Te Pou
o Te Whakaaro Nui

HE RONGOĀ KEI TE KŌRERO

TALKING THERAPIES FOR MĀORI

Wise practice guide for mental health and addiction services

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Disclaimer

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HE RONGOĀ KEI TE KŌRERO

TALKING THERAPIES FOR MĀORI

Foreword

> Kei roto i tō tātou reo tētahi rongoā. Kei te āhua o te reo, kei te wairua o te reo. Mā tō tātou reo e mirimiri te wairua me te hinengaro.
>
> There is healing within our language. It is in the way we speak and the spirit in which it is spoken. Let us use our language to massage our spirit, our soul and our emotions.
>
> (Ngā Tikanga Tōtika, 2001 – Milne)

E ngā mana, e ngā reo, e ngā kārangaranga maha, tēnā koutou. Tēnā koutou i whai whakaaro ake ki te kaupapa "he rongoā kei te kōrero". E ai ki ngā kōrero tuku iho, "ko te kai a te rangatira he kōrero." Nō reira, tēnei ka mihi kau ake ki te reo kōrero o tētahi ki tētahi ki te whakaora i te tangata.

The importance of discussion, debate and examination of ideas and perspectives in Te Ao Māori is expressed in the proverb, "Ko te kai a te rangatira, he kōrero". There are pepeha and whakataukī that emphasise how interaction and communication play an important role in maintaining the mana of people, their whānau, hapū and iwi.

I greet and acknowledge all the mana, the languages and the multiple relationships of the people who are involved in talking therapies. I also greet the language that is spoken and unspoken, and that is used between people to assist in achieving well-being and whānau ora.

This guide is designed primarily to assist practitioners working in mental health and addiction services and has been developed to enhance talking therapies responsiveness to Māori. It is infused with practices and values from Te Ao Māori (ngā taonga tuku iho) that will assist Māori and their whānau to access and benefit from talking therapies.

Me mihi hoki ki a Te Pou o Te Whakaaro Nui, te hunga kawe i ngā whakaaro nui mō te oranga hinengaro, oranga wairua.

Nāku, nā

Moe Milne.

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I need to specially acknowledge the tāngata whaiora and their whānau, who gave freely of their time with a view of contributing to better services for Māori. To the Kaumātua who provided views for the greater wellness of Māori, me pēhea te kōrero mō tā koutou whakaruruhau i te oranga tangata.

Contributors interviewed came from the following organisations:

- Alcohol Advisory Council of New Zealand (ALAC)
- Community Alcohol and Drug Service (CADS)
- Department of Psychological Medicine, University of Otago, Christchurch
- Hauora Whanui – Tupuna Waiora services
- Kaumātua group, Midlands region
- MIHI – Māori and Indigenous Health Institute, Christchurch
- ProCare
- Te Waka Hauora Tāne, Christchurch
- Te Utuhina Manaakitanga Trust – community service
- Te Utuhina Manaakitanga Trust – residential service.

The following individual or collective contributions are acknowledged:

- Consumer consultant
- Independent Māori psychologists
- Kaumātua
- Māori members of New Zealand Association of Counsellors (NZAC)
- Tāngata whaiora and consumers
- Whānau.

Koia anō hoki tēnei te mihi ki te roopu taumata i tiaki pai mai i te kaupapa. E kore e mutu ngā mihi. To the experts who provided advice, kōrero and great insights for the project, I am ever humbled that these people, who are extremely busy, will always contribute to processes, in the hope that a difference will occur for Māori access to the best services. Only the roles relevant to this project have been highlighted, as this is a well-known, multi-talented group of people. Kia ora to:

- **Ana Sokratov** – consumer consultant, analyst
- **Dr Hinemoa Elder** – child psychiatrist
- **Dr Lisa Cherrington** – psychologist, narrative therapist for Māori children
- **Materoa Mar** – consultant, Māori director, innovator
- **Te Puea Winiata** – consultant, strategist, manager
- **Terry Huriwai** – advisor, Matua Raki (National Addiction Workforce Centre)
- **Tohe Ashby** – Tupuna Wai Ora, community counsellor, alcohol and other drugs, Kaumātua
- **Wayne Blissett** – consultant, report writer, general manager Te Roroa Iwi Trust.

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Executive summary

Talking therapies are used in a range of settings and by a diversity of practitioners, including those working in private practice, social services and corrections, as well as in mental health and addiction services. Talking therapies involve talking to someone who is trained to help explore thoughts and feelings, and the effect that these have on behaviour and mood. Understanding all this can support people to make and sustain changes, including assisting people to take greater control of their lives.

This guide has been prepared to actively support the mental health and addiction* workforce to enhance and sustain engagement in, and delivery of, talking therapies with Māori who access services as individuals or as whānau. The recent promotion of Whānau Ora further reinforces the importance of the collective nature of whānau and the necessity to view whānau as a whole, not as a set of individuals. This guide provides a range of Māori values and concepts, practices and principles that can be drawn on to work effectively within a whānau dynamic to assist in healing and well-being.

Access and engagement continue to be significant issues for Māori seeking support for mental health and addiction related-issues. The most recent research to highlight this is *Te Rau Hinengaro: The New Zealand mental health survey*[1], which reaffirmed the high burden of mental health issues for Māori. This guide has been developed as a commitment to lessening the burden of mental illness and addiction on Māori whānau and communities, through equipping practitioners to use talking therapies more effectively with Māori. The *Let's get real*[2] framework identifies the essential knowledge, skills and attitudes to deliver effective mental health and addiction services. One of the seven Real Skills is Working with Māori, which provides performance indicators for practitioners when engaging with Māori.

The medium of sound has important resonance in terms of oratory, healing and well-being in many indigenous cultures. The role of oratory in healing within Māori society is well founded in the traditions of whānau, hapū and iwi, which provide a sound and tested platform for the healing rhythms and patterns of care inherent in talking therapies.

The preparation of this guide demonstrated the significant contribution that talking therapies can make to the recovery journeys and well-being of Māori whānau. It has also illustrated that for talking therapies to make a meaningful contribution for Māori whānau, a number of core Māori values and practices must be integrated to enhance engagement, motivation, intervention and outcomes. These include such practices and concepts as manaaki, whakawhanaunga, awhi, wairua, mihimihi and mana.

* Addiction is a generic term used to denote both alcohol and other drug use, as well as problem gambling.

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E koekoe te tūī, e ketekete te kaka, e kūkū te kererū - there are many voices in the forest.

1. Introduction

Background

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. With this in mind, talking therapies are a natural fit, providing a modern approach to what was a traditional and familiar approach to healing.

This guide seeks to assist those working with Māori to develop that natural fit, as there are key approaches and practices that will assist talking therapies to fit Māori whānau appropriately. Without taking these considerations into practice practitioners may fail to deliver the healing potential of the therapy.

Engagement is a critical element to the success of any intervention with Māori whānau. Engagement consistently emerges as the single most important aspect in creating and sustaining interventions for change[3, 4, 5]. Central to engagement is the consideration of Māori values and dimensions of health and well-being.

Future mental health and addiction services in Aotearoa/New Zealand need to reflect a well-being framework. The recovery approach is a part of the well-being framework and will continue to be an important feature. Recovery is used in this document in its broadest sense to include the recovery of rangatira practices or the ability to self-determine. Recovery as part of a person's journey to well-being will often require a combination of biological, social, cultural, psychological and spiritual interventions.

The evidence continues to grow and there is increasing awareness of the effectiveness of talking therapies. It is essential that people who use mental health and addiction services have access to quality (effective) talking therapies. In response to requests for this access, Te Pou has produced a suite of reports that summarise sector feedback and strategies to enhance talking therapies in New Zealand (www.tepou.co.nz).

1. *We Need to Talk*[6] — examines commonly used talking therapies in Aotearoa/New Zealand mental health and addiction services. This report also identifies which therapies, if introduced more widely, could produce more positive change for those accessing this sector.
2. *We Now Need to Listen*[7] — summarises the issues raised during the feedback process for *We Need to Talk* and proposes a more formal consultation process.
3. *We Need to Act*[8] — provides a summary of the results from the feedback process, and information on a literature review that explored evidence for cognitive behavioural therapy, motivational interviewing and dialectical behavioural therapy. This report also outlines a framework for introducing talking therapies and recommends action points.
4. *Action Plan for Talking Therapies 2008 to 2011*[9] — describes the actions, timeframes and processes needed to increase the quality, sustainability and spread of talking therapies for users of mental health and addiction services in Aotearoa/New Zealand.

Te Pou has also produced *A Guide to Talking Therapies in New Zealand*[10], which provides information to tāngata whaiora and whānau about talking therapies available in Aotearoa/New Zealand*.

A key activity within the *Action Plan for Talking Therapies 2008 to 2011* has been the development of a suite of best and promising practice guides for staff delivering talking therapies to populations with specific needs. Talking therapies guides for working with older adults; Pasifika people; Asian people; refugees, asylum seekers and new migrants; and people who experience problematic substance use can be downloaded from the Te Pou website. This practice guide for mental health and addiction practitioners who use talking therapies with Māori completes the series.

Why are talking therapies important for Māori?

There are several critical reasons why talking therapy services for Māori need to work well. Māori as a population have a higher prevalence and severity of mental disorders than non-Māori. *Te Rau Hinengaro*[1] found that 52 per cent of Māori with serious disorders, 74 per cent of Māori with moderate disorders and 84 per cent of Māori with mild disorders had no contact with the health sector. *Te Rau Hinengaro*[1] also noted differing patterns of sources of referral and admission to mental health and addiction services; Māori were more likely to be hospitalised through a justice doorway, than a mental health or primary care entry point. The 2006/07 New Zealand Health Survey[11] found Māori were four times more likely to be problem gamblers than others in the community, but often contact was with primary care services. See Appendix A and B for further discussion about the health issues faced by Māori.

The Treaty of Waitangi requires the New Zealand government to protect the health and well-being of Māori, as well as to assist Māori to exercise authority in developing and delivering health improvement initiatives. The government also needs to ensure equity in access to health services and equity in health status for Māori[12]. Baxter[13] highlights the need to prioritise Māori mental health and

* This guide can be downloaded from the Te Pou website www.tepou.co.nz.

addiction, intervene earlier and focus on initiatives that lead to improvements in Māori services. Talking therapies are an example of such an initiative, which could lead to improved outcomes for Māori whānau.

Low uptake of mental health and addiction services by Māori may be associated with barriers to access and engagement that are directly related to Māori beliefs, perceptions and understandings of health and mental health[14]. There is still a strong view that illness may be related to spiritual factors, such as the breaching of tapu or transgressing kawa. It is suggested that these beliefs, coupled with past experiences of institutional racism and neglect in the health system, have led to a mistrust of the health system[15]. This presents challenges for mental health and addiction services to improve access and retention for Māori, and to develop a culturally competent and culturally safe workforce, with enhanced cultural fluency, who are able to sustain engagement and to generate trust that their services offer a healing environment.

A core development in response to this is the advent of Whānau Ora, which seeks to provide a delivery mechanism that embraces the whānau as a collective construct[16]. This guide includes explanations of whānau-centred practices, some key Māori beliefs and methods for engagement that can enhance engagement and build trust within a therapeutic relationship.

Purpose

This guide is intended to support the workforce to enhance and sustain engagement in, and delivery of, talking therapies with Māori. It identifies processes that enable effective uptake of talking therapies for Māori, and wise practices for delivering talking therapies. In particular, this guide identifies processes and approaches to assist Māori and non-Māori practitioners to develop and maintain effective therapeutic relationships with tāngata whaiora and whānau, and enhance the therapy process.

Let's get real[2] is a service-user-centred approach to develop the essential knowledge, skills and attitudes to deliver effective mental health and addiction services. Developed by the Ministry of Health, it identifies seven Real Skills that everyone working in mental health and addiction is expected to demonstrate, regardless of their role or occupation. One of these Real Skills is Working with Māori, which identifies a number of performance indicators that contribute to whānau ora. These indicators are te reo Māori, whakawhanaunga, hauora Māori, wairua, tuakiri tangata and manaaki. Throughout the development of this guide, these have emerged as key components to effective engagement and will be referred to within the guide in a number of different ways.

Rather than being a definitive set of guidelines, this resource is intended as a starting point for gathering together evidence of wise practice, for practitioners to consider when using talking therapies with Māori. It is intended as an adjunct to cultural training or training in specific talking therapies.

Target audience

This guide is aimed at both Māori and non-Māori practitioners who use talking therapies with Māori. This may include alcohol and other drug and problem gambling practitioners, general practitioners, occupational therapists, psychiatrists, psychologists, psychotherapists, registered nurses, social workers, family advisors, and others working in mental health and addiction services.

In addition the information in this guide will also have relevance for any practitioner working in mental health and addiction services who wants to build their cultural knowledge and skills to develop stronger engagement when working with Māori.

Development of the guide

Content for this guide was drawn from multiple sources, including consultation, expert opinion and current literature.

A literature review relating specifically to Māori, indigenous populations and talking therapies was carried out, exploring the research and trends in talking therapies for Māori whānau. The paucity of evidence-based research in this area creates complexity in ascertaining what approaches to therapy would be effective for Māori.

To mitigate this lack of evidence-based literature, the views and experiences of practitioners working with Māori whānau in the mental health and addiction field were sought. This included key information from tāngata whaiora and whānau as to their experiences of talking therapies and mental health and addiction services. Care was taken to ensure that the participants covered a fair sample across Kaumātua and whānau, as well as across professional groupings.

Given that this resource is for all staff in mental health and addiction services, care was taken to ensure that Māori and non-Māori experiences were integrated into the guide. In addition, an expert group of Māori health professionals steered the development and production of this guide.

It is worth noting that the consultation with tāngata whaiora and whānau suggested that Māori present to mental health and addiction services late and usually in acute phases, and therefore are often not referred to talking therapies. It was also noted that youth accessing child and adolescent mental health services were more often responded to with talking therapies, when compared with adults accessing mental health and addiction services. A greater consultation sample group would have further increased the strength of the evidence related to these observations.

Traditional Māori wisdom, knowledge and processes can significantly contribute to improving uptake and effective delivery of talking therapies. Therefore, these have been woven through and integrated into this guide.

In summary, this guide is based on informed practice elicited from practitioners and tāngata whaiora within mental health and addiction services, traditional knowledge and experience of Māori practitioners, expert opinion from related literature, and evidence-based research where available.

"How come no one told me about counselling? I've been in and out of mental health services for 12 years and I never had this counselling until now. Why isn't it offered to all tāngata whaiora? This is the best thing that ever happened for me."

- Female tangata whaiora, currently happily married and in full-time employment

Cultural world views for Māori

Māori world views hold unique elements that are specific to the environment and sociological structures of an indigenous people. As tāngata whenua, the structures of whānau and communities (hapū and iwi) are unique to Aotearoa. The role of hapū and iwi in defining and creating these unique structures cannot be underestimated. This is most often reflected in kawa, or the structural rules that alter from hapū to hapū. There are, however, principles and values that are consistent throughout te iwi Māori. This section provides a brief overview of some of these universal principles and values, as the platform for effective engagement with Māori as individuals or within whānau groupings. For further discussion of these key Māori principles and values, and how they can be applied to enhance engagement with tāngata whaiora, see Section 2.

Cultural identity

Cultural identity has been described as a prerequisite for the good health of indigenous people, while poor mental health can stem from an insecure cultural identity[17]. Traditionally, Māori identity was determined by whakapapa (genealogy). This identity was regarded as part of tikanga, a wider set of protocols and customs.

A positive identity requires participation in positive Māori institutions and media, such as kapa haka, Māori sports team, and involvement with marae. The use of te reo Māori, and exposure to Māori music and culture, are also effective contributors to positive identity and self-view. For further discussion, refer to page 23 of this guide.

"Since I have been coming to the Te Reo Programme, I've become more sociable. It gives me a different side to whanaungatanga, and builds a positive sense of self and others"[31] (p. 9).

Tikanga (customs and traditions)

The understanding and recognition of mātauranga Māori (Māori values, knowledge, culture and world view) is essential for the effective provision of services to Māori. Many of the core values, beliefs and practices associated with these world views are recognised as having an adaptive integrity that is as valid for today's generation as it was for generations past[18].

Wairua (spirituality)

Knowledge is obtained from the relationship that Māori have with wider systems: not only through their relationship with inner feelings, or thoughts, but also their interconnected relationships between human experience, extended family and the surrounding elements in the world, such as the sky and the land[19]. All things have spirit, thus wairua embraces the connection to the land, to whānau and to Ngā Atua. The spiritual body and physical body are joined by mauri, making wairua an essential element in healing and recovery. A core commitment is to ensure that wairua is actively included in any assessment processes and therapeutic interventions[20].

Whakawhanaunga (relationships, kinship and connection)

Whakawhanaunga concerns itself with the process of establishing and maintaining links and relationships with others. It is key in developing the therapeutic alliance (a significant predictor of treatment success, irrespective of a range of factors, including the type of treatment provided[21]), as well in promoting inter-sectorial and multi-systems approaches and collaborations. Sharing and exploring whakapapa is one method of establishing a connection[22]. For further discussion, refer to page 34 of this guide.

Māori models of health and practices

Existing Māori models of health and treatment continue to refine and evolve. Identifying and articulating specific Māori healing processes and outcomes has been integral to Māori attempts to improve health care over the past three decades. Often described as holistic, Māori health perspectives characteristically integrate mind, body and spirit within a context of social collectivity.

Customary Māori health placed individual well-being in the context of the individual's whānau and hapū, and as dependent on the balance of a number of dimensions. Models of contemporary Māori health, such as Te Wheke[23, 24] and Te Whare Tapa Whā[15] emphasise balance across a number of personal (including family), environmental (including community), cultural and spiritual dimensions.

Māori descriptions of wellness usually include a sense of identity and self-esteem as Māori, confidence and pride, spiritual awareness, personal responsibility, knowledge of te reo Māori and tikanga Māori, and whānau support[15]. Reductionist Western models have historically separated these areas. Concepts of identity and health have tended to be based on individual autonomy and often the crucial element of wairua is ignored by Western approaches. This can lead to disengagement, and the inability of practitioners to sustain recovery with a whānau[20].

There is emerging evidence that, for Māori, successful models of engagement and intervention are based in Māori cultural world views and processes[25].

The Working with Māori Real Skill identifies the importance of understanding Māori models or perspectives of hauora in service delivery. For practitioners, it identifies the importance of incorporating these models and perspectives in practice, and of using interventions that optimise physical, social, cultural, spiritual and mental aspects of health.

The following models provide examples of a consistent structure and framework. The core principles from these models can be integrated into a talking therapy intervention, to assist in creating an environment for increased engagement and duration of care for Māori whānau. Despite the current pervasiveness of these and other models of practice and of health, the degree of integration and sophistication of their application varies greatly from service to service, and from practitioner to practitioner.

Te Whare Tapa Whā[15]

The first side is taha wairua (spirituality). The second side is known as taha hinengaro (mental health), and the third side is identified as taha tinana (physical health). The fourth side is called taha whānau (family), which identifies the relevance of support networks and a sense of belonging. This side is also noted for being related conceptually to experiencing a sense of purpose[15]. Together, the four sides ensure strength and balance, with each side offering a distinct contribution.

Te Wheke[23]

Te Wheke (the octopus) stems from the education sector, but has been applied in health and social services. Visually, the eight intertwining tentacles represent the relationship between the different dimensions of health, while the body and the head represent the family unit. The eight tentacles are wairuatanga (spirituality), hinengaro (mental health), tinana (the physical side), whanaungatanga (family), mana ake (uniqueness), mauri (vitality), hā a koro mā, a kui mā (cultural heritage), and whatumanawa (emotions).

Meihana Model[26]

The Meihana Model is an assessment and educative framework, which encompasses the four original cornerstones of Te Whare Tapa Whā (wairua, tinana, hinengaro, whānau) and inserts two additional elements:

- taiao, or physical environment (e.g. warmth of their house, access to amenities, service environment)
- iwi katoa, or wider societal context (e.g. societal values, laws and beliefs about appropriate behaviour).

These elements are then placed in the context of individual Māori beliefs, values and experiences. The use of Māori beliefs, values and experiences is not to define and constrict Māori service users or whānau on a continuum or spectrum of Māori-ness, but rather to view Māori as diverse and multidimensional. Exploring an individual's beliefs, values and experiences encourages more in-depth discussion of presenting concerns which, in turn, reveals more about tāngata whaiora and whānau history.

Other models

Process-oriented frameworks, such as Pōwhiri Poutama[27], the Rangi Matrix, Dynamics of Whanaungatanga[28], Mauri Ora[29] and Paiheretia[30] have addressed the dynamic nature of therapeutic and related learning processes. These models allow for, and take greater consideration of, the variables that contribute to the processes of attaining well-being. There are many other Māori models that are relevant to particular hapū and iwi.

Stigma

The question of whether stigma related to mental health and addiction is more prevalent in Māori communities, compared with non-Māori communities has received little attention in the literature.

In a study undertaken by PHARMAC[31] examining the impact of, and barriers to, the use of antipsychotic medication by Māori, it emerged (through interviews with tāngata whaiora and whānau) that there remains some stigma for tāngata whaiora in Māori communities. This study indicated that the mental health literacy of Māori whānau differed from that of the non-Māori population. There are still significant pockets of Māori communities that do not understand mental health issues well. This has been identified as contributing to the stigma that tāngata whaiora experience within Māori communities.

"My whānau thought they might catch it – whānau education is crucial to making a change for us...because if whānau don't understand, they judge you...often wrongly"[31] (p. 6).

A number of the people consulted for this guide identified racism and stigma as key reasons why tāngata whaiora would not seek to access intervention earlier or follow a treatment regime. The system is viewed by some Māori as racist and medical. Stigma towards the system is theorised as being a key barrier to Māori accessing mental health and addiction services[31].

> I was becoming unwell so I rang the crisis team, I was being proactive I thought, next thing there are 3 police cars outside to come and take me away. I guess because I have a history, but that was then and this is now, when this happens you get worried what's going to happen to you, so you try and do it yourself rather than getting help[31] (p. 9).

The role of stigma for Māori is further emphasised by Deane, Skogstard and Williams[32] who identified that negative perceptions of mental health services can act as a barrier to Māori accessing treatment. This study found that "Māori prison inmates had significantly more negative attitudes toward seeking professional psychological help, and were less likely to seek help for suicidal thoughts than those in the European/Pākehā group"[32] (p. 229).

It is important that practitioners acknowledge stigma as a potential barrier to access and participation in care, and create an environment where the tangata whaiora and whānau feel safe to discuss their anxieties and other issues. This includes the ability of practitioners to use strategies to challenge stigma and discrimination, one of the seven Real Skills in the *Let's get real*[2] framework.

Stigma associated with mental health issues is experienced across the Māori community. Kaumātua have discussed the stigma that they experience, both from the system and within the community. A salient example that was identified through the consultation process was the lack of grief counselling. One Kaumātua identified that when his wife of 53 years died and the tangi was over, he was still lonely and desperate to be with his wife, was struggling to cope and needed grief counselling, yet was unable to access it for himself due to his stress and grief. This is a clear example where a talking therapy could have provided a sound and safe process of recovery from the grief and depression being experienced.

In addition, a number of older Kaumātua identified that they no longer attended functions at the marae, because it was assumed that they would pick up the Kaumātua role. However, as age and physical impairments occurred, they no longer had either the confidence or, necessarily, the ability to undertake the cultural duties, but were whakamā to discuss their limitations and impairments.

National evidence

There is a paucity of research that investigates the effectiveness of talking therapies for Māori. While some authors have identified potential general limitations of counselling or therapy when working with Māori[18-20, 33-34, 49], cognitive behavioural therapy is the only specific therapy that has been empirically investigated[25, 33, 34].

Research by Bennett and colleagues[25, 33] and Cargo[34] identified potential cultural limitations when using cognitive behavioural therapy with tāngata whaiora. These limitations primarily stem from the differences in cultural world views between cognitive behavioural therapy and te ao Māori: an individualistic versus socio-centric conception of self, and an emphasis on science versus spirituality[19, 49].

Bennett's[25] study generated specific guidelines for how to adapt cognitive behavioural therapy to include values and world views of Māori. Participants in his study expressed high levels of satisfaction with the adapted therapy, and experienced substantial decreases in the severity of their post-treatment depressive symptoms. However, the study's design meant that generalisability is limited. See page 39 in Section 3 for further discussion.

Apart from Bennett's study, the remaining literature presents expert opinion on aspects of Māori culture that need to be incorporated into therapy in order to be effective for Māori. Key points from the literature include:

- the importance of bicultural therapy (the combination of both westernised and kaupapa Māori health models)
- inclusion of culturally appropriate values, such as whanaungatanga (relationships), whakamanawa (encouragement) and mauri (spirit)[19]
- use of traditional Māori mythology[18]
- maintaining awareness of the diversity of cultural identity among Māori, and avoiding use of cultural checklists or of generalising cultural needs and wants[3].

Another strong theme in the literature is the importance of fostering strong cultural identity, both for Māori adults and tamariki. It is noted that, "although there is neither a single Māori identity prototype, nor any universal desire by Māori to embrace all aspects of Māori culture, the notion was presented that a negative or confused cultural identity is in itself a mental health problem"[17] (p. 51).

International evidence

International literature was drawn from research with indigenous populations. These included Aboriginal Australian, Canadian Inuit, and First Nation people and Native American populations. Although research on specific talking therapies among these populations is limited, a number of papers have been published on indigenous world views and their implications for Western counselling methods. Key issues discussed are differing cultural identities[35], exclusion of spirituality[36] and the importance of understanding family dynamics[37].

Research by Painter and Scannapieco[38] provided evidence of multisystemic therapy's effectiveness across cultural, socioeconomic and racial groups. This therapy was found to improve the mental health of ethnic minority youth living in multi-problem families, at an equal rate to non-indigenous children. Reductions in the families' problems were also observed. There is also evidence to support cross-cultural application of motivational interviewing[39, 40]. However, this research highlighted the importance of understanding differences in cultural norms when assessing motivation and relapse prevention plans[40]. Research into indigenous family therapy also emphasised the need to incorporate culturally sensitive practices and expectations into therapy, and hold an understanding of the political and cultural context of parenting[37].

Narrative therapy was identified as a useful way for indigenous people to express their values and world views, which may align well with Māori oratory cultural traditions. "The telling of stories to inform, educate and learn draws on rich traditional Aboriginal oral ways, indicating a strong cultural connection already exists between narrative therapy practices and Indigenous Australians"[41] (p. 71).

Spirituality and holistic world views are common themes discussed in the indigenous literature. Spirituality is identified as a significant contributor to indigenous mental health[35, 36, 42, 43, 44]. International literature also acknowledges the effect of colonisation on indigenous people's mental health. A study by Warner[45] investigated the effect of forced assimilation, historic distrust, and diversity among Native Americans, and how it can negatively affect treatment outcomes. Warner's findings supported homogeneous group therapy among Native Americans, as opposed to heterogeneous group therapy, as shared client experiences enhanced therapy outcomes. Bucharski, Reutter and Ogilvie[35] also emphasises the need to consider the effects of colonisation, by suggesting that both the historical and current context need to be sensitively addressed when working with Aboriginal women.

Overall, the international indigenous literature reflects similar concepts and values to those that have been identified in New Zealand-based literature as important for Māori health and well-being. Concepts such as spirituality, the effects of cultural assimilation, the importance of family and a strong connection to the environment are common among indigenous cultures. An acute awareness of these concepts and values is essential if practitioners are to effectively engage and sustain a therapeutic relationship with Māori whānau when delivering talking therapies.

Gaps in knowledge and evidence base

While some literature is dedicated to how therapy can be most effective for Māori[18, 19, 20, 46, 47], current discussion relies on expert opinion in the absence of empirical research. Possible directions for future research include building on Bennett's work relating to the adaptation of cognitive behavioural therapy for Māori[25, 33]. Other promising therapies, indicated to have application for indigenous cultures, such as multisystemic therapy[38], family therapy[37], motivational interviewing[39] and narrative therapy[41], could also be investigated. Investigation of talking therapies in te reo Māori, rather than adapting Western-developed models of therapy for work with Māori, is also an option.

'Wai' by Teresa Reihana

Water can be a powerful metaphor but it is also grounded in Māori reality. There is healing power in water.

2. Principles of engagement

Engagement – general

Engagement is the critical element to success in any intervention with Māori as individuals or as whānau. Engagement and the quality of the therapeutic relationship consistently emerge as the most important aspects in creating and sustaining interventions for change[3, 4, 5]. Central to engagement is the consideration of Māori values and dimensions of health and well-being. This section will discuss ways that practitioners can demonstrate responsiveness, to assist with engaging Māori tāngata whaiora, by drawing from Māori world view concepts and values.

> When I was mainstream, all they did was check my medication, make sure I was sleeping and eating, at [...] they have got me into mirimiri (therapeutic massage), got my whānau involved with Kapa Haka and that, much better in Māori Mental Health because they consider all my taha[31] (p. 12).

Key barriers for Māori accessing and engaging with health services have been summarised as follows[48]:

- costs of care – for example ability to, and cost of, travel
- communication – overly technical
- structural – for example, distance to travel, waiting time, time restricted appointments
- cultural issues – different kaupapa, stereotypes and assumptions, lack of respect and understanding of Māori values, discourage whānau support in consultation.

A two-fold approach needs to be taken to improve the responsiveness of mental health and addiction services when working with Māori[49, 50]. That is, to continue to develop kaupapa Māori services, particularly through training more Māori health professionals, utilise Māori models of health and well-being, and also train non-Māori to be more responsive to Māori. While this training or education is not likely to enable a non-Māori practitioner to operate from a Māori-centred base, it will assist the practitioner in establishing a therapeutic relationship.

It is vital that mental health and addiction practitioners demonstrate strong cultural capability and cultural competence (integration of cultural and clinical elements in practice). This is clearly stated in the 2002 revised *Code of Ethics for Psychologists Working in Aotearoa/New Zealand*[51], which stipulates that psychologists should be informed of the implications of the Treaty of Waitangi, including the principles of protection, participation and partnership with Māori.

In addition, the code states that both non-Māori and Māori psychologists should seek advice and training to demonstrate appropriate ways of showing respect for the dignity and needs of Māori. A study by Robertson[52] reported that many Māori

> "A Māori male came in for a session. He was referred by Probation. When I began with a mihimihi he snorted and said "I don't want that Māori stuff". However he allowed me to continue to 'practise' my mihi, then I told him it was his turn. On learning that he was Ngati Whatua I pointed to a picture of a marae on my wall and told him it was a Ngati Whatua marae. He walked around to look closer at the picture and said "Hey Bro, that's my marae". That changed the way our counselling sessions and his engagement began. He attended all of his allocated sessions."
>
> *- Male Pākehā clinician*

are willing to engage with non-Māori practitioners and treatment modalities, provided they are responsive to Māori needs and aspirations.

While this guide provides some guidelines for how practitioners can foster engagement when working with Māori, it is not intended to be a substitute for cultural competency training, which practitioners should seek out.

The *Takarangi Competency Framework*[53] and *Huarahi Whakatū*[54] are examples of practitioner competency frameworks that outline clear steps to understanding and integrating Māori values and beliefs into therapeutic practice. The *Takarangi Competency Framework* extends the Working with Māori Real Skill outlined in *Let's get real* and has also been utilised by non-Māori wanting to further develop their cultural competency skills. Information on the *Takarangi Competency Framework* can be downloaded from the Matua Raki website, www.matuaraki.org.nz.

Cultural competency is an expectation under the Health Practitioners Competence Assurance Act 2003. Within the DSM IV framework, it was considered that all practitioners should be conducting cultural formulation, not only to make their assessments more relevant, but also to inform their processes of engagement, options for interventions and therapeutic alliance.

The *Let's get real*[2] Working with Māori learning modules provide a useful resource to support people working in mental health and addiction to demonstrate the knowledge, skills and attitudes that promote safe and effective therapeutic relationships with Māori whānau, at an essential, practitioner and leader level. These modules assist people to learn some of the basics in te reo Māori, as well as simple karakia for the commencement and completion of the therapy sessions. They include a pēpeha (connection) framework to assist with initial introductions, as well as other information that provides a basic understanding of how to effectively engage and form a relationship with Māori whānau. These modules are designed for self-directed learning and can be accessed from www.tepou.co.nz

"There should be far more training around Māori issues and treaty training. There seems to be a complacency around treaty training and I think this training was extremely useful for me as a practitioner in working with Māori."

- Female non-Māori clinician

Western psychology and Māori world views

As a practitioner, perhaps the first key step to becoming culturally capable when working with Māori is to recognise how some Western concepts that form the basis for therapies used within New Zealand can conflict with Māori world views. To form the therapeutic alliance, practitioners firstly need to examine their own personal assumptions and recognise that their own culture can impact on that of their client (cultural safety).

A study by Elder[55] found that the clinical training of some Māori doctors and psychiatrists did not match ways of working that emerged from their own Māori cultural identity. This incongruence between Western mental health training and their own cultural identity was also reported by Māori psychologists[49, 56].

> Western psychology needs to develop a greater understanding of the nature of Māori models of self, of health and of counselling...the language of psychology – did not adequately express my experience as a Māori woman...I could not construct a coherent account of myself, my whānau, community, and culture through the language of psychology[49] (p. 17).

One key way that Western culture differs from the Māori world view is the independence versus interdependence construct. For example, Māori may view personal assertion of one's individual rights as a sign of immaturity or even irrationality. Instead, interdependence may be viewed as an indicator of healthy social functioning for Māori[3].

It is important to recognise that Māori are not a homogenous group, and individual values, beliefs and ways of seeing the world will differ among Māori. Applying a culturally appropriate assessment framework is important to try to identify the cultural inputs required for each individual (see page 29 for a discussion on approaches to cultural assessment). This will ensure that the most appropriate interventions are drawn on for individual tāngata whaiora at different stages of treatment[3]. To apply these interventions, practitioners need to be aware of key Māori world views and how they may differ from Western models.

"My recovery is about my hinengaro/mind, tinana/body, wairua/spirit and whānau/family. My treatment seems to be only about my tinana with pills and injections"[31] (p. 9).

Importance of positive cultural identity

"Good mental health depends on many factors, but among indigenous peoples the world over, cultural identity is considered to be a critical prerequisite" [17] (p. 14).

Durie[30] explains that possessing a strong cultural identity goes beyond knowing one's tribe or ancestry, it requires access to the cultural, social and economic resources of te ao Māori (the Māori world). Language, family networks and access to customary land underlie cultural identity and reinforce mental health. To support his point, Durie[30] cites the household study Te Hoe Nuku Roa, which is tracking Māori households over a 10-year period. Preliminary results suggest that two-thirds of the Māori households have limited access to Māori resources, such as language and land, and where access is lowest, poor health and lower educational achievement is more likely. In contrast, the study suggested that where access to Māori resources is assured, health is best.

Another study that illustrates the power of cultural identity was undertaken by Huriwai, Sellman, Sullivan and Pōtiki[57]. Māori who received culturally aligned alcohol and other drug treatment were more likely to be satisfied with their treatment and remained in treatment longer than those in services where a Māori component was not explicitly promoted. Most of the tāngata whaiora sampled in this study considered it important that services meet cultural needs as part of the recovery process[57]. It was observed that even those Māori in the sample who seemed to be disconnected from their whānau and tribal roots, and were therefore less connected in terms of belonging to iwi, still considered these things (pride in being Māori and identifying as Māori) important to recovery. Secure Māori cultural identity also reduces the risk of suicide attempts among Māori youth[58].

This research suggests that mental health and addiction practitioners need to apply a holistic approach when working with Māori that stretches beyond the individual to consider cultural, social and economic dynamics. This is recognised in the Māori model for mental health promotion, Te Pae Mahutonga. Te Pae Mahutonga maps four

"There is an assumption that psychology as we learn and know it, is the right way. There is no questioning of does it work for Māori? Or what needs to be done differently to make it work for Māori. I think that potentially any of these therapies could be done differently through the acknowledgement and application of Tikanga Māori."

- Māori psychologist

key foundations of health and two key capacities to realise these (Māori leadership and autonomy), which are essential to include in recovery focussed interventions, such as talking therapy. Durie[17] explains the four foundations as follows.

- Mauri ora: cultural identity and access to the Māori world. Facilitate access to language and knowledge, culture and cultural institutions, sites of heritage, and indigenous networks, especially whānau and community.
- Waiora: environmental protection. Similar to all indigenous cultures, Māori have a close association between people and their land. Health is compromised with pollution, exploitation of land or where access to traditional sites is barred.
- Toiora: healthy lifestyles. Māori people have their own perspective of what health means.
- Whaiora: participation in society. Good health requires Māori to be able to actively participate in the economy, education, health services, modern technologies, incomes and decision-making.

It is important to recognise that some of these contextual factors are beyond a talking therapist's ability to influence. However, when working with Māori, understanding cultural identity means looking beyond ideographic or behavioural presentation, intellect and emotions. Attention also needs to be paid to broader concepts, including the mind-body connection, whānau, spirituality, connection to the land, cultural resources and participation in the community.

The Working with Māori Real Skill includes tuakiri tangata, which acknowledges the importance of identity as Māori to the recovery of tāngata whaiora and the process of whānau ora. Practitioners need to be aware of kaupapa Māori interventions, and support tāngata whaiora's and their whānau's choice to engage in Māori-responsive services and activities that optimise cultural linkages and whānau connectedness.

'Identity' by Teresa Reihana

Tuakiri Tangata embraces all those things that make up identity including whakapapa, connectedness to the whenua, tikanga.

Core Māori beliefs, values and experiences

This section provides an overview of some of the fundamental Māori beliefs, values and experiences that underpin Māori mental health and addiction. These should be considered by practitioners during the delivery of talking therapies.

These core concepts are recognised in the Working with Māori Real Skill as essential to contributing to whānau ora for Māori. All people working in mental health and addiction services need to acknowledge and incorporate whakawhanaunga, wairua and manaaki into their practice.

Awhi(na)

For Māori, helping (or support) is a shared action, where the whole whānau takes part and there is an implicit understanding that people will do whatever they can. As a tangata whaiora's family member explains in Herbert's[59] study on marae-based parenting, "everyone holds on to the baby. You pick them up" and "instead of (just) a cup of tea, you get a meal" (p. 64).

Wairua (spirituality)

The Māori belief is that spirituality is indivisible from mental and physical health. Māori counsellors surveyed by Love[49] suggested that the spiritual aspect was significant to mental health presentation, regardless of whether the tangata whaiora was aware of it. Consequently, they saw it as a professional and ethical imperative to protect and seek guidance from the wairua dimension.

> "We start with the wairua first, then the hinengaro, then tinana, the healing of whakapapa and then deal with the trauma, whereas these others, they start with the trauma first and may or may not deal with the wairua, hinengaro, tinana and whakapapa. There should be recognition of healing the wairua first, then the mind"[60] (p. 19).

The counsellors interviewed by Love[49] did not see themselves as experts in the spiritual realm. Instead, they saw their role as being able to recognise when wairua problems were evident, and link the tangata whaiora with people and services that could provide ongoing spiritual sustenance. Sometimes this additional spiritual expertise may be able to be provided by the mental health and addiction service's Māori cultural advisor. On other occasions, a tohunga (traditional specialist) or Māori clergy may be engaged. The Bicultural Therapy Project is an example of a programme developed in a mental health and addiction service that facilitated cooperative management with Māori community providers[3].

The wairua realm can be acknowledged through use of karakia (clearing spiritual pathways) at the beginning and end of the therapy session. The therapist should check with the tangata whaiora, rather than assuming that karakia will be used. However, it can be a helpful method to enable Māori to feel more comfortable with the therapeutic process. It is important that the karakia process is treated with respect and consideration, given the importance of the process to whānau. Those practitioners who are not familiar or confident with karakia may ask the tangata whaiora if they would like to start the session with a karakia or have someone involved who could fulfil that role. This is a key reason for providing tāngata whaiora with the option of having support people present, or for the practitioner to have a co-worker to support the whānau. If the tangata whaiora would like a karakia,

but is not confident to undertake it themselves, the practitioner can offer to read one with the tangata whaiora. The most important aspect is that there is support and encouragement for karakia to be used in an honest and meaningful way to support the tangata whaiora and whānau in their preference.

An integral spiritual dimension for healing is mauri. This is seen as the life force from the gods that all living things have. In terms of Whānau Ora, whakaoho mauri is often a key task, with the empowerment of whānau to be able to sustain that mauri (building resilience). As one tangata whaiora explains:

"It feels as if my whole Mauri has been jarred and shaken. It is like my Wairua and my tinana are in a state of shock. Can this psychology help to reinstate my mana and my Mauri?"[60] (p. 13).

Durie[19] suggests that practitioners have a duty to put people in touch with their mauri. One way to achieve this is to connect the tangata whaiora with their whānau and tribal origins. Initially, the focus is not on "What is your problem?", but instead it is on "Who are you?".

Whakawhanaunga (connectedness)

This is about establishing relationships, through linking the practitioner and the tangata whaiora to form the therapeutic alliance where healing can occur, and to achieve this link by honouring the relationships between whānau, iwi and hapū[12]. The practitioner needs to understand that the Māori tangata whaiora's sense of self may well be shaped by who they are in connection with others. Therefore, rapport needs to be established through taking the time to make the links. A Māori practitioner in Elder's[55] study explains this:

> But it (whakawhanaunga) wasn't only encouraged in the Māori Mental Health Team – it was expected. And that was part of who you are and who your whānau are and who your ancestors were… and people would say 'now we can place you – now we know who you are – now we can get on with the clinical bit, but if you didn't do the other part properly first, you never really got to the clinical bit[55] (p. 201).

Durie and Hermansson[19] also explain that another way of establishing this connectedness is to work with the family first, as they will often have the relevant background. Whānau is seen as integral to the well-being of Māori and older people are held in high regard. When working with Māori, practitioners may often be negotiating treatment with the tangata whaiora's entire family. Acknowledging the importance of other family members and accommodating their views may be essential to providing the best possible outcome for tāngata whaiora[33].

Kaumātua kōrero has consistently expressed their understanding that whakapapa and intimate knowledge of whānau supersedes any privacy and confidentiality issues. This intimate knowledge is based on the relationships and skills of the whānau who need to be a part of the healing process. Without the support of the whānau this healing will be more difficult and complex. This is a clear example of how whakawhanaunga in action may be quite different to Western notions of ethics and boundaries in the privacy and confidentiality domain.

While clinical practice requires that individual confidentiality takes priority in clinical settings, it is important that any tensions around this are managed carefully.

This can be done by talking through the issues with the tangata whaiora, with the aim of reaching a point where the people involved in the issues can be informed and involved as required. When appropriate, a hui can be arranged to form a consensus about how the tensions should be managed.

Whatumanawa (open expression of emotions)

Love[49] identified whatumanawa as a key concept to emerge from her research with Māori counsellors, where they talked about the importance of feeling deeply emotional and sometimes crying. This was seen as a connection to the wairua and an emotion that the counsellor could share with the person.

"I said to her, "it's fine to cry. It's also fine for me to cry with you". I said "It's good. It's tikanga Māori. We cry together"[49] (p. 375).

Service delivery considerations

The initial session

Know the tangata whaiora's name before first contact. It is important to ensure that your pronunciation is correct, as this helps build rapport and could be considered one of the single greatest ways to show your respect for tāngata whaiora[48]. Practitioners who are not sure about pronunciation should ask first, rather than guess, as this shows recognition of the importance of names in the Māori culture. Also, take the time to clearly introduce yourself and any others who will be involved in the tangata whaiora's treatment. Remember, interpersonal connections are vital to the Māori world view.

The Māori tradition is to identify oneself through one's family and connections. At the first meeting, this establishment of connections may occur through a mihimihi – a structured process of introduction, which may include pepeha, whakapapa, and familial and tribal connections. Or it may occur more informally, such as by having whānau members present. It may also be a process of establishing roles and creating a safe space. Take care to identify the tangata whaiora's preferences in regards to the type of introduction they require. A key consideration in this process is the ability for the practitioner to acknowledge any cultural or ethnic differences, and ensure the exploration of any cultural issues that may impact on the therapeutic relationship.

It is important also that the physical environment creates links to a Māori world view. Having Māori art work, photographs and other cultural resources assists to make links that are centred around comfort and familiarity.

The focus of the first session is about establishing links. It is a conversation about who the person is, rather than what the problems are. "A desirable level of trust may need to be established before a Māori client is willing to disclose information regarding their Māori identity, this may not necessarily occur in the first interview"[3] (p. 14).

It is useful to begin subsequent meetings with a discussion about how the whānau is, as this acknowledges the central importance of whānau to tangata whaiora well-being and sense of self[48]. Once the connection has been established, it is also important to provide a clear explanation of the therapeutic approach, through

> "I realised we weren't getting Māori into our programmes. So I enrolled in te reo classes primarily to pronounce Māori clients' names correctly. I participated in a Hau Ora Day and introduced myself and our programmes to people at the marae. As a result our programme now has a Māori advisor and Kaumātua that we can access for advice and training."
>
> *- Female non-Māori clinician*

providing an agenda, process and purpose for each session. This provides a clear structure and pathway for the tangata whaiora and whānau to understand the why and how of the therapeutic process.

Communication style

Many Māori have a natural desire to seek consensus. For the sake of harmony, while they may not necessarily agree, they may defer to the mental health practitioner who is seen as the expert[14].

"We don't make a noise, it's just not our way. We just sit there and just grin and bear it. It's just not our way to make a fuss, to formalise it, to challenge something"[14] (p. 47).

This can result in the tangata whaiora not following a treatment plan. Therefore it is important to be careful to check for agreement[14, 48]. Another reason for lack of adherence to treatment plans could be because the whānau may not fully understand why a therapy is being used and what the goals are. Take the time to clearly explain the reasons for treatment and continue to check for shared understanding at points throughout the therapeutic process.

Use open-ended questions to actively gather this feedback. Whānau members may also be able to identify the tangata whaiora's degree of understanding of, and support for, treatment[48].

Body language can differ between Māori and non-Māori. While Māori may prefer face-to-face meetings, as opposed to phone or email communications, prolonged eye contact is to be avoided. "Māori often say that "we listen with our ears, not our eyes" [48] (p. 21). Sustained direct eye contact can signal conflict or disrespect. Also, if there are more than two people involved in the conversation, sustained eye contact can exclude the ones not speaking. Also remember that, while lack of eye contact may be a sign of respect, it may be due to other factors such as anxiety, boredom or anger. You will need to attend to other cues to discriminate[48].

Te reo Māori

"Māori language is the basis of Māori culture and is considered a gift from the ancestors...Māori place great emphasis on the spoken word, with words often viewed as links among the past, present and future"[48] (p. 17).

The Working with Māori Real Skill identifies that it is essential to recognise that tāngata whaiora may consider waiata, karakia and te reo Māori as contributors to their recovery. It recognises that te reo Māori speakers may need to be used and that information written in both English and Māori is available when appropriate.

Non-Māori practitioners will benefit from learning some basic te reo Māori to assist their pronunciation of names and understanding of key concepts[48]. It is also important to quickly ascertain the tangata whaiora's familiarity with te reo Māori. For some who feel dissociated from things Māori, a practitioner speaking confidently in Māori, even if only a greeting, might generate feelings of shame.

Taking therapy out of the clinic

Many Māori have a deep connection to the land or sea, and reconnecting them with these elements is one way to foster positive cultural identity. In addition, complementing talking therapies with physical activity, such as a short game of soccer, can increase tāngata whaiora's motivation to actively participate, particularly for younger people. The Māori counsellors in Love's[49] study highlighted the therapeutic value of conducting therapy outside at times, in the natural environment, rather than always meeting in the service's buildings.

The physical environment provides a sound and safe, neutral setting for therapeutic interaction. Links to atua Māori, hapū histories and use of the available natural resources provide the opportunity for externalisation, with a familiar and comfortable set of resources.

Some processes, such as tangihanga, might be more powerful if conducted at the relevant urupā. Undergoing such activity might require time and planning, and a key part of such a process may be karakia.

Cultural support

Key to improving engagement is ensuring that practitioners can draw on cultural support services when needed. Cultural support has been used by a number of organisations to create a safe and supportive environment, particularly for the initial or introductory sessions and assessments. This cultural support is available in a number of different ways, ranging from cultural workers attending clinical and therapeutic appointments with whānau, through to Kaumātua supporting whānau through the entire therapeutic process. Seeking and creating opportunities for cultural support for whānau within the therapeutic process can enhance the opportunities for positive engagement.

Be guided by the individual

As previously mentioned in this guide, it is very important to treat every tangata whaiora as a unique person who may or may not share the same beliefs, values and experiences as other Māori. While it is important to be aware of common Māori world views and how you can accommodate your practice to incorporate them, it is equally important to be guided by the individual tangata whaiora and their whānau. It is essential that a cultural assessment framework is used to inform the practitioner's intervention pathway and develop a person-focused treatment approach.

Principles of engagement – summary

- Provide a process for sharing connectedness.
- Mihimihi and whakatau provides an ethical process that allows for the sharing of belonging and connections between you as a practitioner and the whānau.
- Use te reo as much as possible.
- Take time to learn how to pronounce the names of whānau in advance.
- Convey compassion and genuine care.
- Maintain a structured interview. The pōwhiri process provides a sound framework for maintaining an interview that has a format and structure that are familiar and safe for Māori whānau.
- Ensure that there is a definite beginning, middle and end through the use of karakia or whakatauki.
- Ensure that you speak with the entire whānau, not only the individual referred. The whānau is the best mechanism of sustaining care and intervention.
- Use multiple resources, such as pictures and kinaesthetic tools, to support whānau participation and engagement.
- The physical environment provides a safe and secure ground where the wairua is free to connect with the physical environment.
- Ensure you have access to sound cultural supervision where you can discuss your challenges and successes.
- Cultural training and advice are essential to support you.

Engagement – assessment issues

Current practice indicates that effective intervention for people accessing mental health and addiction services is heavily reliant on accurate assessment and formulation of the presenting issues. For Māori whānau, effective intervention requires sound engagement. The Māori models discussed in the previous section point to the importance of engagement through the processes of whakawhanaunga. This requires that practitioners engage with Māori whānau beyond static questions, to create familiarity and evoke a sense of comfort, hope and respect through mutual connections.

Although it is recognised that comprehensive assessment should include consideration of, and responsiveness to, cultural variables[61-64], the degree to which such factors are considered, and the depth of analysis given to these, varies. It has been suggested that mental health professionals, including those in the alcohol and other drug sector, have moved "from active neglect to benign accommodation" in terms of attending to cultural issues[65]. In reality, this means that only lip service is being paid to culturally related considerations in assessing and managing a range of problems.

Limitations of psychometrics

> The sociological literature is full of studies which show how physical and psychological signs and symptoms are interpreted very differently according to cultural and religious factors, social class, ethnicity, gender and social networks in which people live. That means that what one individual or group defines as being ill or healthy may be very different from the definitions of others, even though the signs and symptoms may appear to be similar[66] (p. 27).

The mental health and addiction assessments commonly used in Aotearoa/New Zealand have often been developed in Western countries. They are unlikely to possess Māori normative data to compare results with. This poses a risk, as the Māori population may differ significantly in their presentation and understanding of mental health and addiction issues, when compared to other populations in Aotearoa/New Zealand. The main risk frequently identified in the literature[26, 66, 67] is that these psychometric assessments do not ask the questions required to gain a full assessment of a Māori person's mental health. As one Māori illustrates in Milne's[60] study, "The Pākehā methodology of psychology is having the right questions to ask...and in between are the gaps. These gaps are the ones that can Awhi (help) the people"[60] (p. 13).

Assessment with Māori needs to explore the cultural and spiritual factors associated with the problem, such as the tinana, whānau, wairua and other key concepts identified as vital to Māori identity and well-being. Without assessment of these broader factors, misdiagnosis and mistreatment is a risk.

The four components of cultural formulation currently promoted in the Ministry of Health Coexisting Problems Initiative are: cultural identity; pertinent cultural factors (idioms of distress, models of problem and well-being); intercultural elements (including factors affecting responsiveness); and social environment and functioning (includes elements of connectedness). These components are well-expressed and explained in *Te Ariari o te Oranga*[68].

Hua Oranga

Hua Oranga was developed by Kingi and Durie[66] and is a consumer-focused holistic outcome measure that determines Māori tangata whaiora responses to assessment and treatment. It is not a stand-alone tool, instead it is to be used alongside other mental health and addiction measures. Hua Oranga moves beyond a simple focus on symptom relief, to a focus on re-establishing dimensions of well-being.

The outcome measure gathers the perspectives of three groups: clinical staff, the tangata whaiora and the whānau, at different stages of the assessment and treatment process. In the Hua Oranga model the following dimensions are assessed.

Wairua – disparate and individual perceptions of wairuatanga. Considers aspects of wellness that are often nondescript and intangible. Four dimensions to measure outcome: dignity and respect / cultural identity / personal contentment / spirituality (non-physical presence).

Hinengaro – related to thoughts, feelings and subsequent behaviours. Four dimensions to measure outcome: motivation / cognition and behaviour / management of emotions and thinking / understanding.

Tinana – it is inconsistent to isolate mental well-being from physical well-being, or to deliver psychological therapies without considering physical health. Four dimensions to measure outcome: mobility and pain / opportunity for enhanced health / mind and body links / physical health status.

Whānau – measures the quality of the relationship between the client and whānau across four dimensions: communication / relationships / mutuality / social participation[66] (p. 35).

Involving whānau

The *Let's get real* Working with Families/Whānau Real Skill highlights that families/whānau need to be encouraged and supported to participate in the recovery of tāngata whaiora. Families/whānau, including the children of tāngata whaiora, must also have access to information, education and support.

The importance of involving whānau in Māori tāngata whaiora's care has already been stated extensively throughout this guide. This is because Māori often define themselves in relation to their whānau, with an individual's mental health intrinsically connected with his or her familial links. Consequently, whānau will often see it as their responsibility to take care of their members' health needs, and therefore require close involvement in all aspects of the service user's assessment and treatment programme[48].

Whānau involvement needs to discussed up front with the tangata whaiora, remembering that each individual may have different preferences. Given that whānau is so interwoven with Māori concepts of well-being and identity, if a tangata whaiora prefers not to involve their whānau, the practitioner should take care to explore this. A number of complex issues could be present, and sometimes it is about discussing, "Under what circumstances could we start to involve your whānau, and who might be the first members we start to include?" In other situations, some of the whānau can be part of perpetuating the difficulties. A core aspect of the therapy is holding this tension and negotiating with the tangata whaiora how they wish to proceed. As noted in the Huriwai[57] study, even when Māori seem to be disconnected from their families and tribal roots, they still considered these things to be important to recovery. Therefore, part of the therapeutic work may involve strengthening familial connections.

O'Connor and MacFarlane[18] suggest that genograms (pictorial displays of a person's family relationships) can be a useful tool to facilitate conversations about whakapapa and whānau. When working with Māori, traditional genograms can be extended to include cultural variables, such as ancestral ethnicity, migration, acculturation, spiritual orientations, ancestral land and socioeconomic status. Use of a three generational genogram with this cultural overlay can provide a wealth of information to guide therapeutic conversations. In addition, Māori's valuing of stories can be drawn upon through this work, where tāngata whaiora can be encouraged to tell stories about the character of relevant ancestors or whānau members.

Conversations about whakapapa can also reveal the roles, responsibilities and purpose of the service user in relation to others[49]. Each whānau member holds a specific function within their whānau, which it is important for the practitioner to understand. The *Let's get real* Working with Māori learning module explains some of these familial roles and responsibilities. This can be downloaded from the Te Pou website: www.tepou.co.nz. Additional information can be sought from cultural advisors.

A key role within the whānau is performed by a Kaumātua, or a knowledgeable whānau member when a Kaumātua is not available. A Kaumātua may speak on behalf of the whānau or iwi. Kaumātua resolve conflict, carry the culture and nurture younger people. Involving Kaumātua in the therapeutic process, particularly at decision-making points, may be important.

Whānau Ora

Over the past decade, Whānau Ora has emerged as a unifying concept in Māori mental health, where whānau is a key component of Māori identity and the healing process[16]. Whānau Ora is about building whānau capability and supporting Māori families to achieve their maximum health and well-being (toiora)[14]. It is the vertical and horizontal integration of services to whānau, which aims to revitalise and rejuvenate whānau (whakaoho Mauri) to take ownership of their own health and well-being.

The Whānau Ora[16] perspective:

- centres on a strengths-based approach
- ensures the individual and the whānau are being enabled to participate in the treatment and care planning processes
- means that practice is underpinned by 'Ngā kaupapa tuku iho
- includes care plan review processes that incorporate celebration of individual and whānau successes (whakangahau)
- encourages the building of relevant and effective networks in Māori communities (whakawhanaunga)
- enables effective assessment that considers the entire whānau system, not only the individual (Aro Matawai).

It is believed that this new approach will lead to better outcomes for whānau[16] and is a suggested model of social service delivery given its strong focus on tikanga Māori.

Support of community

The *Let's get real* Working within communities Real Skill highlights the need to recognise that tāngata whaiora and their whānau and families are part of a wider community, and that tāngata whaiora must be supported to develop or maintain connections with their community. For tāngata whaiora community can include a wider network of support structures, such as hapū, iwi and Māori communities.

Finding ways to engage the community to support the tangata whaiora's recovery journey has been identified as a fundamental pathway to good health. There are significant disparities between Māori and non-Māori in society participation measures[69]. Durie[69] highlights that marginalisation can lead to trapped lifestyles involving drug use, violence and poor mental health. Therefore, tāngata whaiora participation in society is required to promote good outcomes, and needs to be considered when delivering talking therapies. During later stages of therapy, it is important to look for opportunities to enhance tāngata whaiora's participation in the economy, education, health services, modern technologies and decision-making. Linking the tangata whaiora with relevant community resources is an important part of this therapeutic approach. Within Whānau Ora this activity is described as navigating whānau to the right doors. Key opportunities may include involvement in kapa haka, sports teams, te reo classes and linking in with a local marae. An important community resource to draw upon could be Māori healers or tohunga.

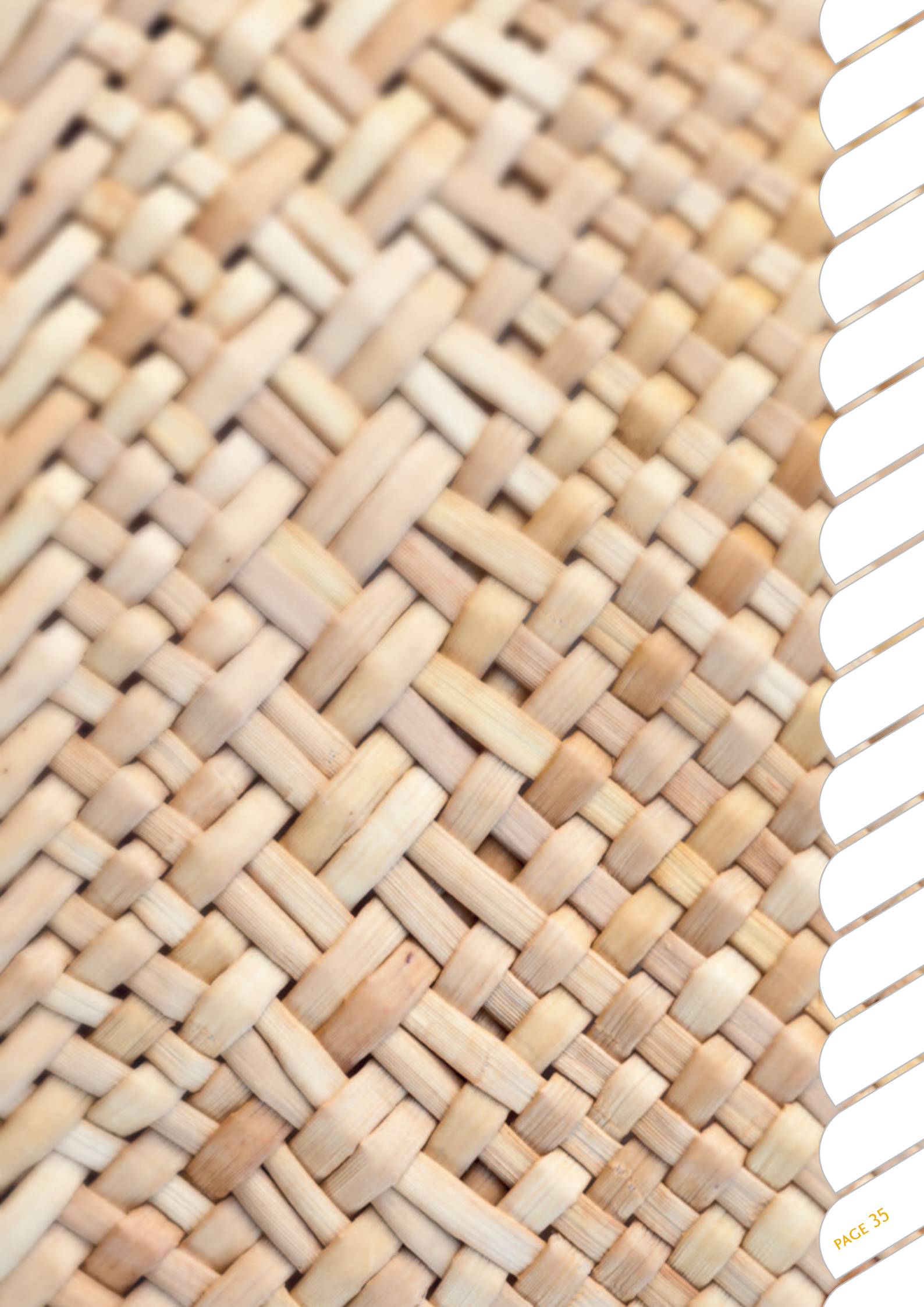
Medication

Medication can form part of an integrated intervention approach when using talking therapies. When used in conjunction with talking therapies, it is essential that the side-effects and impacts are clearly understood both by the practitioner and the tangata whaiora and their whānau. In their qualitative investigation of the impact and barriers to use of anti-psychotic medication by Māori, PHARMAC[31] identified that the barriers to use were largely based in the mistrust of Western science. This, coupled with the mistrust of the health system, has assisted to create significant barriers to integrating medication into any treatment regime.

> The medication side effects are a huge impact at times on the things you can do especially from a physical point of view. Feeling sleepy, dozy, drowned out, hungry all the time, putting on weight, dizzy, low energy levels, body slowed, feel run down, shaking, all these things impact on relationships and the ability to participate[31] (p. 7).

Consultation for this guide revealed accounts of whānau seeking alternatives to the medications they were on, because of the significant side-effects and the impact on their day-to-day well-being. The PHARMAC research[31] indicated that integrating Rongoā Māori with western science was preferable for Māori. See page 38 for more discussion on Rongoā practice. There are a number of organisations that integrate therapy and rongoā to create a holistic intervention for tāngata whaiora and whānau.

"Our psychiatrist here, he's really good. He works with our Kaumātua to let us have rongoā and Pākehā medication. It works really well for some of us, they should do this everywhere" [31] (p. 10).



'Tuna' by Teresa Reihana

Tuna are renowned for 'rolling with resistance' as they navigate the waterways.

3. The therapies

This section outlines a range of talking therapies currently used in Aotearoa/New Zealand. It provides an overview of the approaches, and includes reading lists for accessing more detailed information and support material.

Given the paucity of research on talking therapies with Māori, it is unknown which therapies have most impact for Māori. However, where expert opinion or research with indigenous populations has indicated how therapies can be adapted to maximise their effectiveness, these comments are included.

What became clear in the consultation is that cultural competence is the integration of cultural and clinical elements in practice. It does not really matter which model of talking therapy is being used, as long as what underpins the application of the model are practices and principles consistent with Te Ao Māori and an understanding of the social and cultural context of the individual and their whānau.

Traditional therapies

Customary practices

Traditional Māori healing tends to encompass the spiritual and psychological dimensions of health[70]. It employs a holistic perspective, taking into account the wider whānau, as well as the social, cultural, economic and environmental context of the individual. Concepts such as tapu, noa, mauri, wairua, and whakapapa can have meaning for Māori when considering their health. This is reflected through the use of rongoā rakau or māra (plant-based medicines) for healing, as well as karakia (prayer) and mirimiri (therapeutic massage). In 1993, Ngā Ringa Whakahaere o te Iwi Māori, a national body of Māori healers was established (www.nrw.co.nz). Ngā Ringa Whakahaere o te Iwi Māori advocates on behalf of traditional healers and promotes the wise use of rongoā and traditional healing. Traditional Māori healing has re-emerged as an important strand in health care for Māori, after many years of repression through the Tohunga Suppression Act 1907[71]. In 2008, Te Paepae Matua was established as the whakaruruhau wisdom keepers for rongoā Māori (http://rongoāmāori.com). The Working with Māori Real Skill highlights that it is essential to acknowledge that Māori may consider using traditional healing processes and practices to support health and well-being. Practitioners need to be familiar with local resources, and promote access to them, in order to support recovery choices and whānau ora.

Tapu and noa

In pre-colonial times, the health of the Māori community was protected through tapu and noa. Tapu was the basis of law and order, and designated what was safe and unsafe. Transgression of tapu could lead to mental illness, sickness, physical illness or death. Noa dictated everyday practices, as a complement to Tapu[72, 73]. For tāngata whaiora and whānau to participate in therapy, they must be in a state of noa. The use of karakia and pōwhiri helps move the whānau to a place of noa.

Rongoā – traditional Māori healing practices

Rongoā are healing practices that draw on native plants to create medicines that can prevent sickness, or provide remedies where sickness has already occurred. Rongoā are used to deal with a range of complaints, from fevers to infected wounds, boils and burns, stomach upsets, insect stings and insomnia[72, 73]. Core elements in Rongoā include spiritual healing and the use of traditional Māori practices, to support health and well-being across the four taha of hinengaro, wairua, whānau and tinana.

Mirimiri (therapeutic massage)

Mirimiri provides for physical and spiritual healing through the use of touch and connection to the elements. Mirimiri often uses rongoā to support the massage process and to create the spiritual connection with the atua and physical environment.

Atua Māori – Te Tuakiri o te Tangata

Te Tuakiri o te Tangata is a model of intervention that draws on the creation theories of the Māori paradigm and links the characteristics of ngā atua to that of whānau. The identity and core concepts that make up the whānau are externalised through an activity, where the strengths and characteristics are used to construct a tuakiri, which the whānau or individual takes with them. The tuakiri is then able to be used as a therapeutic tool to explore issues and challenges through conversation and pūrākau or legends.

Karakia (prayer)

Karakia is the means by which spiritual pathways are cleared. It can assist the process of transition – making space, so the mahi can be done. Karakia can be an integral and ongoing part of therapy, and can also be associated with other rituals, such as wai tapu[72, 73].

Reading list

www.nrw.co.nz — Ngā Ringa Whakahaere o te Iwi Māori is an independent national network of Māori traditional practitioners and Whare Oranga, established in 1993 to achieve greater recognition for Māori traditional health and healing practices.

www.esr.cri.nz/SiteCollectionDocuments/ESR/PDF/RongoāMāoriFullReport.pdf — *The Future of Rongo*ā Māori: A report for the Ministry of Health.

www.bpac.org.nz/magazine/2008/may/docs/bpj13_rongoā_pages_32-36_pf.pdf — *Demystifying Rongo*ā Māori: Traditional Māori *healing*.

Cognitive behavioural therapy

Cognitive behavioural therapy (CBT) is a form of therapy that aims to adjust thoughts and behavioural patterns to create more adaptive outcomes. Sessions are highly structured and focus on identifying the cognitive and environmental factors controlling the problem behaviour. Cognitive techniques (e.g. challenging negative thinking) and behavioural work (e.g. rehearsal of new skills and increasing pleasant activities) are employed to achieve behavioural change. These techniques may be provided in a group or individual format[74].

International research has found CBT to be helpful for a wide variety of mental health-related issues, including depression, alcohol issues, anxiety, eating disorders, and symptoms of bipolar and schizophrenia[10]. However, these studies have not identified the response of ethnic minority groups to the therapy, due to under-representation in sample groups[33].

Potential issues

Criticisms of CBT's usefulness for Māori relate to the importance placed on rational thinking and seeking objective evidence, and the therapy's grounding in a scientific view of the world that may be ineffective with clients who hold more spiritually based beliefs[33].

Hirini[3] comments that a core world view of CBT – the promotion of assertiveness and independence – may be a less relevant indicator of healthy social functioning among Māori. The whakatauki "kāore te kūmara e kōrero mō tōna reka" emphasises the importance placed on modesty and understatement within Māori society. With regard to the notion of rationality, the implicit exclusion of the spiritual dimension in the cognitive-behavioural approach is a considerable limitation when working with Māori[3].

It is also noted that the cognitive-behavioural traditions do not account for situations where a person's issues of concern are not internal or personal-bound. For example, community racism and consequent discrimination may be more important than internal cognitive structures during therapeutic work, and cannot be adequately addressed solely by internal change on the part of the person[3].

International literature by Organista and Munoz[75] provides some recommendations for adapting CBT. Their research with Latino people found that self-disclosure in early sessions, for example, by the practitioner sharing background information, such as where they are from and who their families were, built trust with Latino service users. This study also advocated integration of religion into the therapeutic work.

Taking into consideration these potential limitations of CBT, Bennett et al[25, 33], in collaboration with an advisory group of Kaumātua and Māori clinical psychologists, adapted CBT for use with Māori clients with depression. The protocol consisted of 12 sessions of CBT, for treatment of a major depressive episode, with the following adaptations:

- extended use of Māori metaphor, including whakatauki (Māori proverbs) to guide sessions
- use of culturally relevant examples, and referral to Te Whare Tapa Wha
- use of karakia or whakatauki to open and close sessions
- self-disclosure on part of the practitioner
- extended use of visual stimulus, and deeper exploration of whakapapa through use of genograms
- whānau involvement encouraged in sessions and treatment objectives
- use of Māori language.

The research [25, 33] sought to provide specific guidelines for how CBT can be adapted to integrate relevant cultural constructs for Māori into the therapeutic package. It is also the first trial examining the clinical efficacy of CBT for Māori clients with any kind of disorder.

Bennett's study found that depressive symptoms decreased substantially for the participants, who also reflected positively on the adaptations incorporated into therapy. However, the cause of this positive outcome is unclear, as delivery was by one practitioner, which makes it difficult to identify whether it was the strength of the therapeutic alliance or the adapted technique itself that led to the positive results. In addition, the sample group was small and participants were also receiving other treatments. A further clinically controlled study, using a larger sample size, would provide more strength regarding the generalisability of these findings.

Cargo's[34] paper also reported the effectiveness of applying an adapted CBT model with Māori tamariki. While this was not empirically based research, it highlights some useful clinical applications. For example, the importance of using visual stimuli and examples that tamariki can understand to convey the key CBT concepts, and staying focused on ways to build cultural identity.

Reading list

www.rational.org.nz/prof/docs/Intro-CBT.pdf — a brief introduction to CBT, including an extensive reading list. This website also includes a variety of other CBT-related links and resources.

www.rcpsych.ac.uk/mentalhealthinfoforall/treatments/cbt.aspx — information on CBT from the UK Royal College of Psychiatrists.

www.psychnetuk.com/psychotherapy/psychotherapy_cognitive_behavioural_therapy.htm — this page of the Mental Health and Psychology Directory UK provides a wide variety of useful CBT resources.

Computerised cognitive behavioural therapy

Like CBT, computerised CBT is designed to help solve issues or overcome difficulties by assisting to change an individual's thinking, behaviour and emotional responses. The therapy is provided through a website, CD or DVD, rather than through face-to-face sessions with a practitioner, and can be useful with mild depression and anxiety[10].

This therapy can be used by those interested in personal growth, who are likely to comply with a self-guided format. It can also be used as a complement to other therapies where people can engage in online counselling between sessions.

Potential issues

Currently no research has occurred in New Zealand to indicate whether computerised CBT is a useful therapy for Māori. However, the University of Auckland is conducting a study aimed at making a computer simulation focused on CBT coping strategies relevant for Māori tamariki (named SPARX). Focus groups have indicated that tamariki want characters that they can identify with, such as characters with moko and Māori designs on costumes and buildings.

Māori whānau also stated that it would be important to have an application that was relevant to them. The version for whānau would contain information about how to support tamariki with depression and ways to support whānau members with similar issues. These points have been structured into the development of SPARX, and the feasibility of using this programme to treat depression in Māori tamariki is currently being tested[76].

Reading list

http://bjp.rcpsych.org/cgi/content/full/185/1/46 — *Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: Randomised controlled trial*. The Royal College of Psychiatrists, UK.

www.beatingtheblues.co.uk — Beating the Blues is a widely used and evidence-based computerised CBT programme for the treatment of depression.

Counselling

Counselling helps people to increase their understanding of themselves and their relationships with others, to develop resourceful ways of living, and to bring about change in their lives. Counselling can involve sessions with an individual, or sessions with couples, families/whānau, or groups[10]. Counsellors are usually trained in a number of techniques, and can help with a variety of issues.

Potential issues

Literature has illustrated significant contrasts in the cultural paradigms of counselling in New Zealand[18-20, 77, 78]. Generally these contrasts are centred on individualistic versus collectively-oriented concepts of self. This can be demonstrated by comparing values, expectations and traditional knowledge of Māori, against the scientific insights of psychology[79]. More specifically, key concepts of whanaungatanga (relationships), wairua (spirituality), and whakamanawa (encouragement) are often conflicting with common Western counselling models, which tend to focus on rational thinking and seeking empirical, objective evidence for thoughts[19].

The literature has highlighted counselling approaches that may be particularly effective when engaging with Māori.

- Self-disclosure by the practitioner in order to establish a meaningful connection with the tangata whaiora. Information such as whakapapa, work history and family background could be shared.
- The inclusion of spirituality, or wairua, potentially including an exploration of access and connection to cultural resources (e.g. maunga, awa, whānau).
- Whānau, or extended family, to be included in counselling, as supporters, collaborators and active participants where possible.
- The explicit use of whakamanawa (encouragement) and manaakitanga (caring and compassion). Durie and Hermannson[19] state that, "it is not so much trying to get people to talk about how they are feeling, but making sure they are actively looked after when they are distressed" (p. 114).

Reading list

www.nzac.org.nz — the New Zealand Association of Counsellors, Te Roopu Kaiwhiriwhiri o Aotearoa is the national professional association that acts for and with counsellors to monitor and improve the service they provide.

www.nzac.org.nz/nzjc.html — online version of *New Zealand Journal of Counselling*.

www.theaca.net.au/journals_and_articles.php — online version of Australian Counselling Association journals.

Family therapy

Family therapy uses various therapeutic approaches to nurture change and development within the family. This form of therapy can be used for issues that affect the family as a whole, for example problems such as marital conflict, mental illness, substance abuse and bereavement. Family therapy tends to view change in terms of the systems of interaction between family members, and emphasises family relationships as an important factor in psychological health[10].

In the early years of family therapy's development, many clinicians defined the family in a narrow, traditional manner, usually including parents and children. As the field has evolved, the concept of the family is more commonly defined in terms of strongly supportive, long-term roles and relationships between people who may or may not be related by blood[18, 79].

Family therapy supports the strengths of the family/whānau to solve issues, and is often used to address behavioural issues with children, or communication between young people and their caregivers or parents. Disorders that family therapy is effective for include anorexia nervosa, depression, anxiety and schizophrenia in a family member[10].

Potential issues

Although there is no empirical evidence supporting the effectiveness of family therapy with Māori, the concept is embedded in much of the literature[18-20, 77, 78]. It is supported in all Māori models of health, including Te Whare Tapa Whā[15, 80] and Te Wheke[23]. The importance of the family is also reflected in the government's introduction of Whānau Ora. It is important to distinguish family therapy from family-inclusive practice. While family therapy is a very specific therapy that requires training to deliver and views the family as the client, family-inclusive practice focuses on involving the family in all aspects of treatment where applicable and appropriate, but does not necessarily follow the family therapy model.

Whānau has been proposed as a key component of Māori identity and the healing process, and is also a core feature of kaupapa Māori theories of social change[23, 53]. Understanding the importance of whānau, and how whānau can contribute to illness and assist in curing illness, is fundamental to understanding Māori health issues[53, 80]. The essence of whanaungatanga and whānau is the establishment and maintenance of links, relationships and responsibilities, and in therapy this also assists the establishment of therapeutic rapport and the development of relevant interventions[12].

Durie[17] advocates for the whānau-based intervention model, called Paiheretia or relational therapy, where the whānau practitioner can engage all of the relevant family members in a range of culturally compatible interactions, with the aim of reducing risk, enhancing known protective factors, and assisting in the acquisition of skills.

International literature also discusses the significance of family therapy. Turner and Sanders[37] research with indigenous people highlights the need to incorporate culturally sensitive practices and expectations into any type of family therapy, along with understanding the political and cultural context of parenting. Therapists need to avoid classifying family interaction patterns as pathological, simply because they deviate from arbitrary social norms that may be culturally biased[79].

Reading list

www.anzjft.com/pages/contents_abstracts.php — *The Australian and New Zealand Journal of Family Therapy*. Web link where you can view the contents of every issue published, as well as abstracts on selected articles and links to sample articles.

http://bouverie.org.au/taxonomy/term/259 — Bouverie Centre is Victoria's Family Institute, a unique public institute located within La Trobe University's Faculty of Health Sciences. This web page includes PDFs for a variety of articles on family therapy.

Interpersonal psychotherapy

Interpersonal therapy is a short 12 to 16 session course of therapy that focuses on past and present social roles and interpersonal interactions. During treatment, the practitioner generally chooses one or two problem areas in the person's current life to focus on. Examples of areas covered are disputes with friends, family or co-workers, grief and loss, and role transitions, such as retirement or divorce[10].

Interpersonal therapy does not attempt to delve into inner conflicts resulting from past experiences. Rather, it attempts to help the person find better ways to deal with current problems. It is used to develop communication skills and improve relationships, and has been found to be an effective treatment for depression, anxiety and anorexia nervosa[10].

Potential issues

Although there is currently no research investigating the effectiveness of interpersonal psychotherapy with Māori populations, the literature[18, 19, 55] has identified whanaungatanga (inter-relationships) as a key component to improving mental health. This aligns with the constructs of interpersonal psychotherapy that focus on interpersonal interactions.

Reading list

www.interpersonalpsychotherapy.org — the website of the International Society for Interpersonal Psychotherapy. Includes links to a variety of articles and other resources.

www.ncbi.nlm.nih.gov/pmc/articles/PMC1414693 — *Interpersonal psychotherapy: Principles and applications*.

Motivational interviewing

Motivational interviewing aims to generate behaviour change through assisting the person to resolve ambivalence about treatment. This is achieved through assisting the person to become more aware of the implications of changing, or not changing, in a non-judgemental interview where the person does most of the talking. While person-centred, the approach is also directive in that it guides the tangata whaiora towards behavioural change. During the interview, four key skills are employed by the practitioner to enable this change:

- expressing empathy
- developing discrepancy, where the person can begin to see gaps between their values and current problematic behaviours
- rolling with resistance, where reluctance to change is respected
- supporting the person's self-efficacy[81].

Motivational interviewing can be used alongside other treatments, to build motivation to address emotional distress or engage in other forms of therapy.

Potential issues

There is currently no literature investigating the effectiveness of motivational interviewing with Māori populations. However, there is international evidence to support cross-cultural application of motivational interviewing[39, 40]. A brief intervention that combined the principles of motivational interviewing, problem-solving therapy and chronic disease self-management, was well received by service users and carers from indigenous backgrounds, in remote communities, where the service user had experienced enduring mental illness. However, the study highlighted the importance of understanding cultural settings and norms, for example limited resources and community priorities. Understanding cultural values and priorities specific to Māori, and the way in which these may differ from the priorities of non-Māori people, will be important when assessing motivation and relapse prevention plans[40].

Reading list

http://motivationalinterview.org — motivational interviewing resources for clinicians, researchers and trainers.

www.eurobesitas.ch/articles/pdf/dom331.pdf — an article summarising the evidence and application of motivational interviewing, from the *Advances in Psychiatric Treatment Journal*.

Multisystemic therapy

Multisystemic therapy is an intensive family and community-based treatment that is being used to address the multiple determinants of serious antisocial behaviour in young offenders. The multisystemic therapy approach views individuals as being nested within a complex network of interconnected systems, which encompass individual, family, and extra-familial (peer, school, neighbourhood) factors. Intervention may be necessary in any one, or a combination of, these systems. In multisystemic therapy, this ecology of interconnected systems is viewed as the client. Multisystemic therapy strives to promote behaviour change in the person's natural environment, using existing strengths within each system (e.g. family, peers, school, neighbourhood, informal support network) to facilitate change[82]. While primarily used with youth, multisystemic therapy has wider applicability.

Potential issues

There is international evidence of multisystemic therapy's effectiveness in indigenous populations. Painter and Scannapieco[83] found multisystemic therapy to be an effective therapy for youth minority populations in America. National research by Russell[84] has also found multisystemic therapy to be an effective therapy for youth offenders within New Zealand. However, research investigating multisystemic therapy's application for Māori youth is not available, and therefore requires ongoing evaluation in New Zealand.

Reading list

http://muir.massey.ac.nz/handle/10179/720 — Russell, C. (2008). *Multisystemic Therapy in New Zealand: Effectiveness and prediction of outcome*. PhD thesis[84].

www.mstnz.co.nz/newzealand.htm — website of MST New Zealand.

www.mstservices.com — this website contains an abundance of information about multisystemic therapy.

Psychotherapy

Psychotherapy is a term often used to refer to a wide variety of talking therapies. This discussion will focus on psychodynamic approaches which typically involve analysis of previous life events and the influence of the unconscious on current behaviours and thoughts. Psychodynamic psychotherapy uses the relationship between the person accessing therapy and the practitioner to explore interpersonal issues[85].

Potential issues

There is currently no evidence-based literature investigating the effectiveness of psychodynamic psychotherapy with Māori. However, literature has discussed the general limitations of Westernised therapy models in their application to Māori. For example, Māori perspectives and world views may conflict with talking therapies that seek to gain answers from within, through exploring thinking, feelings and intelligence, while Māori cultural views often gain answers from the wider systems, such as whānau/family, environment and spirituality[19, 25]. Consequently, practitioners who deliver psychotherapy will need to take care to actively explore these broader concepts during therapy with Māori.

Reading list

www.nzap.org.nz — New Zealand Association of Psychotherapists, Te Rōpū Whakaora Hinengaro.

www.anzapweb.com/html/downloads/journal-article.html — Australia and New Zealand Association of Psychotherapy website, which includes a range of articles to download.

www.anzsja.org.au/subjective_experience/UsesOfSubjectiveExperience.pdf — a paper by the Australian and New Zealand Society of Jungian Analysts.

Psychotherapy with children

Psychotherapy with children refers to a variety of techniques and methods used to assist children and adolescents who are experiencing difficulties with their emotions or behaviour. Although there are different types of psychotherapy, each relies on communication as the basic tool for bringing about change in a person's feelings and behaviours. Psychotherapy may involve an individual child, a group of children, a family, or multiple families. In children and adolescents, playing, drawing, building, and pretending, as well as talking, are important ways of sharing feelings and resolving problems[86].

Psychotherapy can assist children and adolescents to resolve conflicts with people, understand feelings and problems, and try out new solutions to old problems. Goals for therapy may be specific changes in behaviour, such as improved relations with friends or family, or reductions in anxiety and better self-esteem. The length of psychotherapy depends on the complexity and severity of problems[86].

Potential issues

Although there is no evidence-based research examining the effectiveness of psychotherapy with Māori children, research by Elder[55] has investigated the experience of Māori psychiatrists and registrars who have worked with tamariki (children), taiohi (adolescents) and their whānau. Elder's paper highlights the conflict Māori practitioners often experience between their clinical training and their culturally based understanding of how to work with Māori. These practitioners talked about needing to "do the work differently" when working with tamariki, which seemed to emerge from their own sense of being Māori. They placed an emphasis on whakawhanaungatanga (actively building connection through relationships).

Evans[79] also comments that Māori perspectives on children's mental health needs tend to be holistic and to emphasis the role of the extended family. Therefore, rather than working individually with a Māori child, practitioners need to consider involving the whānau and other influential groups (i.e. school, neighbourhood, peers).

Reading list

www.werrycentre.org.nz/site_resources/library/Workforce_Development_Publications/FINAL_EBP_Document_12_May_2010.pdf — The Werry Centre has produced this excellent summary of evidence-based age-appropriate interventions.

Other talking therapies

The following evidence-based talking therapies are used within New Zealand, but have not been subject to research or expert opinion regarding their effectiveness for Māori.

Acceptance and commitment therapy

Acceptance and commitment therapy uses strategies of mindfulness, acceptance, commitment and behaviour change to increase cognitive flexibility. Acceptance and commitment therapy teaches people to notice their thoughts, feelings and sensations, rather than to actively change them. People are then encouraged to apply the knowledge gained from noticing their thoughts, feelings and sensations to activities that they value[87].

There is promising evidence for the effectiveness of acceptance and commitment therapy. In a recent meta-analytic review[87], acceptance and commitment therapy was found to be more useful than no treatment, or treatment as usual, for a variety of mental health conditions, such as psychosis, and physical conditions, such as chronic pain. Evidence was weakest for anxiety and depression, where it was not superior to control conditions. Overall, the meta-analysis concluded that while acceptance and commitment therapy is a useful treatment, it does not appear to be more effective than other established treatments, such as CBT and problem-solving therapy.

Reading list

http://contextualpsychology.org/act — website of the Association for Contextual Behavioral Science, a professional organisation dedicated to acceptance and commitment therapy, relational frame theory, and functional contextualism. Also provides helpful information about professional training opportunities.

Bibliotherapy

Bibliotherapy involves the use of books, printed material, audio tapes, play scripts, pamphlets and other resources, such as self-help materials, for personal growth[88]. Practitioners can recommend the use of these tools, and tāngata whaiora and community members may also personally seek them out for purchase.

Evidence conducted in Western populations indicates that bibliotherapy is useful for mild to moderate depression. There is also evidence to support the use of bibliotherapy with anxiety disorders, self-harm, panic disorder, obsessive compulsive behaviour, personal development, managing long-term illness, and helping children and young people with issues like bullying and divorce[10, 88]. There is limited evidence of its effectiveness with alcoholism, and few studies with more clinically severe populations[88].

Reading list

www.abal.laurentian.ca/BibTHP.htm — a summary article by the Association for Bibliotherapy and Applied Literature.

Dialectic behaviour therapy

Dialectical behaviour therapy aims to improve interpersonal, self-regulation and distress tolerance skills, by integrating behaviour strategies and mindfulness practices[89]. The dialectical aspect of the therapy refers to its focus on validating the service user's acceptance of themselves as they are, whilst creating motivation for change[89]. Dialectical behaviour therapy is a relatively new form of therapy, designed for use with people diagnosed with borderline personality disorder, for which other modes of therapy have had little success. Dialectical behaviour therapy delivered in outpatient settings typically involves individual psychotherapy, group skills training, and telephone counselling[89].

There are promising results for the effectiveness of dialectical behaviour therapy in reducing self-harming behaviours in people with borderline personality disorders[90]. However, this form of therapy is relatively new and there are only limited controlled studies of its effectiveness.

Reading list

www.tepou.co.nz/file/PDF/2006___BTECH__DBT_Efficacy_Effectiveness__Feasibility___Executive_Summary_NIRN_MAY_06v4.pdf — *Dialectical behaviour therapy: Efficacy, effectiveness and feasibility.*

www.behavioraltech.com — the home of dialectical behaviour therapy, this website provides a wide variety of resources.

Problem-solving therapy

Problem-solving therapy focuses on identifying issues, and developing approaches for solving these specific issues, as well as building long-term problem-solving skills[91].

Research with general populations shows that this form of therapy is useful for depression, anxiety, chronic illness, suicidal thoughts and behaviour, behaviour change and personal growth[91].

Reading list

www.problemsolvingtherapy.ac.nz — Problem Solving Therapy NZ website. Provides an overview of problem-solving therapy and case studies.

A masterful carving is said to “speak” to the viewer.

4. Resources

Primary health organisations, mental health and addiction services in New Zealand

Contact details for New Zealand's primary health organisations, and mental health and addiction services are available online.

- For primary health organisations, see the Ministry of Health's website: www.moh.govt.nz/moh.nsf/indexmh/contact-us-pho.
- For mental health services, see the Healthpoint website: www.healthpoint.co.nz/findaservice.do?serviceType=108&branch=specialists.
- For addiction services, see the Addictions Treatment Directory: www.addictionshelp.org.nz.

Information resources for service users

A Guide to Talking Therapies in New Zealand
A user-friendly guide to talking therapies for service users and family members. Produced by Te Pou: www.tepou.co.nz.

What is Talking Therapy?
Produced by the Mental Health Foundation of New Zealand: www.mentalhealth.org.nz.

Resources to assist with developing cultural capability

Cultural Awareness Tool for Mental Health Workers in Primary Care
This book provides guidance for primary care mental health workers about delivering culturally sensitive care. The book is designed to be a first step to developing cultural competence. It is available online at: www.mmha.org.au/mmha-products/books-and-resources/cultural-awareness-tool-cat.

Guidelines for therapeutic work with tāngata whaiora and whānau

Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Post-traumatic Stress Disorder
Evidence-based guidelines for responding to post-traumatic stress disorder: www.acpmh.unimelb.edu.au/resources/resources-guidelines.html.

Guidelines for Assessing and Treating Anxiety Disorders
Evidence-based guidelines on assessing and treating anxiety disorders: www.nzgg.org.nz/guidelines/0038/Anxiety_guideline.pdf.

Assessment and Management of People at Risk of Suicide
Evidence-based guidelines on assessing and managing people at risk of suicide: www.nzgg.org.nz/guidelines/dsp_guideline_popup.cfm?guidelineCatID=8&guidelineID=5.

New Zealand's Health and Disability Services (Core) Standards

These core standards include recommendations for working with Māori tāngata whaiora and whānau, and all services should have a copy of them. They can be ordered at a cost through the Standards New Zealand website (use the catalogue search function): www.standards.co.nz.

Workforce training resources

Matua Raki is the National Addiction Workforce Development Centre within Te Rau Matatini Ltd, and is funded by the Ministry of Health. See: www.matuaraki.org.nz/.

Te Pou is New Zealand's National Centre of Mental Health Research, Information and Workforce Development and supports a wide variety of initiatives focused on improving mental health

Appendix A. Mental health issues for Māori

Te Rau Hinengaro: The New Zealand mental health survey[1] provides important and not previously available information about the prevalence of mental disorders, and their patterns of onset and impact for adults in New Zealand. This report captured the diversity of Māori across a range of demographic, social, economic and cultural indices. To ensure unbiased and precise estimates for Māori people, oversampling was used by doubling the number of Māori included in the survey.

The study reports the prevalence of mental disorders in Māori was 50.7 per cent over their lifetime, 29.5 per cent in the past 12 months (compared with 19.3 per cent for non-Māori), and 18.3 per cent in the previous month.

Māori have a greater burden of mental health (including addiction) problems. The prevalence of disorder in any period is higher for Māori and Pacific people, than for other people living in New Zealand; 29. 5 per cent of Māori had a disorder in the past 12 months, compared with 24.4 per cent for Pacific people, and 19.3 per cent for 'Others'. Among Māori who experienced a disorder in the past 12 months, 55.5 per cent had only one disorder, 25.7 per cent had two disorders, and 18.8 per cent had three or more disorders[1].

The most common disorders among Māori were anxiety disorders (19.4 per cent, compared to 14.1 per cent for 'Others'), mood disorders (11.6 per cent, 7.5 per cent for 'Others') and substance use disorders (9.1 per cent, 2.7 per cent for 'Others'). The most common lifetime disorders among Māori were anxiety disorders (31.3 per cent, 24.9 per cent for 'Others'), substance use disorders (26.5 per cent, 12.3 per cent for 'Others'), mood disorders (24.3 per cent, 20.0 per cent for 'Others') and eating disorders (3.1 per cent, 1.7 per cent for 'Others')[1].

Lifetime suicidal ideation was reported by 22.5 per cent of Māori (15.7 per cent for 'Others'), with 8.5 per cent making suicidal plans (5.5 per cent for 'Others') and 8.3 per cent making suicide attempts (4.5 per cent for 'Others'). Māori females reported higher rates of suicidal ideation, suicide plans and suicide attempts, compared with Māori males across lifetime and 12-month periods. Māori had higher suicide mortality rates than non-Māori (16.5 per cent, compared to 10.2 per cent), and males of both ethnic groupings had significantly higher suicide mortality rates than their female counterparts. For Māori, the age group with the highest suicide rate was young people aged 15 to 24 years. For non-Māori, adults aged 25 to 44 years had the highest suicide rate[1].

Much of the disparity in mental health problems between Māori and other people living in New Zealand appears to be because of the youthfulness of the Māori population and their relative socioeconomic disadvantage[1]. Statistics have shown that younger people have a higher prevalence of disorder. Also, people who are disadvantaged, whether measured by educational qualification or household income, have a higher prevalence of disorder.

After adjusting for socio-demographic correlates (age, sex, socioeconomic status), no ethnic differences in the prevalence of anxiety and depression disorders in the past 12 months are apparent. But even with adjustments, the prevalence of bipolar disorder remains higher for Māori people (3.4 per cent, compared with Pacific people at 2.7 per cent, and 'Others' at 1.9 per cent), along with substance use disorder (6.0 per cent for Māori, compared to 3.2 per cent for Pacific people, and 3.0 per cent for 'Others')[1].

Any 12-month mental disorder among Māori adults	
• Māori population†	29.5%
• Younger adults≠	32.9–33.2%
• Low education level^	34.2%
• Low household income*	40.9%
• Most deprived areas‡	32.5%

† Attributed in part to younger age, sex, lower education and income.
≠ Aged 16 to 24 years – 33.2%, and 25 to 44 years – 32.9%.
^ No educational qualifications.
*Under half of the median equivalised household income.
‡ NZDep 2001 deciles 9 and 10.

Source: *Te Rau Hinengaro* (2006)[1]

Access to mental health services

Among Māori who have experienced a disorder in the past 12 months, 32.5 per cent had contact with a provider of services, compared to 41.1 per cent for 'Other'. This was divided among mental health specialist services (14.6 per cent), general medical services (20.4 per cent) and non-healthcare providers (9.1 per cent)[1].

For Māori health care, contact increased with severity: 47.9 per cent of Māori with a serious disorder (58.0 per cent for 'Other') had contact with health services, compared with 25.4 per cent of those with a moderate disorder (36.5 per cent for 'Other'), and 15.7 per cent of those with a mild disorder (18.5 per cent for 'Other')[1].

Te Rau Hinengaro[1] reported differing patterns of sources of referral for admission, with Māori being more likely to be hospitalised through a justice doorway, than through a mental health or primary care entry point.

Addiction issues for Māori

The information and statistics provided in this section are from the 2006 report *Substance Use Disorders in Te Rau Hinengaro: The New Zealand mental health survey*[92]. This report took the data from the original *Te Rau Hinengaro*[1] mental health survey, and subjected it to further analysis to determine the prevalence of substance disorders in New Zealand, and their patterns of onset and impact for adults in New Zealand.

Substance use disorders include abuse and dependence on various substances, both legal and illegal. Some of the common substances include alcohol, cannabis, opioids (morphine, heroin), prescription medications that may be abused (such as sedatives), and other drugs[93].

Substance use disorders

The prevalence of substance use disorders in any period is higher for Māori and Pacific people than for other people living in New Zealand; 9.1 per cent of Māori, 4.9 per cent of Pacific people, and 2.7 per cent of other people living in New Zealand reported a substance use disorder in the past 12 months. Similar to the Māori general mental health profile, some of this burden appears to be due to the youthfulness of the Māori and Pacific populations and their relative socioeconomic disadvantage. After adjusting for socio-demographic correlates, the prevalence of substance use disorder reduced, but still remained higher for Māori (6.0 per cent), than for Pacific people (3.2 per cent) and 'Others' (3.0 per cent)[92].

Hazardous alcohol use

About 80 per cent of the current population within New Zealand drinks alcohol. Drinking is equally common among Māori and other ethnic groups. However, Māori have a higher prevalence of alcohol disorders and hazardous alcohol use. The observed prevalence is 35.4 per cent for Māori, 21.4 per cent for Pacific people and 17.9 per cent for 'Others'[92]. After adjustment for exceptions of youthfulness and socioeconomic disadvantage, the prevalence of hazardous drinking reduced, but still remained higher for Māori (29.6 per cent) when compared with Pacific people (18.1 per cent) and 'Others' (18.6 per cent).

Drug use disorders

A slightly different pattern occurs for drug disorders. Māori (26.2 per cent) are much more likely than Pacific people (11.3 per cent) or 'Others' (12.1 per cent) to use drugs. Among Māori drug users the prevalence of drug disorders is higher than for other drug users, even after adjustments for socio-demographic correlates (13.1 per cent for Māori, compared to 8.7 per cent for 'Others').

Māori men and women have significantly higher rates of cannabis disorders (abuse - 1.9 per cent; dependence - 3.0 per cent), compared with men and women in the total population (abuse - 0.9 per cent; dependence - 0.5 per cent). There were no other drugs that Māori men and women were significantly more likely to have used in the past year, compared with the general population[92].

Appendix B. Māori in Aotearoa/ New Zealand

Proportion of total population

At the time of the 2006 Census[94], there were 565,329 people (14.9 per cent) who identified with the Māori ethnic group, making Māori the second largest ethnic group in New Zealand after Europeans (76.8 per cent). The Māori population has increased by 30 per cent in the past 15 years, up from 434,847 in 1991 to reach 565,329 in 2006[94]. The Māori population has a high growth rate (average annual increase of 1.2 per cent) relative to non-Māori (average annual increase of 0.6 per cent). Between 2006 and 2021, the Māori population is expected to grow by 20 per cent, whereas the non-Māori population is predicted to increase by 10 per cent[11].

Ethnicity

Māori were counted in two ways in the 2006 Census: through ethnicity and through descent. Māori ethnicity and Māori descent are different concepts; the former refers to cultural affiliation, while the latter is about ancestry. In 2006, there were 565,329 people (14.6 per cent) who identified with the Māori ethnic group, and 643,977 people (16.6 per cent) who were of Māori descent. Just over half (52.8 per cent) of all people in the Māori ethnic group identified Māori as their only ethnicity, while 42.2 per cent of Māori stated that they also identified with European ethnic groups, 7.0 per cent with Pacific ethnic groups, 1.5 per cent with Asian ethnic groups, and 2.3 per cent also gave New Zealander as one of their ethnic groups[94].

Geographic distribution

In 2006, the majority of Māori (87.0 per cent) lived in the North Island and just less than one-quarter were in the Auckland region (24.3 per cent). In 1956, nearly two-thirds of Māori lived in rural areas. Fifty years later, 84.4 per cent of Māori living in New Zealand lived in urban areas[94].

Age and sex

The Māori population is relatively young. The median age of Māori was 22.7 years at the 2006 Census[94], compared with the European median age, which was 36.9 years. Of the total New Zealand population aged 65 years and over, only 4 per cent were Māori in 2001, while 92 per cent were European[94]. The Māori population overall will become older, but will continue to have a much younger age structure than the rest of the New Zealand population, due to higher Māori birth rates[95]. Overall, the trend for the next 10 years suggests that the age structure will not change significantly, which creates significant imperatives for planning and delivery of health services to Māori.

Employment and income

In December 2009, the overall unemployment rate in New Zealand reached a 10-year high of 7.3 per cent[14]. As with historical increases in unemployment, Māori experience the effects at a significantly higher rate. Currently the rate is twice as high among Māori (14.8 per cent); that is, at least one in seven Māori are currently unemployed. Māori were among those groups hit hardest by the recession of 1987 to 1992[14]. Unemployment rates have gradually declined since 1992, but remained persistently higher for Māori and Pacific people[14, 96].

Today about one in three Māori adults meet diagnostic criteria for mental illness or alcohol or other drug disorder, and there is evidence of early onset of serious mental illness for Māori[1]. With the current age structure, this provides a clear platform for careful consideration and intervention to ensure that the health needs of Māori are addressed at the earliest opportunity. The New Zealand mental health survey[1] outlined a number of risk factors contributing towards mental disorder, which included lower household income, educational attainment and living in more deprived areas. Considering the high rate of unemployment among Māori[14], and the associated risk that unemployment has on mental illness[1], Māori are at a higher risk of developing a mental disorder.

Appendix C. Glossary of Māori terms

Atua

Atua is often translated as god. Many Māori would say they trace their ancestry from atua, through their whakapapa, and it is from this idea that concepts such as tapu, mana and mauri are derived. Atua are also regarded as ancestors with influence over particular domains.

Auahatanga

Creativity or the creative potential.

Awhi

To embrace, aid, help and cherish.

Hapū

A kinship group, commonly a sub-tribe or a section of a larger kinship group.

Hauora

Health and well-being. In traditional kōrero, hauora was the breath or spirit of life that gave shape and form.

Hinengaro

This is often viewed as the psychological or mental dimension. In traditional kōrero, hinengaro is the deep mind or consciousness.

Hui

To gather; congregate; assemble; meet.

Iwi

An extended kinship group; tribe; nation; people; nationality; race. Often refers to a large group of people descended from a common ancestor.

Kapa Haka

Māori performing arts. Kapa Haka is an avenue to express heritage and cultural identity.

Karakia

Often defined as prayers and incantations, karakia provide a mechanism to clear and mediate spiritual pathways. There are many types of karakia, and traditionally everyone had a repertoire to use on different occasions.

Kaumātua

An elder, either man or woman. In a more traditional sense, these people were guardians as they often held knowledge of whānau, hapū and tikanga.

Kaupapa

Philosophy; foundation; platform.

Kawa

Protocol and etiquette.

Kōrero

Speech; speaking; narrative; discourse.

Mana

Often defined as status and standing, mana is the spiritual power that may be accorded to a person or group through ancestral descent, possession of certain gifts, or achievements. Personal mana can be enhanced through the collective opinion of the people, or through force in a person, place or object.

Manaaki

Activities that enhance the mana of others and promotes active hosting and support.

Marae

A traditional meeting place for whānau, hapū and iwi members. More specifically, marae is the courtyard or open area in front of the wharenui (meeting house), where formal greetings and discussions take place. It often also includes the complex of buildings around the marae, e.g. wharekai, whare karakia.

Mauri

This is the element that binds the spiritual and physical realms. To work with wairua is to work at revitalising and rejuvenating the life essence and source that is mauri.

Mihimihi

Mihi means to praise, mihimihi is thus greeting, paying tribute, or thanking. It can also signal an understanding of role and process.

Mōteatea

Classic Māori chants. These take various forms and are for multiple purposes.

Noa

To be made neutral, ordinary or unrestricted, and made free from the extensions of tapu.

Oranga

Well-being; survivor; livelihood; welfare; health; living.

Oriori

Lullabies that were originally used to outline the philosophical and conceptual world. An oriori is an educational tool for children, explaining their whakapapa, certain events in the history of their hapū, and the expectations of them when they grow up.

Pepeha

The term includes proverbs, witticisms, figures of speech and boasts. They give an insight into the wisdom of times gone by and often are metaphoric.

Pōwhiri

A ritual of encounter that sets a safe space for discussion to take place. It can be considered a transactional engagement.

Pūmanawa

Natural talents or skills, sometimes skill sets.

Pūrākau

A myth, ancient legend or story.

Rangatira

A chief (male or female). The term is used to describe the qualities of a leader, who ensures the integrity and prosperity of the people, the land, the language and other cultural treasures (e.g. oratory and song poetry), and a sustained response to outside forces that may threaten these.

Rangatiratanga

Self-determination.

Reo

Language; Māori language. Traditionally, language to Māori was the livelihood of the culture – a gift from the gods.

Tamariki

Children. Normally used only in the plural.

Te ao Māori

The Māori world.

Te reo Māori

The Māori language.

Tangata Whaiora

This is a term used to describe a person who uses services. It is literally translated to mean a person who is pursuing health, wellness and recovery.

Tāngata Whaiora

The plural form. People seeking wellness; service users.

Tangata Whenua/ Tāngata Whenua

A term used to describe the local people, hosts, indigenous people of the land, or people born of the whenua (land).

Tapu

A term used to describe something sacred, prohibited, restricted, set apart, confidential or forbidden. It is a state that provides the link between the mana of the gods and the spiritual powers of all things derived from them. In modern times, tapu has been reframed in a protective sense to encompass secular things. Restrictions and prohibitions protect tapu (well-being, dignity and sacredness) from violation.

Tauparapara

Introductory salutation or chant recited before making a formal speech. They are fragments of longer compositions (usually karakia). There are different types of tauparapara (in some areas once known as tau marae) for different occasions, but they are used to arrest the ear of listeners.

Tikanga

Code of conduct, method, plan, meaning, criterion or custom. The correct procedure and custom.

Tinana

Physical dimension; the body.

Tuakiri tangata

Often defined as the persona, personality and identity of a person. Tuakiri tangata embraces aspects of mauri, hinengaro, auahatanga, whatumanawa, tinana, wairua, pūmanawa, mana, tapu and noa.

Urupā

Cemetery; burial grounds; burial places.

Waiata

By far the most performed songs are waiata, which take many forms and are used for a variety of purposes. Waiata are often performed at the end of whaikōrero (speeches) to support what has been said. They can also be sung to remove tapu, or to engage, entertain, calm or comfort the listener. In some therapy groups, they can help gauge the mood or mauri of the group, and build cooperation and cohesion, as well as offering an outlet for creativity.

Wairua

An expression of forces beyond those of this world; often defined as spirit or spirituality. Wairua pervades all things. Spiritual pathways can be cleared and mediated using karakia.

Wairuatanga

Spirituality (as opposed to wairua, which is spirit or spiritual).

Whaiora

A term used to describe the pursuit of health, wellness and recovery.

Whakamā

To be ashamed; shy; embarrassed. Whakamā can be experienced by an individual or a group (e.g. whānau). It can also affect how a collective might relate to an individual.

Whakapapa

Genealogy; genealogical table; lineage; descent. In the talking therapy context, it might be how causes are explained or made explicit, to help to see the layers upon which things are built.

Whakatau

A welcome or welcome speeches often considered to be less formal in nature.

Whakatauāki

A proverb, saying, or aphorism, particularly those urging a particular type of behaviour, attitude or value.

Whakawhanaunga

This term is used to describe relationships, linkages and interconnectedness. It also relates to the processes and practices of establishing and maintaining these. Traditionally the most important means of establishing connection was through whakapapa. In a contemporary context, it might be about shared experiences, as well as shared purpose.

Whānau

Describes a group of people related by whakapapa. Inherent in this relationship are a number of responsibilities and obligations to and for one and another. In a contemporary context, the term has been extended to include people connected by a common theme, i.e. kaupapa whānau. As well as family, the term is also used to describe people who are important to the service user.

Whānau ora

Māori families achieving their maximum health and well-being.

He nui maunga, e kore e taea te whakaneke; he ngaru moana, mā te ihu o te waka e wāhi
- a mountain cannot be moved but an ocean wave can be pierced by the prow of the waka.

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