

Whakawhanaungatanga was discussed by the participants in both focus groups as being instrumental in the process of establishing and maintaining relationships. The pukenga atawhai identified connection and engagement as important aspects in working with Māori and agreed the powhiri process can play a positive role in whakawhanaungatanga.

The participants acknowledged that traditionally Māori follow the powhiri process for any type of hui. The pukenga atawhai recognised the powhiri process as deriving from traditional custom that encompass karakia, waiata, whakatauki, korero and kai. Kaupapa Māori research is underpinned by important components of tikanga Māori, and the concepts identified by these participants resonate very strongly within Māori culture. The powhiri process is more of a structured hui with a variety of core tikanga Māori values. Participants from both focus groups thought barriers can be removed when Māori tangata whaiora are feeling safe.

Participants also confirmed the importance of clear boundaries when engaging with Māori tangata whaiora and their whānau. The participants spoke in the context of being clear about the roles of the different health professionals, stating this helped Māori tangata whaiora and their whānau in their understanding of what health professionals are able to provide in supporting them in the recovery process.

Whakarongo was ranked as one of the top five responses for both focus groups, with the participants sharing the importance this rates for Māori and their whānau. Participants identified Māori tangata whaiora and their whānau feeling frustrated with having to repeat themselves on multiple occasions with clinicians asking the same questions. Participants also recognised that whakarongo and good communication are essential in the engagement process with Māori tangata whaiora and their whānau.

Participants in the pukenga atawhai focus group affirmed that they work with Māori tangata whaiora and their whānau from a cultural perspective, stating their purpose is to ensure they support the mental stability of Māori tangata whaiora by offering support in any cultural capacity that may be required by others caring for Māori tangata whaiora.

Pukenga atawhai agreed that their attendance enhanced clinician engagement with Māori tangata whaiora in the context of Māori feeling safer and being able to express what may be occurring for them. Pukenga atawhai further suggested that when Māori tangata whaiora feel culturally supported in the knowledge there are those present with an understanding of their worldview, this can improve the engagement process.

Clinician focus group

In this focus group, as previously discussed 26 ideas were generated (Table 4.8) and further reduced to revise 14 responses (Table 4.9) and the clinicians selected their top

11 with their five top choices (Table 4.10) being whakawhanaungatanga /powhiri process, effective treatment, identification based on cultural identity, open to cultural diversity and whakarongo.

Table 4.8 Ideas generated from the clinicians focus group

Focus group two: Clinicians – initial list of generated ideas	
A	Identification based on cultural identity
B	Include whānau (ask patient)
C	Whakawhanaungatanga – building on relationships
D	Effective treatment – medication/psychotherapy
E	Information about illness, services to patient and whānau
F	Physical health, diet and exercise (tinana)
G	Alcohol and drugs
H	Hearing whānau stories (nil diagnosis to presentation)
I	Connection with culture, iwi and whānau
J	Accommodation status, financial status, active supports
K	Being supportive, not directive
L	Care of children
M	Being heard, being listened to, being present, time (spending time with patient and whānau)
N	Visiting, seeing, meeting in their own place environment
O	Balance of power
P	Sharing of information – where I am from and how long I have been in New Zealand
Q	Open to cultural diversity, tapu and noa, whakama (indigenous diagnosis)
R	Recognising person’s spirituality, spiritual beliefs
S	Utilise pukenga atawhai
T	Ask, invite Māori patient if they would like to utilise the powhiri process
U	Impact, effect of medications on Māori
V	Engagement
W	Planning where to go next/progression – wellness
X	Whānau focused and whānau driven
Y	Mana enhancement
Z	In-depth understanding of the Treaty of Waitangi – understanding from the clinician’s perspective and experience

Table 4.9 Ideas generated from the clinicians focus group (revised list)

Final revised list of ideas	
A	Identification based on cultural identity
C	<p>Include whānau (ask patient)</p> <p>Whakawhanaungatanga - building on relationships</p> <p>Hearing whānau stories (nil diagnosis to presentation)</p> <p>Connection with culture, iwi and whānau</p> <p>Sharing of information – where I am from and how long I have been in New Zealand</p> <p>Ask, invite Māori patient if they would like to utilise the powhiri process</p> <p>Engagement</p> <p>Whānau focused and whānau driven</p>
D	Effective treatment – medication/psychotherapy/physical health, diet and exercise (tinana)/alcohol and drugs
E	Information about illness, services to patient and whānau
J	Accommodation status, financial status, active supports
K	Being supportive, not directive
L	Care of children
M	Whakarongo - being heard, being listened to, being present, time (spending time with patient and whānau)
Q	Open to cultural diversity, tapu and noa, whakama (indigenous diagnosis)
R	Recognising person's spirituality, spiritual beliefs
S	Utilise pukenga atawhai
W	Planning where to next/progression - wellness
Y	Mana enhancement
Z	In-depth understanding of the Treaty of Waitangi – understanding from the clinician's perspective and experience

Table 4.10 Collective ranking of ideas by order of importance from the clinicians focus group

*Ideas listed
in table 4.9*

Participants A - E

	A	B	C	D	E	Total
C	7	7	7	6	5	32
D	6	4	3	2	6	21
A				7	7	14
M	2	5	5			12
Q		6		3	3	12
Y	3	1	6			10
Z	5			5		10
W	4	2		1	1	08
K		3	2		2	07
J	1				4	05
R			4			04
S				4		04
E			1			01

Whilst the participants spoke around their choices they were not surprised regarding the outcome, especially the importance of whakawhanaungatanga and the powhiri process. Participants shared the importance of the initial engagement process being dependent on their ability and interpersonal styles, further sharing this can have far reaching consequences for future engagements, which can either promote or hinder the pathway forward for Māori tangata whaiora and their whānau.

Participants shared that whakawhanaungatanga plays a vital part in the journey of recovery for Māori tangata whaiora, and those who experience bipolar disorder are at risk

of being unable to maintain relationships. Therefore, participants thought it is imperative for rapport to be established and maintained throughout all interactions of treatment planning and recovery for Māori tangata whaiora and their whānau. Furthermore, suggesting building a genuine relationship with Māori is an important component of whakawhanaungatanga.

The outcome, as discussed by the participants in the clinical focus group, suggests the importance of health professionals having an understanding of Māoritanga for the purpose of being able to work from a place of understanding which allows Māori tangata whaiora to be responsive. Furthermore, participants suggested the powhiri process allows opportunities for questions from the whānau and Māori tangata whaiora around bipolar disorder, which offers clinical participants the opportunity for expanded education around this disorder.

Participants talked about effective treatment options such as psychotherapy being utilised to improve medication adherence and helping with relapse for those diagnosed with bipolar disorder. However, they shared they were not aware of any cultural psychotherapeutic interventions that were specifically targeted at Māori diagnosed with bipolar disorder. They did however, comment that working from a kaupapa Māori framework teaches others the value of being inclusive, working collaboratively, and overall, caring for Māori tangata whaiora in a manner indicative of putting their needs and the needs of their whānau at the forefront.

The importance of correct identification of Māori tangata whaiora based on their cultural affiliation and understanding was considered by participants to be very significant, largely as this helped inform their ability to offer an appropriate treatment plan which

allowed the participants to integrate te ao Māori to ensure a culturally safe journey for Māori and their whānau.

Some participants, however, noted that not all Māori wish to identify with their cultural identity for a number of reasons, so the importance of asking Māori tangata whaiora about their connection or identity would seem to be a reasonable one. However, it was suggested by the participants that things can change for Māori during their hospitalisation and whilst out in the community, so it would be important to keep an awareness of the cultural identity aspect of Māori tangata whaiora throughout their treatment.

One of the key responses of the clinical focus group was the need to be open to cultural diversity, which encompasses tapu and noa, and includes whakama. The participants spoke to the importance these Māori components have for some Māori tangata whaiora, and acknowledged the need for understanding these concepts when working with Māori. Participants shared the value of understanding the implications of whakama as they suggested this could be a barrier for Māori tangata whaiora. The clinical focus group suggested engaging experts in tikanga Māori to help clinicians understand these concepts for Māori.

Individual interviews and focus group outcomes

The following table (4.11) demonstrates the outcomes from the individual interviews and focus groups and recognises the connection and similarities between the three groups. This emphasised the understanding the participants have of Māori tangata whaiora and furthermore indicates the participants believe around best effective interventions when working with Māori diagnosed with bipolar disorder.

Table 4.11 Illustrates the comparisons between the individual interviews and focus groups

Individual interviews	Pukenga atawhai	Clinicians
Importance of Māori worldview	Whakawhanaungatanga	Whakawhanaungatanga/ powhiri process
	Powhiri Process	Effective treatment
Tikanga Māori	Whakarongo	Identification based on cultural identity
	Communication	Open to cultural diversity, tapu and noa including whakama
Understanding the whānau context	Clear boundaries	Whakarongo

Summary

This chapter identified interventions that focus on Māori world view, interventions that incorporate tikanga Māori, and lastly interventions that involve whānau. Some clinical interventions suggested through the interviews were not standard western interventions, however, participants who work with Māori tangata whaiora have learned by first-hand experience what is effective as evidenced throughout this chapter.

Interventions discussed by participants included utilising the powhiri process which incorporated the three themes identified following analysis. Recognising this method as an option would create not only a process for Māori who connect with this kaupapa, but also demonstrate participants' understanding of the value of the powhiri process. Engaging with Māori outside of the usual environment and utilising nature as an intervention was

demonstrated as a strength in working effectively with Māori tangata whaiora. Furthermore, this also created an opportunity for discussion to flourish.

The focus groups top five ideas demonstrate a variety of ways of being effective when working with Māori tangata whaiora. These ideas offer opportunities for clinicians across the health and social sectors in being able to work in a manner which is not only effective for tangata whaiora but also promotes the importance of understanding Māori concepts.

Participants spoke quite knowledgably about a variety of cultural components within Māori tangata whaiora's life. These included whānau as a collective, the use of kapa haka, being able to korero in te reo, and engaging within a Māori environment with a means of connecting and feeling safe.

Throughout this chapter, narratives shared by participants have signified the role whānau play in the lives of Māori tangata whaiora. Whānau play a critical role in being strong foundations and support systems for Māori tangata whaiora, and this allows for a greater depth of intervention when including whānau in discussing treatment and recovery options.

The contribution from the participants and their shared knowledge has led to identifying key aspects in working with Māori tangata whaiora diagnosed with bipolar disorder.

CHAPTER FIVE: DISCUSSION

Introduction

This final chapter discusses the findings that emerged from the individual interviews and focus groups and relates these to the existing literature in relation to the research question: “What are the important characteristics of interventions for Māori with bipolar disorder according to clinicians and those knowledgeable in hauora Māori?”

This study identified that effective interventions for Māori with bipolar disorder need to incorporate te ao Māori, tikanga Māori and whānau. Furthermore, the process of providing these interventions were also identified as needing to incorporate the powhiri process, whakawhanaungatanga, Māori models of care, the identity of tangata whaiora, and open communication that requires whakarongo and clear boundaries.

These interventions and processes are discussed with a view to identifying and strengthening best clinical practice when working with Māori tangata whaiora, and improving pathways for Māori diagnosed with bipolar disorder.

Te ao Māori and the Western models of health

The findings from this study suggest that participants shared similar understanding of Māori needs, and recognised the value of engagement with Māori and their whānau in a therapeutic relationship. In 1995 Durie emphasised that Māori require connection when engaging with services and the importance of establishing a therapeutic relationship (Durie, 1995a), but the process of implementing this approach,

while generally approved and accepted (Te Rau Matatini, 2015b; Todd, 2010) has faced challenges.

Western models of health are now known to be less effective when applied to indigenous populations (Houkamau & Sibley, 2010; Jeffrey, 2005; Wratten-Stone, 2016) as these models do not take into consideration indigenous ways of being and knowing but are generally underpinned by Western ways of knowing and understanding (Chino & DeBruyn, 2006; Durie 2006, 2018).

Findings from this study support this lack of alignment between Western and indigenous models of health. Participants spoke explicitly about Māori experiencing tension between Western frameworks confirming that Western models do not meet the needs of Māori. Durie (2011) described Māori often experiencing disempowerment and alienation in a system underpinned by Western perspectives and Western clinicians. Participants acknowledged the need to consider options other than Western models of care, and spoke about these other models encompassing areas of wairua and being inclusive of whānau.

In Aotearoa, mainstream models of health do not fit for Māori tangata whaiora and can therefore work in conflict rather than working in partnership, which continues to create division and inequalities for Māori (Elers, 2014; Mark & Lyons, 2010). Both the literature (Bennett & Liu, 2018; Brannelly et al., 2013; Houkamau & Sibley, 2010) and the participants supported the current drive towards utilising and implementing Māori models of health when working with Māori, and research has demonstrated quite thoroughly how this can be done (Boulton, Gifford, Kauika, & Parata, 2011; McNeill, 2009; Pitama et al., 2014). However, this study confirms that adopting a Māori model of health in practice is largely dependent on the individual clinician and their cultural expertise in understanding te ao Māori. Participants also noted that

regardless of their own willingness to adopt a Māori model of health they were often constrained by the structure of their services they work within particularly the use of time and environment.

Clinicians are responsible for ensuring they work with Māori tangata whaiora in a manner that is conducive to their wellbeing and acknowledges te ao Māori. Although the literature finds that some clinicians struggle to work successfully with Māori (Crengle, Robinson, Ameratunga, Clark, & Raphael, 2012; Johnston & Read, 2000). The New Zealand participants in this study were reasonably confident about their ability to work in a culturally effective way, but at the same time recognised their limitations; one participant was comfortable calling a kaumatua when spiritual issues were identified.

The participants recognised the significance of te ao Māori, when working with Māori, and acknowledged the importance of applying key values from a Māori worldview to ensure support along the recovery pathway.

Tikanga Māori

Tikanga Māori practices such as tapu and noa are critical in understanding Māori views on behaviour. Participants discussed the concepts of tapu and noa and how these historical values continue to occur for some Māori tangata whaiora today. Durie (2018) suggests tapu and noa are no longer as instrumental within today's society as they use to be, but acknowledges they continue to be observed on a marae setting.

The breach of tapu was discussed by participants, who described the transgression of tapu being something that they could be working with as it can lead to manifestations of physical and mental illness. Participants discussed the importance

of being open to these cultural aspects, and of having kaumatua, pukenga atawhai or other cultural experts available to offer support in these matters.

The value of working collaboratively with cultural experts was another important finding in this study. All participants recognised the importance of offering safety in an unusual setting for Māori tangata whaiora to assist building rapport. The literature supports the intervention of collaboration between traditional healers and conventional psychiatrists to improve the care of Māori tangata whaiora (Dyall et al., 2014; Harmsworth, 2005; Kingi, 2006b; NiaNia et al., 2017).

Findings from this research highlighted the value of calling on pukenga atawhai and other cultural experts within the community in a variety of cultural situations, including being present, using karakia, being able to talk in te reo and helping explain to whānau the processes that their loved one was going through.

Some participants spoke about utilising a kaumatua, and one participant described contacting a kaumatua with the intention of working holistically with a Māori tangata whaiora, understanding that some of the manifestations that occurred for their patient were out of the realm of their practice, so called on a traditional healer in the belief that in this way they could appropriately support the patient they were caring for. Furthermore, this was not an isolated case in this study, as there were other examples of kaumatua being utilised to support clinicians in moving Māori tangata whaiora forward in the treatment of bipolar disorder.

This finding indicates the importance of clinicians being able to call on cultural experts, to access a depth of cultural understanding that could be lacking in a clinician. Given the collectivist view underpinning their willingness to collaborate tikanga

Māori, demonstrates the strength of working together as health professionals with the intention of promoting best practice when treating Māori.

In recent years the literature has supported working alongside clinicians when working with Māori however this is not a standard practice, although the use of traditional healers is included in some health services (Kingi, 2006b; Te Rau Matatini, 2015b). It is evident from this study that when combining expertise from a cultural perspective alongside a Western perspective, knowledge can be expanded, together with greater understanding of Māori.

Understanding the whānau context

The Māori health strategy – He Korowai Oranga recognises whānau as the foundation of Māori society (Ministry of Health, 2014a), and the participants in this study also acknowledged from their experience of Māori tangata whaiora coming from a collective perspective, and having their whānau give them strength at a time when they are feeling uncertain. Participants in this study discussed Māori tangata whaiora being estranged from their whānau, but having others they could call upon as their whānau, in times of need; Māori with similar interests have been known to be identified as whanau (Durie 1994; Kidd, Gibbons, Lawrenson, & Johnstone, 2010). Smith (1995) defines whānau as being a collective group of Māori who associate together based on common interests. The participants saw whānau as an integral part of the recovery phase of Māori tangata whaiora, particularly within discussions around information and diagnosis.

Communication and the process of providing interventions

Communication

Effective communication skills are a critical element of working with Māori, particularly as this improves relationships between the participants and tangata whaiora and their whānau (Te Pou o Te Whakaaro Nui, 2010). Participants believed communication, information sharing, connecting by fostering relationships and developing trust contributed towards improving health outcomes. They described communication as being critical for Māori tangata whaiora, many of whose experiences had not been positive initially. *Te Pou o Te Whakaaro Nui* (2010, p. 9) describe the link between communication and healing in Māori society:

The role of oratory healing in Māori society is well founded in the traditions of whānau and hapū. Oriori, karakia, mōteatea, waiata and tauparapara are all salient examples of how the use of the word has an active and meaningful role in supporting, protecting, informing and healing within Māori society.

Participants described the importance of communication to gain better insight and understanding of Māori tangata whaiora's values and beliefs. The participants described the engagement process and the importance of being authentic and genuine in engaging with Māori tangata whaiora. Specific processes of engaging that participants identified are discussed below.

Powhiri Process

Smith et al. (2016) describes the concept of powhiri process within a marae setting, with tangata whenua and manuhiri being two distinctly different groups, yet being able to merge as one group. As previously discussed the powhiri process is a

cultural practice that allows the exploration of groups, in this case clinicians and Māori tangata whaiora and their whānau, an opportunity to form a relationship that seeks to generate cohesion as well as identify the commonalities between the two groups (Durie, 2003b). For example, Māori tangata whaiora may have been admitted into hospital, often with their whānau in attendance, and the clinicians meet both tangata whaiora and their whānau. The powhiri process allows for the two groups to discuss their concerns, agree on effective treatment for the Māori tangata whaiora, and then identify commonalities in how they will manage and support the Māori tangata whaiora.

The powhiri process was approved by the participants as being traditionally the right way of doing things when meeting Māori tangata whaiora and their whānau for the first time. However, the powhiri process would need to be explored with Māori tangata whaiora first to ensure this is a practice they follow (Huriwai et al., 2001). Whilst most participants spoke about the value of the powhiri process in creating rapport with Māori and their whānau, they acknowledged that the traditional process of powhiri could be time consuming. Some participants suggested adapting some of these values and possibly reducing the time, so as to incorporate what Māori required without this process going over the time available.

Whakawhanaungatanga

Whakawhanaungatanga was a topic that was discussed consistently throughout the three groups. Participants described the role of engaging with tangata whaiora and their whānau as being of great importance, as this was the opportunity to form a connection that could solidify the therapeutic alliance, although participants acknowledged this was an ongoing journey.

It is well established that Māori respond differently from non-Māori, and to ensure Māori have the best opportunity to improving their health and reduce inequalities, clinicians need to know how to engage in the first instance. Participants agreed that there needed to be cultural practices that catered for Māori and they expressed being comfortable in self-disclosing information, which they believed helped in making a connection with whānau and tangata whaiora they worked with.

Lacey et al. (2011) support this view, describing whakawhanaungatanga as a step-up from building rapport. Whilst Lacey et al. (2011) acknowledge building rapport is important for all, they cite connecting on a personal level and drawing from clinicians' own knowledge of cultural aspects regarding tangata whaiora as important to improve the relationship between the two. Furthermore, Lacey et al. acknowledge the importance of clinicians sharing some form of appropriate self-disclosure as a means of connecting which in turn builds trust.

Māori Models of Care

More formal processes of providing interventions for Māori health are the various models of care that have been developed in recent years. The study participants identified a number of appropriate models of care for Māori mental health. This included holistic models of care which compliment te ao Māori. Working from a holistic framework and incorporating whānau, tinana, hinengaro and wairua supports Māori, which is the kaupapa that underpins Māori services and is consistent with their delivery of care (Abel, Gibson, Ehau, & Tipene-Leach, 2005; Boulton, Tamehana & Brannelly, 2013). Conversely, mainstream services work in their particular specialty, and whilst holistic models of care are available, not all services utilise this kaupapa. Yet evidence suggests success for Māori in their recovery is based on utilising

interventions underpinned by Māori worldviews (Durie, 2007; MacFarlane & MacFarlane, 2012; MOH, 2014a).

The participants all agreed Māori models of health were helpful when engaging with tangata whaiora and their whānau throughout their engagement, and particularly in the assessment phase. These models helped build rapport and contributed to formulating treatment and recovery plans for Māori tangata whaiora. However, it emerged from the individual interviews and focus groups that the participants were not aware of any psychosocial interventions that had been adapted specifically for Māori with bipolar disorder. However, as discussed in the literature review, research has been undertaken by Bennet (2009) describing modifications to CBT for Māori which demonstrated positive outcomes (Bennett, Flett & Babbage, 2016), although this was done on a small scale.

Many Māori models of health have been developed (Wratten-Stone, 2016) and it is argued that that these will be the way forward in Māori health, for example, the Meihana model (Pitama et al, 2007, 2014), Te Wheke (Pere, 1991), Te Pae Māhutonga (Durie, 1999) and Te Whare Tapa Wha model (Durie, 2011). Participants shared that while these frameworks are available to be utilised, they will only be as effective as the understanding of the health professional of the concepts that underpin the models. Additionally, the majority of participants agreed that they were less familiar with other models in comparison to Te Whare Tapa Wha model, created with the intention of providing a Māori perspective on health. This was one of the first Māori models of health to be supported and implemented within government services in Aotearoa, which gave Māori a distinctive voice in health care services (Durie, 2011).

Te Whare Tapu Wha model is a holistic Māori model of care, which is represented as a whareniui with four cornerstones of Māori health (Durie, 2011). These

are taha tinana, taha wairua, taha whanau and taha hinengaro which are all interrelated and rely on one another, suggesting if one is out of balance this then manifests itself in the form of an unstable state, such as poor health or disease (Durie, 2003a; Kumar et al., 2012). The participants acknowledged the importance of ensuring these areas were supported, and they were also aware of the influence one aspect has on the others.

Pitama et al. (2007) have used Te Whare Tapu Wha model as the foundation of developing the Meihana Model and, state that the Meihana model was created with the intention of providing guidelines for clinicians working with Māori (Cram, 2014). The Meihana model has now been updated (Pitama et al., 2014), following greater understanding around caring for Māori tangata whaiora and therefore suggesting changes to clinicians as well as wanting to influence change in improved history taking by clinicians' engagement with Māori tangata whaiora. The pukenga atawhai participants commented on utilising Te Wahre Tapa Wha model in their cultural practice, where other participants who were less familiar with Māori models of health relied on the expertise of cultural staff such as pukenga atawhai and kaimahi.

Identity

Participants spoke about the importance of recognising identity as a key aspect of te ao Māori, as it allows Māori tangata whaiora to distinguish who they are. However, some participants, whilst they agreed with this, were unsure how to identify whether individual Māori related to their cultural roots. Pitama et al. (2014) assert it should be common practice for clinicians to ask all patients what their ethnicity is, and if they confirm being Māori, then this should guarantee services being offered that are underpinned by a kaupapa Māori practice.

Māori identity has changed over time and continues to evolve following Māori life time experiences. There are familiar markers which can identify a Māori person, and these include knowledge of one's whakapapa, knowledge of matauranga Māori, speaking te reo and, for some, having ta moko as evidence of who they are. However, not all Māori subscribe to these markers. Durie (1995b) is well renowned for his statement about Māori living in diverse realities. Therefore, it is important as health professionals to have this awareness, but also to consider cultural heritage and identity as important factors when working with Māori (Hirini, 1997).

According to participants' responses in this study, Māori live in between a Western and Māori worldview and may be conflicted in their identity. Participants described the importance of supporting Māori tangata whaiora in exploring their whakapapa, with a view to being able to identify their Māori roots as a way of recovery.

Whakarongo

Another important attribute of intervention for Māori identified by the participants was whakarongo and the importance of participants listening to tangata whaiora and their whānau. Participants described Māori tangata whaiora feeling frustrated over having to tell their stories repeatedly, and this led the participants to identify whakarongo as an essential component when engaging with Māori. Participants in both the individual interviews and focus groups discuss Māori having to repeat themselves being a barrier to engagement, suggesting the importance of clinicians taking time to listen and communicate in an understandable manner to develop a therapeutic and effective partnership.

Another component of listening is allowing tangata whaiora the time to tell their stories, sharing who they are and what makes them one of a whole or collective. The Meihana model, which comprises of the hui process, allows for clinicians to enhance their relationship specifically with Māori, and encourages the process of making a connection by being open and inclusive (Pitama et al., 2007). The model was created with the intention of ensuring all clinicians have a framework they can use, to ensure cultural safety and cultural competence and improve recovery for Māori (Cram, 2014; Pitama et al., 2014).

Participants discussed the value of listening to tangata whaiora and acknowledged this was a positive way of hearing about who Māori tangata whaiora are as a person and as a collective within their whānau.

Boundaries

The nature of boundaries was another topic that required discussion, according to the participants, and they described the importance of Māori tangata whaiora knowing the roles and expectations of those supporting them as well as their own responsibility in working with clinicians towards recovery.

Matauranga Māori and tikanga Māori provide a framework to address issues in relation to boundaries. Matauranga Māori includes indigenous knowledge and philosophies of Māori (Ahuriri-Driscoll et al., 2012; Harmsworth & Awatere, 2013). Tikanga Māori reflects cultural values that continue to inform Māori in their everyday life (Durie, 2006; Kingi, 2005).

Boundaries were discussed by the participants in the context of Māori tangata whaiora and their whānau, having an awareness of what roles everyone plays within this integrative group of people, and working in collaboration for the purpose of best

recovery focused outcome. Furthermore, this awareness recognises that Māori tangata whaiora do not live in isolation, but continue to be a part of wider system, which is inclusive of others (Durie, 2011; Pitama et al., 2014).

Strengths and Limitations

This study provides critical information for clinicians working with Māori diagnosed with bipolar disorder. Although the sample size was small, the findings of the individual interviews (n=6) and focus groups (total n=11) are significant in the similarity of the participants' responses regardless of their group. One explanation for the consistency of the pukenga atawhai responses could be that the way they work is specifically underpinned by their cultural knowledge; however, this reasoning does not account for the responses from the clinician focus group and individual interviews, given the diversity of the participants.

The use of the DSM-5 in relation to Māori mental health can be questioned as the DSM-5 is based on Western concepts of mental health. Although the DSM-5 has a cultural section, this does not of course take into consideration the uniqueness of being Māori. Nonetheless, the DSM-5 remains the standard reference for the diagnosis and treatment of bipolar disorder, and is therefore important as a basis for considering how and why a Māori approach to treating bipolar disorder could or should differ.

Another potential limitation of this research could be seen in an expert Māori clinician, working in a kaupapa Māori service, being included with the clinician focus group. This inclusion could be seen as potentially influencing the outcome of the focus group, but could also be seen as a strength in being able to share knowledge around te ao Māori.

Utilising NGT as a form of analysis can be seen as a strength in being an effective method for obtaining group consensus; furthermore a modification was made to align with tikanga Māori, which is underpinned by a collectivist perspective rather than an individual perspective.

A further strength of this study was utilising kaupapa Māori research for the purpose of privileging Māori and promoting te ao Māori.

Implications of the present study

This study reinforces the importance of Māori tangata whaiora experiencing bipolar disorder deserving to have culturally competent clinicians capable of applying the interventions identified in this study. Furthermore, it is suggested that whilst there are a variety of cultural education courses for clinicians, it needs to be asked how clinicians' understanding of te ao Māori is measured, and how they are applying this knowledge in their clinical practice when working with Māori tangata whaiora diagnosed with bipolar disorder.

As this study explored the perspectives of clinicians and experts in hauora Māori, further research would be useful to explore whether the participants' views align with Māori tangata whaiora's experiences and perspectives. Additionally, this study could be replicated to include other communities in Aotearoa to see if other clinicians and experts in hauora Māori share the same perspectives of those who participated in this research.

Conclusion

This study has identified three major themes that participants saw as essential to successful interventions when working alongside Māori tangata whaiora. These themes are the importance of te ao Māori, tikanga Māori and understanding the whānau

context. These themes have been identified as key factors in being able to work effectively with Māori tangata whaiora diagnosed with bipolar disorder. The themes demonstrate the importance of acknowledging Māori in a way that is open to working in a culturally appropriate and culturally safe manner for Māori tangata whaiora.

Other significant findings that emerged from the data in this study clearly indicated the processes involved in providing effective interventions. These processes are:

1. Communicating in a manner which is transparent
2. Offering the powhiri process as a means of meeting for the first time if tangata whaiora are wanting this
3. Utilising whakawhanaungatanga throughout engagement from admission through to discharge
4. Implementing Māori models of care
5. Identifying tangata whaiora as Māori
6. Whakarongo, listening to the stories shared by Māori tangata whaiora and their whānau
7. Finally having clear boundaries where tangata whaiora are able to know what roles health professionals play in their recovery and an understanding of their role as Māori tangata whaiora in working alongside health professionals.

Throughout this study it was evident that effective interventions for Māori diagnosed with bipolar disorder need to be a reflection of who Māori are. One of the important factors that was reiterated throughout this study was identifying the importance of Māori tangata whaiora being asked if they are Māori. Once this was

established, participants were then able to offer interventions they could apply from a cultural perspective, which ensured a collective rather than individual recovery plan.

This study was commenced with the aim of finding out what interventions were most effective and best utilized for Māori tangata whaiora diagnosed with bipolar disorder. It is evident that the findings have far wider relevance and application for all clinicians working with Māori tangata whaiora. Use of the culturally appropriate approaches defined by the participants in this study offer the opportunity to reduce the mental and physical health inequalities seen in Māori population under the monocultural use of Western models of health.

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APPENDIX ONE

University of Otago Human Ethics Committee



15/141

Academic Services
Manager, Academic Committees, Mr Gary Witte

28 October 2015

Dr C Lacey
Department of Psychological Medicine (ChCh)
Terrace House, 4 Oxford Terrace
University of Otago, Christchurch
University of Otago Medical School

Dear Dr Lacey,

I am again writing to you concerning your proposal entitled "**Clinicians' Views of the Important Characteristics of Psychosocial Interventions for Maori with Bipolar Disorder**", Ethics Committee reference number **15/141**.

Thank you for your response of 23rd October 2015 addressing the issues raised by the Committee.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Professor R Porter Head Department of Psychological Medicine (ChCh)

APPENDIX TWO

Specialist Mental Health Service Research Committee

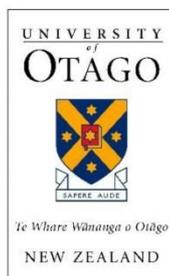
Canterbury District Health Board <small>Te Pōan Hauora o Waiata</small>	Specialist Mental Health Service Research Locality Assessment									
<p>Step one: Researcher to complete this section</p> <p> Researchers name: CASSANDRA STAPS Proposed timeframes Research title: PSYCHOSOCIAL INTERVENTIONS FOR MARI WITH BIPOLAR DISORDER Start: Sept 2015 Research location: Mostly in community but will include Māori clinicians employed by SMHS and Te Kōwhiri Completion: Aug 2017 </p> <p>Please attach proposal.</p> <p>Have you sought funding? No If so, from where?</p> <p>Are there any resource implications for SMHS (staffing or other costs)? If so, what? Interview times</p> <p>Is it your intention to publish any part of this research or findings?</p> <p>Is ethics approval required?</p> <ul style="list-style-type: none"> • If no, briefly state why? <input checked="" type="radio"/> If yes, has application been made for ethics approval? Attach copy of application. Does not require full Ethics Committee • If ethics approval has been given, attach copy of approval. <p>The researcher accepts accountability for ensuring that all ethical and/or regulatory obligations are met and that appropriate consultation is undertaken.</p> <p> Researcher's signature: N. Keane (for Cassandra Staps) Designation: PROFESSOR Date: SMHS </p>										
<p>Step two: Service Leadership Team member to complete this section</p> <p>SLT approves the research being undertaken and will monitor progress of the research. The proposal is recommended for approval.</p> <p> Chair's signature: [Signature] Name: Nerdy Lowerson Designation: ND Date: 11/10/2015 </p> <p>SLT is not appropriate for the monitoring function, the SMHS Research Committee will appoint an appropriate monitor.</p> <p>A scanned copy of this form and proposal is to be emailed to SMHS Research Committee now SMHSResearch@cdhb.health.nz</p>										
<p>Step three: SMHS Research Committee to complete this section</p> <p>Prior to approval, the SMHS Research Committee will consider the following:</p> <p>Vulnerable populations' rights are protected</p> <p>Privacy issues are identified and mitigated</p> <p>Health Information Privacy Code 1994 is adhered to</p> <p>Benefits and risks (including mitigations) are transparent and acceptable</p> <p>Resource implications for SMHS (staffing and other costs) are transparent and acceptable</p> <p>The proposed study meets generally accepted ethical standards</p> <p>The locality is suitability</p> <p>Local researcher has the ability to undertake the study</p> <p>SMHS Research Committee approves the proposal and recommends the General Manager approve.</p> <p> Chair of Research Committee signature: [Signature] Name: Cate Kearney Designation: SM Date: 11/10/2015 </p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="padding: 2px;">Yes/no</th> </tr> </thead> <tbody> <tr><td style="padding: 2px;">N/A</td></tr> <tr><td style="padding: 2px;">✓</td></tr> </tbody> </table>	Yes/no	N/A	✓	✓	✓	✓	✓	✓	✓
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<p>Step four: General Manager approves the research to commence.</p> <p> Name: S J Bigwood Signature: [Signature] Date: 11/10/2015 </p>										

APPENDIX THREE

Information Sheets

Application Form for ethical consideration of research and teaching proposals involving human participants

28 October 2015
Reference Number: **15/141**



WHAT ARE THE IMPORTANT CHARACTERISTICS OF PSYCHOSOCIAL INTERVENTIONS FOR MĀORI WITH BIPOLAR DISORDER, ACCORDING TO CLINICIANS AND THOSE KNOWLEDGEABLE IN HAUORA MĀORI?

INFORMATION SHEET FOR PARTICIPANTS.

Tena koe, you are invited to participate in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

This aim of this thesis is to identify psychosocial interventions that are culturally appropriate for Māori. This will involve interviews with clinicians and those knowledgeable in Hauora Māori to look at current practice and capture their experiences of working with Māori with bipolar disorder.

Participants will be asked to describe their experiences of psychosocial interventions that are effective in helping Māori and may lead to identifying what differences (if any) are evident when working with Māori to determine best treatment outcomes.

The aim of this project is to explore factors that Māori believe are important in the delivery of psychosocial therapies. This research intends to improve treatment outcomes for Māori by improving service delivery and raising awareness for clinicians who deliver treatment and psychosocial interventions to Māori.

This will involve the experts describing their experiences of psychosocial interventions that are effective in helping Māori and it is hoped that this thesis will also raise the profile of culturally appropriate and effective psychosocial interventions for Māori.

Application Form for ethical consideration of research and teaching proposals involving human participants

What Type of Participants are being sought?

Clinicians and others knowledgeable in Hauora Māori will be approached and invited to participate in this research project. Participants will be purposefully recruited based on their cultural and clinical expertise. There will be a contribution towards travel expenses for your participation.

It is envisioned that there will be between 16 and 25 participants involved within this study. Information received from the individual and group interviews will be used with the intention of improving delivery service which will impact on treatment outcomes for Māori.

Information gathered and collated will be available for participants to access if they wish, as a result from participating in this research study.

What will Participants be asked to do?

Should you agree to take part in this project?

We would like to interview clinicians and others knowledgeable in Hauora Māori with the intention of hearing your experiences around delivery of care to Māori specifically around psychosocial interventions. This will encompass individual interviews as well as include focus groups. Participants interviewed individually will meet with an interviewer and the interview will last for 30-45 minutes. Time, place and venue will be discussed to suit individuals. The focus groups will include two groups of cultural experts and one group of clinical experts in psychotherapy. The focus groups will be held at a time and in a venue which will allow for those outside of Otautahi to participate. Focus groups will last for 90 minutes and the interviewer will ask questions for the group to discuss.

Individual interviews will be completed first to create an opportunity to collate information and gather these into themes, which will then give an opportunity to generate pre-determined questions for the focus groups. Those who have participated in the individual interviews may be invited to attend the focus groups, however they can opt to decline further participation. The general line of questioning includes participants understanding of psychosocial interventions for Māori with bipolar disorder. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that you feel hesitant or uncomfortable you may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

When we meet, the interviewer will be available to answer questions and discuss the project. If you agree to participate you will be asked to sign a consent form. Furthermore we would like to record the interviews and focus group discussions, with your permission. The purpose for this is to ensure that we have captured responses accurately and are able to collate material into themes.

Application Form for ethical consideration of research and teaching proposals involving human participants

What Data or Information will be Collected and What Use will be Made of it?

The individual and group interviews will be audio recorded for the purpose of ensuring accurate information is gathered which will be reflected in the data and information collected. Demographic information will be requested which may include gender, age, years of experience, ethnicity and geographical area of work, however nil material will be used without your consent, which could identify you.

The only people who will have access to any material in relation to this research will be those personally involved who have been identified on this information sheet

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for **at least 5 years** in secure storage. Any personal information held on the participants [*such as contact details or audio tapes, after they have been transcribed etc,*] may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

Can Participants Change their Mind and Withdraw from the Project?

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Cassandra Staps

and/or

Cameron Lacey

Department of Psychological Medicine

Department of Psychological Medicine

and Māori Indigenous Health Institute

University Telephone Number: 03 372-0400

University Telephone Number: 03 372-0400

Email Address: cassandra.staps@otago.ac.nz

Email Address: cameron.lacey@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

APPENDIX FOUR

Research Questions

Research Questions

Thesis proposal question:

What are the important characteristics of psychosocial interventions for Māori with bipolar disorder according to clinicians and those knowledgeable in hauora Māori?

Individual interview questions:

What do you understand about mental health care needs of Māori with bipolar disorder?

What do you understand about bipolar and Māori?

What is your understanding of what Māori with bipolar disorder may need from psychosocial interventions?

What aspects of Māori culture could be integrated into psychosocial interventions for Māori with bipolar disorder?

Focus groups question:

What is required to provide effective care to Māori with bipolar disorder?

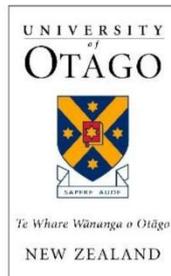
APPENDIX FIVE

Demographic Information

APPENDIX SIX
Informed Consent

Application Form for ethical consideration of research and teaching proposals involving human participants

28 October 2015
Reference Number: **15/141**



What are the important characteristics of psychosocial interventions for Māori with bipolar disorder, according to Clinicians and those knowledgeable in Hauora Māori?
CONSENT FORM FOR PARTICIPANTS

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. Personal identifying information e.g. audio recordings may be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least five years;
4. The results of the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand), but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.....
(Signature of participant)

.....
(Date)

.....
(Printed Name)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.