SHADY LENSES:
THE HOUSE OF INTEGRATED APPROACHES AS EVIDENCE BASED PRACTICE

By

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Abstract

This thesis is about Kaupapa Māori theory and praxis as evidence based practice. The context for this research will be to understand what evidence based practice is in the mental health sector with a specific focus on therapeutic practices that are recommended for working with rangatahi (youth) and whānau. A case study of a Māori whānau will be mapped back to a Māori model of practice (Pounamu Model¹) to demonstrate that indigenous knowing counts. Two Kaupapa Māori mental health services will act as further case studies in order to identify the common themes of practice that are derived from Māori ways of knowing. The importance of this thesis topic is due to the move towards importing evidence based models from overseas into New Zealand. As a consequence of this development, current Māori models of practice are marginalized as they are not recognized as being evidence based according to the definitions². The writings will look at the topic through a critical lens and consider how critical theory contributes to Kaupapa Māori theory and praxis as evidence based practice.

The title “Shady Lenses” refers to the many lenses I use in writing this thesis to accommodate an environment that continually challenges Māori identity as both individuals and as a part of a wider collective Māori community. The house of integrated approaches refers to the range of knowing (experiences and knowledge) that contributes to Kaupapa Māori theory and praxis as evidence based practice in the Māori mental health sector. Kaupapa Māori theory and praxis is a framework that validates Māori models of practice as evidence based practice. We experience these understandings through the privilege of sharing 20 years of practice in Māori mental health and the stories from our Māori whānau who have been consumers of the justice and mental health system.

¹ A Māori Model of Practice that I have developed over the 20 years of my practice in Mental Health. It is a tool that can be applied at different stages of intervention and engagement.
² A commonly cited definition of evidence based practice is the “Conscientious, explicit and judicious use of the current best evidence in making decisions about the care of individual patients” (Sackett et al., 1996)
In conclusion, it is through the implementation of Māori models of practice (such as the Pounamu model) that we see old time ceremonies in practice in more contemporary times. This thesis proposes that through the implementation of Māori ways of knowing and being, Whānau Ora can be achieved.
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Ko ia nei te timatanga, te mutunga o nga mea katoa.
Ki ngā taonga tuku iho o ngā tīpuna, e tu, e tu, e tu.
Kia rātou ma kua huri atu ki tua.. mō ā koutou, poipoi wairua, waiwai hinengaro,
Whakahou whakaaro tikanga.
Me mihi i runga i te aroha
Haere haere haere.
He mihi kia koutou, ngā kā rangaranga hapū, ngā whānau maha, ngā kaumatua
Tāua-a-Māori, Tāua-a- Tau iwi, huri atu kia koutou o rāwāhi, i akiaki, whakatikatika,
Tohutohu, kōreroro, me ngā ahua whakatoa kia tipu.
E kore koutou, e kore e tutuki ēnei tuhinga, te puawaitanga o ā koutou manaaki.
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Chapter One

Introduction

Whāngaia te Hinengaro,
Feed the mind
Tiakina te Tinana,
Take care of the body
Kia Pai te Whānau,
For the good of the Whānau
Hei Oranga mo te Wairua
For the wellbeing of the spirit.

In New Zealand we have Māori models of well-being that are evidence based models of practice from an indigenous stance and yet current practice in the mental health area continues to use imported models of evidence based practice. The aim of this research is to provide evidence that Kaupapa Māori theory and praxis is evidence based practice that originates from generations of debate, tradition and lived realities over time and can stand alongside imported counterparts as an ideal Māori mental health model. In order to evidence my hypotheses I will firstly review current evidence based clinical approaches and their benefits for Māori. Secondly, I will review Kaupapa Māori theory and praxis as a framework for a Māori-centred model of evidence based practice. In the third section of this thesis I will review, through a series of case studies, a current model called the Pounamu model.

The Pounamu model is developed from a Māori perspective and is currently being used by a number of Māori Health providers. By using case studies of the Pounamu model in practice I will demonstrate how ’indigenous knowing’ counts in Māori mental health treatment programmes. Knowings is defined as the lived realities we bring to our

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3 A proverb developed by the writer for the purposes of a Whānau Ora Expressions of Interest for Youth Horizons Trust, July 2010.
4 Defined here as a knowledge that has been tested against traditions or generations of time
practice and how those values we bring from our own cultural realities not only sit within our daily lives, but as a natural progression are also translated into our professional practice.

The research hypothesis; that Kaupapa Māori theory and praxis is evidence based practice, summons a number of questions that I will be answering throughout the course of the thesis to provide an understanding of the definitions of what is Kaupapa Māori theory and praxis and what constitutes evidence based practice. The first question to ask is: what is Kaupapa Māori theory and praxis? This enquiry provides a framework to understand how Kaupapa Māori and theory is defined from an indigenous scientific perspective. The second question asks: what is evidence based practice?

The understanding of definitions that form evidence based practice from a western perspective allows the research to highlight the marginalization of indigenous knowing that continues to disturb or challenge the lenses we wear as kaimahi. The third question to ask is: what are Kaupapa Māori models? This question provides the context of this thesis, where I maintain that Kaupapa Māori models are formed from a foundation of knowing based on an integration of knowledge from the older Māori generations and that from more contemporary times. The Pounamu model is one of many perspectives of the strategies of evidence based practice we utilize in improving service delivery to Māori who interface with Māori mental health.

The penultimate, question, however concerns Kaupapa Māori theory and praxis: evidence based practice and Māori knowings, and asks: does indigenous knowing count when considering the wellbeing of Māori? The Pounamu model captures these knowings through a case study from a whānau who have utilized this approach as a means of Whānau ora. The final question then concerns which current evidence based clinical practices work best for Māori. Again, the Pounamu model will serve as an exemplar of an applied model of practice that allows for indigenous knowings to underpin treatment programmes and demonstrates that Kaupapa Māori models are evidence based practice.

The Pounamu model highlights the need for service delivery to Māori in Kaupapa Māori mental health, to take an approach that is integrated clinically and culturally but primarily

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5 Kaimahi is a term used to refer to workers or staff. In the context of this thesis it refers to workers or staff members who work in the mental health sector.
formed from an indigenous perspective in making a difference for Māori. This introduction will focus on writings that provide some understandings and definition(s) of Kaupapa Māori theory and praxis, Māori knowing and evidence based practice. Kaupapa Māori theory and praxis will be considered in regards to historical definitions as well as more contemporary meanings. The literature on evidence based practice will be specific to evidence based clinical models of practice. This analysis of the current literature in both Kaupapa Māori theory and evidence based practice will then be interwoven throughout the Methodology chapter. Finally, this present research will investigate Māori models of practice, and the common themes that emerge from these approaches across the identified services being interviewed.

1.1 Writing myself into the thesis

Chapters within this thesis will capture stories and experiences from my 20 years in mental health, particularly in Māori mental health. The lens by which they will be viewed will be one that is critical, Māori, from a nursing perspective that brings experience from working in a Kaupapa Māori mental health setting and environment, and from one who has her own story to tell. As such, much of my writings will be in the first-person narrative as they are very much a reflection of my own experiences within the mental health sector, and the way I have developed a model to incorporate Māori ways of knowing into my practice.

Freire (1993) refers to cultural workers (in this case, Māori workers) as workers who are border crossers. By Freire’s definition I could be referred to as a ‘border crosser’ because I have worked across several specialty areas in health. In this area of work (Māori mental health) a practitioner moves from one reality to the next. The environment in which a person is operating is different although the traditions of practice become the baseline for how practice occurs. The space between the border crossing and the new zone can be an opportunity to transform the new ideas in practice. For example, Māori models of practice and clinical integration can be used as the framework for Kaupapa Māori theory and praxis as evidence based practice. A more specific example of such an approach is reflected in the developments of the ‘Pounamu model’ which has been developed as a therapeutic tool over the past 20 years while working across the mental health sector. I
think about the ‘ballet of concepts’; the range of terms (Freire, 1993), for example, how we use clinical language to describe what we are doing in our practice. From a more grass roots perspective, as border crossers (kaimahi that have worked across a number of sectors within a specific area of health, such as mental health and for example Kaupapa Māori mental health), we use a range of terminology to rationalise what we do in our practice. During these travels across these sectors, we share Māori knowings, so we are all, in some way, contributing to workforce development through educating colleagues and helping to define theory. Exiles are those who are breaking borders, such as us as Māori border crossers, who are driven by the kaupapa which stretches across, and into a range of sectors. As an example, Kaupapa Māori mental health moves into child and adolescence, rangatahi and adult mental health service delivery, and so we are moving through a number of borders. We are always crossing different zones and environments, so have an open approach and are better placed to stand back and take a look at what is happening in the workplace, in regards to the post colonialism realities. From this, it can be argued that we need to unlearn some of what we know so we can truly come from a neutral position when transforming new practices (Freire, 1993). We should be calling on the theories of other cultures to develop best practices for the betterment of all; for example, Kaupapa Māori theory and praxis, as an integration of the clinical and cultural realities.

1.2 Organization of chapters

The chapters will be introduced by way of the common themes that whānau often present with on contact with mental health providers. The purpose of using this approach is to provide an overview of each section of the Pounamu model. The Pounamu model approach reflects the ill effects from colonisation, such as loss of identity. It also provides a framework by which we can keep the bureaucracy of the mental health system at bay; for example, the risk management structures of the system tie the kaimahi down into a number of operational processes so we have less face to face contact with Whānau but, when we work with Māori models of practice, it allows a dual accountability so we can work in a meaningful way with our Whānau. Fanon (1965) states that the colonial world is a world of compartments, therefore we experience service delivery that is fragmented. Kingi (2005) refers to this as an experience
throughout parts of the world which has revealed the extent to which indigenous populations have suffered from the impact of colonisation. A key practice of working with the ‘Pounamu model’ is looking at yourself as the practitioner and what your picture looks like. This is important in understanding how colonisation has impacted on individuals. It allows a personal story to unfold as we move through the chapters. Sim (2001) refers to the magpie fashion approach, which is taking a bit of the theory and applying our own personal approach, and so each theme that is covered will have questions and aspects that require specific attention and elaboration.

In line with traditional wisdom, each chapter will be introduced with a whakatauki (proverb) that have been given to me over the years to apply as tools. This wisdom provides for rich sources of understanding; they are not only historical sayings but are still heard today in formal speeches on the marae and in the oral writings handed down from past generations (Mead & Grove, 2001). I have used these whakatauki in practice to keep me and those whom I work with safe. The knowledge that is contained within the whakatauki is created from years of experience and knowing that has been passed through generations; through our Māori stories, our songs and the ways we live. It is on this basis that we question what counts as evidence based practice.

Falls et al. (2003) note that practice needs to be informed by science, but that science needs to be adjusted by the real world experience of practice. The whakatauki are a reflection of the principles that govern the way in which we engage with whānau therapeutically, otherwise defined by western research as evidence based thinking. Evidence based thinking reflects an approach that attempts to prove that treatment works (Falls et al, 2003). Therefore, whakatauki are tools of evidence for Kaupapa Māori approaches.

A critical theory approach provides a framework to work in a meaningful way with Māori. For the purpose of this thesis, this approach will be explored through some key concepts that weave together the clinical and cultural knowledge. The right combination at the right time allows for approaches to be integrated when they are needed. The struggles of identifying the right intervention at the right time is about understanding the multiple layers and complexities that need to be managed, and the conflicts between a non-Māori process and Māori paradigms. The use of our own language acts as a medium
for communicating the change. Working with whānau requires interventions that weave across all sectors of health. The practice of weaving different interventions highlights the complexities of the presenting issues, and often how and when you do integrate is dictated by the opportunity when it arises. This requires some assessment of what is happening throughout the entire working relationship. Weaving is also about the linking of the issues and how and why they impact on one another. This approach integrates the clinical and cultural knowledge, along with practitioner experiences in applying a range of approaches at any given time the whānau require it. This is about knowing when to weave different pieces of ‘knowing’ and understanding into the treatment process and when to take a particular focus on either clinical or cultural deliverables. This requires an approach that identifies when to link new pieces of information with what is happening at the time of engagement with clinical and cultural insight. Bishop⁶ (1998) notes it is also about not wanting anything from the experience for one’s self. All our knowledge and experience is directed towards the best interest of the Whānau.

A survey exploring the Pounamu model in Māori mental health will be utilized to critically review the topic, combined with integrated writings and a perspective of 20 years of practice in mental health. The common themes of the Pounamu model include five key areas. The first of these areas, Presenting Issues, is about features of concern and safety; harm to self and others, physical complications and social stressors. The second area, Strategies, concerns substance use and abuse, violence, acting out behaviours and the adoption of alternative lifestyles. These are themes we see emerging on presentation to mental health that are often used as strategies for coping. The third area is about Family Dynamics. These dynamics include isolation, parenting issues, sibling rivalry and understanding the whānau and who the whānau are. The fourth area is about Relationship Issues, and looks at how we conduct peer relationships, sexual relationships and social lifestyle. The fifth and crucial component is the Underlying Issues. This area incorporates the underlying causes for the illness and includes grief, abuse, childhood issues, identity and spiritual issues of concern.

⁶ cited in Heshusius (1994)
1.2.1 An overview of each theme

The theme, *Presenting Issues*, will be explored from the time that whānau first make contact with the mental health service. These will be discussed using the following variables: features, physical complications and social stressors, strategies, family dynamics, relationship issues and the underlying issues. These are common presentations that we see when working across the mental health spectrum with whānau. Under each presentation is an outline of the range of complexities that we see when working with whānau. There are a number of terms that are used to describe one who is a consumer of services. Tangata whaiora is a person who is seeking better wellbeing; however whānau is the term that will be used throughout these writings. Whānau is defined in two ways; as Whānau-ā-Whakapapa and Whānau-ā-Kaupapa. The term Whānau-ā-Whakapapa refers to those significant others whom we are related to through blood ties. The term Whānau-ā-Kaupapa could include, for example, kaimahi who work alongside us as a mental health service provider. This allows the individual themselves to define who their whānau are (Durie, 2001).

The first thing to consider with *Presenting Issues* is the issue of diagnosis and the features of concern with respect to misdiagnosis. These issues remain problematic, for example, the difficulty in making a full diagnosis when one may only be engaged at a superficial level of rapport. This can affect the assessment phase and treatments may be inappropriate because of lack of important information. Durie (1999) states that, ‘categorisation (labelling) of presentations’ has contributed little to the management of mental illness. The current concern and on-going issues with regard to misdiagnosis is in response to the spiritual related features of concern, such as matakite; a seer, foreteller of future events (Riley, 1994) being diagnosed by clinical presentations, such as psychotic episodes. Māori models of practice capture the essence of these presentations and ensure that the interventions are culturally appropriate but, more importantly, they provide an assessment of the indicators. This helps to determine what the presentation is from a cultural perspective, as well as the perceived clinical presentation. In understanding these enquiries, it allows us to consider the integration of clinical and

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7 Matakite; a gift that allows one to see into the spiritual world. A connection to a range of spiritual senses outside of the physical. Ruha (1995)
cultural interventions, such as Māori models of therapeutic intervention, alongside a more psycho-medical approach, such as medication.

Health professionals are familiar with why Māori have poor health outcomes. This may be partly due to health services continuing to fragment the way in which Māori receive care, combined with the constant referrals from one point of entry to a whole range of providers who operate as individual providers rather than facilitating a pathway that is more holistic. Durie (1999) mentions that there is no evidence that the situation is changing, and that poor mental health continues, particularly for Māori youth (rangatahi). The presentation of issues now requires a strategic approach and wider community engagement at all levels. Māori have a high incidence of suicide rates and, more recently, alarming rates of homicide (Durie, 2001). However, current practices do have some positive aspects and, in light of this, I will also examine positive aspects of the current system that do keep Māori safe and investigate how evidence based practice takes different cultural realities into account. In addition, we must understand the importance of practice that is culturally and clinically integrated.

Mental health often combined with poor physical wellbeing (from a number of external influences) means Māori have a number of physical complications and social stressors impacting on their lives. In relation to this issue, Carpenter et al. (2001) explains Brofenbrenner’s ecological model of human development, which uses cultural specific practices to help others consider the impact of social policy, economic conditions and the effect on family life. Most of the Whānau we come in contact with have a range of complaints about their health. A key symptom commonly reported is the incidence of head injury of some sort, which is not necessarily captured in the information received upon referral. Durie (1999) notes that the problem of poor mental health is reflected in hospital admissions, with high admission rates in acute services, rates of suicide among Māori, an increase in offending and imprisonment, abuse within families, risk filled environments and additional issues of their own (for example, transient and therefore difficult to locate). All of these ‘stressors’ combine to further complicate the health and well-being of the individual, and are present within the theme of: Presenting Issues.

The second theme identified above is Strategies, which are the coping techniques we adopt; both as the tangata whaiora and whānau and mental health practitioner. The introduction of substances such as alcohol and drugs often contributes to the incidence
of violence in homes. Strategies through the adoption of alternative lifestyles are often prevalent amongst Tangata whaiora and whānau. Freire (1993) looks at history as a way of reclaiming power and identity through the politics of hope. Māori are well placed to look to the tools of the past and the tools from the ancestors in order to develop good coping strategies (Mead & Grove, 2001). In looking to the past, we can draw on principles of Kaupapa Māori theory and praxis that provides us with a lens by which we can view the world. Those experiences we have can then be understood through a particular world view; for example, a Māori knowing to help us navigate through the realities by which we are faced (Sim, 2001).

The third theme, Family Dynamics, relates to the fact that the current clinical practice is to involve Whānau. Jenkins et al. (2001) identifies Whānau as a fundamental cornerstone of culturally relevant pedagogy. Whānau is used here in the sense of aroha (love), awhi (support), manaakitanga (hospitality) and tiaki (guidance). Knowing who the Whānau are and what their Whānau system looks like are important first steps. The practice today seems to involve a phone call or feedback from the provider advising they spoke with mum, dad or aunty (for example) and indicating that “there are no Whānau interested”, or documentation littered with notes that suggest that the Whānau are too high risk to engage with face to face. The system therefore can become a place whereby the workers do not engage, and all interfaces are managed by phone or correspondence. Working with Whānau is an important factor in affecting change. Durie (1999) recommends that clinical research be the basis for good practice, but notes that this also needs to give consideration to the cultural realities, such as Whānau engagement. There is a need for Māori methodologies which allow for an expression of Māori health perspectives. To assist in this, Durie (1999) developed the Puahou model, a five pronged strategy that allows us some opportunity to improve the ways of knowing when looking at service delivery for Māori in mental health. It provides a framework for delivery of services to Māori through the promotion of a secure cultural identity, which includes working with Whānau.

The health system provides a range of evidence based medical interventions and practices that treat various presenting issues and family dynamics. Causative factors, for

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8 Puahou: a five pronged strategy in improving service delivery to Māori: Access to a secure identity, active participation in society, aligned services, accelerated workforce and autonomy and control.
example, are aspects that require lifelong interventions which are seen to be complex, so this area has not been well addressed. The consequence is that the intergenerational cycles of abuse, such as underlying grief and abuse remain problematic. Durie (1999) states that the task is to ensure Māori have access to culture, a range of resources, and, more importantly, to a supportive extended Whānau and positive family development. He asserts that this must be a priority. This focus allows for discussion about what happens operationally, and a framework to demonstrate how Māori approaches contribute to better mental wellbeing for Māori. To do this, we will consider a case study that is mapped against the Pounamu model. This will highlight the use of indigenous knowledge in ways that matter and are effective for treatment.

A good practice approach reflected in the Pounamu model provides an opportunity to undertake a range of discussions or psycho-educational / korero / talking therapy components that we must consider when engaging in Whānau mahi or therapy. The components for further discussion are around Kaupapa Māori processes of keeping yourself safe in practice, and tools we can call on when applying spiritual processes (for example, karakia to open and close the korero). This provides for discussions about understanding where the issues stem from, understanding our own issues in terms of backyard / front yard, and knowing when your own issues are distracting your focus on the work at hand.

An important part of my role as a nurse is to use the practice of linking to allow me to understand the concerns where the issues originate from and how we continue to perpetuate those ways. We link one issue to the next and divide the issues into the micro-issues that form the complexities in our work practices. It is not uncommon for Whānau whom we work with to complain about not understanding (or to disagree) with the treatments being recommended. As a health professional, Whānau we are working with often report we do not feedback the information in a manner that is meaningful. This practice is important to make sure we have interpreted the information they have given correctly. Making the links to where the issues stem from, how they then impact

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9 Intergenerational cycles of abuse refer to the behaviours and ways of life that we continue within the Whānau cycle for example, the drinking, violence, sibling rivalry, relationship fallouts (personal note. P.Ruha)

10 Talking therapy; talking to a trained professional to understand thoughts and feelings, a document published in (2010) by Te Pou on Talking therapies for Māori.

11 Backyard and Front yard; refers to the practice of looking at your own issues and problems.
on the way in which the issues are dealt with, and the consequence for the Whānau and the wider relationships is a necessary skill in breaking intergenerational cycles of abuse. In the mainstream [Western] system, we tend to focus on the issues pertaining to the mental ill health of people rather than focusing on feeding back information we collate from our assessments with individuals and Whānau. Access to cultural identity is therefore fundamental in breaking these cycles (Manna, 2002). An environment where the unknown makes people fearful of any situation in which they are placed can potentially cause anxiety and lead to the development of emotional issues. (Krauss, 2000) believes that humility, honesty and mutual respect are important in defining the relationship between the nurse and patient, and that this is an on-going process. The clinicians will be considering how they will approach the work, what the best way is, and whether they have the skills to work with the presenting whānau (Manna 2000). It became very clear early in my psychiatric nursing career that dealing with your own issues, and understanding how to manage these, was a useful tool when looking at working in mental health. This practice ensures that, when we are working with Whānau who share similar experiences with ourselves, we are able to identify these moments and access strategies to manage these times, in particular when you are in therapy. Transference is a term from Freud (1856-1939), and is when an individual may have strong negative or positive feelings that impact on the rapport being built between the whānau and the therapist. One example of this is called “Transcultural Analysis” (TA). Another term is psychodynamic which deals with “unresolved issues”, and yet another is “parallel process / issues” where, with the likelihood of suppressed issues coming to the surface, the practitioner is better placed and equipped to handle any stressful situations. The therapeutic space is more recently being pressured by the need to account for statistical outcomes such as return on investments, a value for money approach (Stickley & Freshwater, 2009). It is important to be diligent in knowing when issues of counter-transference dominate the therapeutic space and how the space then becomes the space for the therapist, thus becoming a distraction during interaction with the whānau (Winstanley, 2006). Part of this is also about knowing who you are and understanding where you yourself sit in the context of the identity continuum (Durie, 2001). The continuum highlights that Māori have different lived realities of being Māori, and so while some of us have a
compromised sense of being Māori, there are those who a notional sense, positive and secure sense of who they are as Māori.

Tangata Whaiora is a term that describes a person who is seeking better wellbeing which, in itself, creates much controversy. Historically, other terms that have been used interchangeably in mental health included client, tūroro, someone who was sick, and consumer. Tangata Whaiora and whānau are preferred terms because we are all seeking wellbeing in some shape or form. In the journey to seek better wellbeing, looking at our own issues is an important part of this healing, so that when mental health workers are privileged to be part of our Whānau hīkoi (journey), they will have the skills to manage the moments that arise when one is touching on matters that are familiar. In my experience, health workers can forget what a privilege it is to be part of one’s story and get tied up in the complexities and difficulties that mental health workers read and hear in the referrals. Developing a strong understanding of our role as a nurse and our responsibility to Māori is one of the most difficult challenges health workers face when living in a society that pressures you to label and treat problems. Bishop (1998) highlights that self-determination requires self-disclosure and openness. It may be easier to go with the status quo when we have a number of responsibilities (being a mum, being professional, a sister, an aunty, a nanny, a colleague and a friend).

Effective practice involves making effective and realistic changes. The change is about planting seeds and hope so that, throughout their life, tangata whaiora and Whānau can be reminded of the impact of the seeds planted by the many that we get to share our life breath with (Ruha, personal communication, 1995). The outcomes are not always immediate, but may become evident when least expected or when significant developments or relapses eventuate. The recovery from unresolved issues can be a lifelong journey. Genero (1995) highlights the idea of resiliency which involves understanding the ‘social inequities of racism’ (p. 31). Resiliency is about “hanging in there”, having hope when no one else does, and knowing that there is a need to tolerate the negative side of what we work with in order to effect change. Masten (2009) refers to this as a process rather than an individual behaviour.

The importance of the use of self as a therapeutic tool requires health workers to understand the complexities of the workload when working in mental health. The demands of meeting the needs of the Whānau we are working with and self-care are
critical in managing the movement of one’s practice across the spectrum of care. The naturalistic researcher believes that the enquirer and the object of enquiry interact to influence one another, and that the knower and known are inseparable (Mehra, 2000). Therefore, managing my story and how and when this applies to practice is important. The seed you plant now may not be of use for some time in their lives, but the hope is that they will be able to recall this knowing in times of need. Repper and Perkins (2006) maintain that nurturing hope is a key to recovery. Making change requires an approach from one or more sources at different times and it is about knowing when to do this. Everyone has a contribution to make; it is about the right fit at the right time. Bishop (1998) acknowledges that this practice involves the development of a participatory mode of consciousness so that a health professional becomes part of the process. Throughout this process we are also challenged to remain true to who we are as Māori. The consequence is that we are always juggling with more than one reality, and are often placed in the position of being Māori (p. 14) we are always forced into wearing different hats at different times, for example, having to integrate the Whānau hat with being the professional supporting the Whānau through the process of treatment. Mehra (2000) notes an important perspective of research is that there is a need for the health professional to have an understanding of their role of self, the role of their people, and the issues and boundaries of territory as naturalistic researchers. It is important to consider such elements when working with Whānau to ensure all involved in the research are kept culturally safe. (Smith G. H.2000) provides a platform by which Māori researchers can move more freely and safely, through the intricacies of researching one’s own ethnic group, and this is presented below. The following table highlights the elements of Kaupapa Māori principles and how they are translated as practices for treatment when working with Māori tangata whaiora and Whānau. An example is allowing tangata whaiora and Whānau to determine their own path (Tino Rangatiratanga) through being who they are.
Table 1: Kaupapa Māori Intervention Elements in Practice (Smith, G.H 2000)

<table>
<thead>
<tr>
<th>Kaupapa Māori Intervention Elements</th>
<th>In Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tino Rangatiratanga (the self-determination principle)</td>
<td>Being Māori all the time, where ever I go.</td>
</tr>
<tr>
<td>In the Treaty of Waitangi; the right to protection of what matters for the interest of Māori, our right to participate and the need to work in partnership. A reminder to our visitors that we know what is in our best interest.</td>
<td>Access to our own realities in any environment with equal relationships within western dominated environment.</td>
</tr>
<tr>
<td>The heart of Kaupapa Māori</td>
<td>The People ‘He aha Te mea nui o Te ao, he Tangata, he Tangata’.</td>
</tr>
<tr>
<td>Autonomy</td>
<td>A position of power over our own destinies. Determining what’s right for Māori.</td>
</tr>
<tr>
<td>Mana Motuhake</td>
<td>Legitimizing Māori knowledge.</td>
</tr>
<tr>
<td>Self determination</td>
<td>Telling our own story.</td>
</tr>
<tr>
<td>Independence</td>
<td>Actively engaged.</td>
</tr>
<tr>
<td>Sovereignty</td>
<td>Living meaningful lives.</td>
</tr>
</tbody>
</table>

1.3 Research Dynamics

Indigenous epistemology fits well with the concepts discussed in Table 3 above, because it acknowledges the interconnectedness of everything; all living things, the universe, the stars. It recognizes that the universe is fluid, nonlinear, and relational (Kovach, 2005). Naturalistic, indigenous ways of knowing accept both the physical and nonphysical realm as reality. In accepting the non-physical, one must accept that reality cannot always be quantified.

As discussed earlier, critical theories provide us with a lens by which we can view the world, an understanding through a particular eye view to help us navigate through the realities by which we are faced (Sim, 2001). Kaupapa Māori, as a critical theory, provides us with this platform and acts as a cloak of safety as we travel through environments
that are of an imported origin. Critical theory allows for different interpretations and debate, and therefore Kaupapa Māori, as a theory, creates this space for Māori (Smith, 2008). The notion of Kaupapa Māori as evidence based practice is about acknowledging definitions that sit outside of western ideology.

Te Pou o Te Whakaaro Nui (2010) evidence based practice is a growing movement that health funding groups are now looking to with regards to improving service delivery in the health sector. Evidence based models are being implemented, for example, in the treatment of those who have a diagnosis of severe conduct disorder. Te Pou o Te Whakaaro Nui (2010) multi-systemic therapy and multi-dimensional therapeutic foster care are two evidence based approaches from overseas that are currently in operation throughout the country. Kaupapa Māori thinking recognizes the eclectic ways of ‘knowing’ that can contribute to Māori mental health and its strategic movement forward into more contemporary times.

Table 2 highlights the alignment of theories in response to defining research that captures indigenous research realities.

<table>
<thead>
<tr>
<th>Indigenous Epistemology</th>
<th>Qualitative Research</th>
<th>Indigenous health professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Interconnectedness of everything</td>
<td>e.g. No research is free from bias (Berg, 1995)</td>
<td>e.g. The histories of the beginning of our time</td>
</tr>
<tr>
<td>All living things</td>
<td>From the inception of the topic</td>
<td>The stories, genealogy and the traditions</td>
</tr>
<tr>
<td>The universe and the stars</td>
<td>To the interpretation of the results</td>
<td>Kaupapa Māori theory and praxis</td>
</tr>
<tr>
<td>The physical</td>
<td>The researchers point of view affects the topic</td>
<td>Identifying my place in the research</td>
</tr>
<tr>
<td>The non physical realms</td>
<td>Not seen as valid</td>
<td>Māori models of practice</td>
</tr>
</tbody>
</table>
1.4 A Māori-Centred Qualitative Research Approach

Māori must operate from a collaborative stance in what we do to find strength in one another, to strengthen ourselves to resist the colonization of our minds, hearts and souls as indigenous peoples (Smith.G,H 2000). It is through the teachings of our forefathers that we will find opportunities and refreshing ideas to strip away at the layers of neoliberal contamination which, in turn, has contributed to the disparities of poor mental wellbeing amongst our people. Kaupapa Māori provides us with this advantage and a platform to bring about this change, which has been used as the strategy over the years by many of our Māori leaders who are driven by the desire to give back to the people (Diamond, 2003). This is a practice that continues today and is seen in many projects undertaken by Māori.

Through this research, the stance is that Kaupapa Māori theory and praxis is evidence based practice. The research approach then has been to identify common Kaupapa Māori theory and praxis evidence based practices by examining two Kaupapa Māori providers, and how they apply a Māori model that captures ‘when indigenous knowing counts’. In line with this, a review of the current literature of evidence based clinical approaches will provide further data on what constitutes evidence based practice and the benefits of current evidence based clinical approaches for Māori. The research aims to develop an evidence based Kaupapa Māori model for Māori by Māori.

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12“Blood Memory”; it is believed that thoughts, beliefs, and actions are conveyed from one’s ancestors through the blood. Spiritual knowledge cannot be observed by physical means; therefore, as it cannot be measured or quantified. Often dismissed by western researchers. Of these three sources of knowledge, one is not seen as more important or more valid than the others in indigenous society, all are seen equally valid and interconnected.12
(Royal.C 1998) highlights that the golden rule of research is that it contains the truth about those being researched. With these matters at the forefront, the following steps have been considered in implementing the research.

The plan

a. To interview a Māori Family and map this back to a case study, using Te Pounamu model (a Māori model of practice), to tell this family’s story and demonstrate how this approach has contributed to their wellbeing as a Whānau.

b. To identify and interview two Kaupapa Māori services to identify common themes of Kaupapa Māori approaches.

c. To review the literature specific to the implementation of evidence based models and their effectiveness for Māori.

Kaupapa Māori theory and praxis will be explored because it allows for the implementation of Māori theoretical and methodological ways of knowing (Bishop, 1998). It is through the implementation of Māori models of practice that we see ‘old time ceremony’ in action. The perspective that is being taken is driven by my experiences working in the mental health sector.

Kaupapa Māori theory aligns with critical theory in the act of exposing underlying assumptions (Smith.G,H 2000). Therefore, Kaupapa Māori frameworks provide a position whereby we can detect hidden colonial agendas and a space for Māori knowledge, and frameworks to engage with and be engaged with alongside other knowledge frameworks.

Indigenous evidence based approaches, in the context of this research, would look at finding an understanding through the writings around Matauranga Māoritanga. Matauranga Māori is the indigenous knowledge of this country as the first language of the native people of New Zealand. Walker (1974) stated that the retention of old time ceremony is a perspective that is being considered in this research as a focus of Kaupapa Māori evidence based knowledge. It supports the notion that indigenous knowing counts. This will be demonstrated through the case studies, which will be connected to a Māori model of practice.

Kaupapa Māori methodology provides a pathway where we are well placed to draw on Māori knowledge that is distinct and unique to Māori. The methodology identified for
this research allows for a better understanding and possibilities for change (Johnston, 2003). A Māori centred qualitative approach provides the path to challenge the existing ideology, that “Kaupapa Māori theory and praxis is just a cultural view point” and not evidence based.

When referring to Gramsci’s (2001) ideas about the organic intellectual, it can be seen that Kaupapa Māori theory and praxis disrupts hegemonic spaces, more specifically, as a way of challenging the ‘taken-for granted’ assumptions that dominant groups hold about Māori (Johnston & McLeod, 2001). A Māori centred qualitative approach, as discussed below, challenges the assumptions about what constitutes evidence based practice. For the purposes of this research, the approach being considered is based on age old traditions, as noted by Linda Tuhiwai Smith. L(1998) in her writings in decolonizing methodologies (see below, table 3).

The following is a table that contains a summary of how research is defined from a Kaupapa Māori perspective and what this looks like in practice. An example is Aroha ki te tangata, ensuring that we respect and care for the wellbeing of the person as paramount when undertaking research with Māori, and then that we show how that translates into practice.

Table 3. Māori Centred Qualitative Research Approach (Smith I. 1998 p. 120).

<table>
<thead>
<tr>
<th>Māori centred qualitative research</th>
<th>The approach in practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aroha ki Te Tangata</td>
<td>Respect for the people.</td>
</tr>
<tr>
<td>Kanohi kitea: The seen face</td>
<td>Present yourself face to face.</td>
</tr>
<tr>
<td>Titiro/whakarongo</td>
<td>Look, listen to what’s happening in the environment.</td>
</tr>
<tr>
<td>Manaaki ki te Tangata</td>
<td>Share and host people, be generous, treat others as you would expect to be treated.</td>
</tr>
<tr>
<td>Kia tupato</td>
<td>Be cautious in terms of confidentiality, protection of both the researcher and researched. Take heed of the advice from kaumatua.</td>
</tr>
<tr>
<td>Kaua e takahia Te mana o Te Tangata</td>
<td>Do not trample on the authority of the</td>
</tr>
<tr>
<td>Kaua e mahaki</td>
<td>Do not flaunt your knowledge, as academic institutions encourage you to promote yourself. Humble yourself at all times.</td>
</tr>
</tbody>
</table>
Kaupapa Māori Theory and Praxis: an Indigenous Approach

Lifelong layers of intervention in Māori mental health

13 Kaupapa Māori theory and praxis model for intervention

Resilience

Resilience is a practice that draws on Māori knowing from the ages to strengthen you as a practitioner when working with the complex issues with our Whānau. Identifying what works at the right time, linking and planting seeds of knowing are crucial to the process of recovery. We add these knowings to our baskets of understanding of recovery in Māori mental health, as we move through the different sectors of mental health. Practitioners have a responsibility to understand their own issues and to build a practice of resiliency.

Hope

Hope is a practice of developing a rapport with our Whānau, a rapport that allows you to have hope when no one else does; the sharing of our stories from our life experiences; knowing that every contact is a therapeutic contact.

13 A model that reflects the integration of Kaupapa Māori theory, praxis and knowing with key tenants for recovery.
Recovery
A practice of embracing our own issues and understandings as a means of healing one another.

Kaupapa Māori Theory, Praxis and Knowing
A practice that allows practitioners the ability to weave the many physical and non-physical relationships of Māori knowing and understanding that sit as a foundation of one’s practice.
Chapter one discussed the aim of the thesis and summoned a number of questions in regards to understanding what is Kaupapa Māori theory and praxis, what is evidence based practice, and finally what are Kaupapa Māori models? The position that is being taken throughout these writings is that Kaupapa Māori models, such as the Pounamu model are formed from a foundation of knowing, based on an integration of knowledge from the older Māori generations and from more contemporary times. In chapter two we look at definitions of evidence based practice in health and where it is located in Kaupapa Māori theory and praxis.
Chapter Two
Evidence Based Practice

Ko Te Aroha
Love
Ko Te Mārama
Understanding
Ko Hau
I am who I am
Ko Papatuanuku tōku whāea
Mother Earth is my mother

Love and understanding defines who I am and where I come from
(Ruba, 1995)

Caccioppoli and Cullen (2005) highlight that the western / mainstream system is “institutionally racist and discriminates against Māori” (p. 159). The diagram below describes the cycle of practice that contributes to Māori ill health and demonstrates how it is then justified using evidence based practice. When you look at what it means to work from a Kaupapa Māori perspective; it is focused on understanding ones story and getting to know who the individual is.

<table>
<thead>
<tr>
<th>The Cycle</th>
<th>Evidence Based Practice</th>
<th>Kaupapa Māori</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosed</td>
<td>Professional identifies the</td>
<td>Manna (2002): Develop a</td>
</tr>
<tr>
<td></td>
<td>appropriate medicines</td>
<td>rapport</td>
</tr>
<tr>
<td>The professional knows</td>
<td>Treatment based on medical</td>
<td>Identify and engage with</td>
</tr>
<tr>
<td>best</td>
<td>evidence</td>
<td>the Whānau</td>
</tr>
<tr>
<td>Professional enquires</td>
<td>Professionals complete an</td>
<td>The Whānau tell their story</td>
</tr>
<tr>
<td>about</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.1 What is evidence based practice?

Evidence based practices in our current health system are predominantly models that are imported from other countries and originate from western frameworks. These frameworks position Māori as a problem (or inferior) and are reinforced by the adoption of the associated practices (Johnston, 2003). Evidence based practice has various perspectives attached, which have a focus towards being vigorously researched and scientifically proven. Thyer (2004) noted that evidence based practice is not a static knowledge and is a constantly evolving state of information. Māori knowledge is also a lived ‘knowing’ that we carry with us in our everyday lives; it is also not a static knowledge and is constantly evolving, as is reflected in the development of Te Reo Māori.

Thyer (2004) highlights that there are a number of perspectives surrounding the definition of what is evidence based practice. Definitions of evidence based practice include an approach that is empirically science based practice which has been evidenced, practice guidelines that are evidence based, and approaches that are empirically supported treatments. In the archives of Māori histories, we hear the journey of our people and how scientific methods were used to bring us to Aotearoa. Moon (2005) captures a snapot of some of these journeys of our histories during his interviews and journaling of discussions with Hohepa Kereopa in 2003. Everything has a life force or a Mauri. Papatuanuku (mother earth); when we are born, our whenua (afterbirth) is returned back into the hands of Papatuanuku; we are forever connected to her, linked backed to the land. We live in harmony with the natural elements of our environment. The earth is a source of food which has sustained us for generations; we are beings of our natural environment to which we also are returned. We hear stories about the beginning of time and how we come to be in these lands, which are evidenced in our Whakapapa and the reciting of Māori genealogy. Te Pou o Te Whakaaro Nui (2010)
refers to this knowledge as traditional Māori wisdom which contributes to the mental wellbeing of Māori.

2.2 Evidence based practice: definitions

The development of an evidence based practice framework from a Kaupapa Māori perspective requires working with the tangata whaiora, the individual, and the Whānau. So in the context of the writings, tangata whaiora is inclusive of the Whānau, or the Whānau inclusive of the tangata whaiora. Kaupapa Māori research methodologies may include the stories that are woven through our Tukutuku panels which line the walls of ancestral houses. The woven pattern tells a story of past times which can also be linked to contemporary times. Māori mythology is derived from the science of the stars, the atua of Te Ao Māori and, more importantly, the practices, protocols and pathways from generations before. Kaupapa Māori evidence based practice is to lay claim to our knowledge and have it recognised as evidence based approaches. Evidence based approaches are predominantly imported models from overseas that have been vigorously researched against western frameworks and then applied with minority groups who make up the highest percentage of poor health statistics, such as Māori in New Zealand. The approaches focus on meeting the outcome measures of the approach, so are not necessarily flexible and suitable as they do not comply with a holistic way of working.

Thyer (2004) notes that evidence based practice is not a static knowledge and is a constant evolving state of information. It is an integration and critical appraisal of research evidence, with clinical expertise and clients values and circumstances taken into consideration. The practices currently being applied are not necessarily holistic but also, more importantly, they fail to consider the spiritual dimension of wellbeing. The spiritual dimension is intangible and cannot be touched, therefore cannot be dissected into pieces. Today, the spiritual experience is seen as a profitable experience however, because it breaks all the rules and regulations of the ethics of practice and what the evidence says is best practice. These dimensions do not exist in the writings around evidence based practice. There is little or no evidence based writings that are specific to indigenous peoples and so the paucity of information brings into question the research
methods that are used to define evidence based scientific and randomized trials and controls of research.

Falls et al. (2003) highlight that research about evidence based practice covers a number of descriptions of practice. Descriptions for consideration are firstly that it is a specific type of practice or service intervention; such as case management as a way of following up clients in the community. This provides a spectrum of intervention from initial assessment to follow up therapy. Considering Whānau Ora as a compliment to case management assists in removing barriers to access so that one has the ability to move freely through the health services.

Secondly, evidence based practice is a way of conducting a clinicians practice: from understanding models of practice, operating systems and processes, and competently practicing within the code of professional practice. The process of changing the way we think is the movement from one knowing to the next, and being able to apply those ways of knowing along a continuum of intervention at any time that particular practice or knowing is required. Evidence based practice is also about using the best knowledge available whether this is clinical controlled trials described in literature or a practice that is generally driven by psychiatrists and psychologist. Evidence based practice drives this in developing the knowledge for a particular intervention. Evidence based practice calls for consultation with other clinicians through the building of relationships. This is a key theme in developing your practice professionally. It is knowledge and understanding through observing how relationships are nurtured and understood for the betterment of all. Building and developing relationships is a key area of development.

Evidence based practice allows for trying of new approaches to obtain the same outcomes with similar types of individuals: an approach that works well for Māori. The basis for this is that the issues are integrated and complex, so a range of interventions go well in terms of healing, however, it is more about the clinician’s ability to integrate its application into treatment which is about the best practice.

Lastly, evidence based practice is about continuous learning and the utilization of interventions that highlight what the client wants and needs. It is important to understand what the client’s specific needs are and what are the potential risks are. This provides information for assessing what the priority areas for interventions are, followed by the on-going strategy for working through the issues of concern.
It is expected that, before evidence based practices are applied into the field, they are rigorously examined to prove they are of value. This is the concern about how evidence based practice is defined. It acknowledges the rigorous examination from a research perspective that excludes a research process based on stories, history, genealogy, and ways of knowing and traditions of practice. The rigorous examination process does not acknowledge this perspective from a Kaupapa Māori theory and praxis approach. Pomare (2007) reminds us that colonisation is a constant situation in which we are placed as our histories and stories are seen as myths from the past and not validated in understanding and improving our health status.

2.3 Evidence Based Practice in Health

The presentations in the mental health system today are fraught with layers of complexities that now require intervention from a range of practices, approaches and evidence. To treat one aspect of the picture, interventions must either coincide with or be in balance with the rest of the individual’s needs. Evidence based medicine has its place in Kaupapa Māori theory and praxis and is one of many evidence based approaches of best practice. Sackett et al. (1996) defines evidence based practice, which is being evolved and adapted, as based on good judgments and the use of the best evidence in making decisions about care. This involves integrating clinical expertise with the best external evidence from systematic research. The question of enquiry is what systematic research looks like in relation to the ethnic populations, and the paucity of information available in the current research and evidence available. In regards to systematic research that is available, how do we know what the ethnic population percentile is? The answer is that we do not.

One way of determining that Kaupapa Māori is evidence based practice is to first look at what evidence based practice is and where it is located within Kaupapa Māori theory and praxis. This will help to determine how effective the applications of Māori ways of knowing are to finding culturally relevant approaches in the mental health sector. The reality is that we have a range of complexities that we present with. Some issues are so long and entrenched or so serious that they require stabilisation with the intervention of medical medicine. The integration of evidence based medicine plays a role in the process of healing, and the mechanisms of how this happens are important to understand.
assessment of the presentation plays a key role in determining what evidence based medicine is implemented. As discussed earlier, a strong rapport aides in the identification and definition of the problems, and in turn, helps drive the identification of the best research and evidence for the best treatment.

The time and period of this intervention is also important to review. Sackett et al. (1996) states that evidence based medicine is not restricted to randomised trials and meta analyses, rather it is about tracking down the best external evidence with which to answer our clinical questions.

The following are principles that fall out of the application of Kaupapa Māori theory and praxis; WhakaWhānaungatanga, Whānau, Kanohi ki te Kanohi, Manaakitanga and Aroha ki te tangata. Waitere-Ang et al. (2000) refer to these approaches, discussed further below, as techniques for addressing the unequal power relationships between Māori and Pakeha by incorporating appropriate decision making forums for Māori. These are usually for Māori by Māori.

These are examples of forums that are for all by Māori which are applied in practice as a means of addressing the power inequalities of the relationship. They are key themes of practice that align with the engagement process when looking at the family dynamics. The first of these principles, WhakaWhānaungatanga, provides the platform for weaving the culturally and clinically integrated knowing across the spectrum of wellbeing. This practice is happening all the time, during the phase of interface between the health worker and the tangata whaiora and Whānau. The clinical jargon that clinicians use to describe these very processes is the practice of working with families. The second principle, Whānau, has always been a knowing of Māori traditions and practices. Working with Whānau is not a new concept and yet, today we see the current shift towards including Whānau in service delivery for best health outcomes. This has been a move practiced by Māori health workers for generations. Mutu (1998) states it is the wise use of knowledge that brings us to Te Ao Marama, not the misuse and abuse of knowledge.

Kanohi ki te Kanohi, the face to face, provides the interface between the health worker and the tangata whaiora and Whānau. This should be a core practice; however it tends not to happen between clinicians in the field. The main reason given for the poor face to face engagement is lack of time, but it is an established way of building a trusting
relationship. As Smith.G,H (1992) notes, it is a way of knowing that has been “born in
time; connectedness, kinship commitment and participation have been fine-tuned as
terms of engagement for generations.

The fourth principle identified is Manaakitanga, which is the practice of caring for others
and self in every moment, and of being in the life breath of others. In clinical terms, we
would refer to this as the etiquette of practice; introducing one’s self, professionalism
towards colleagues, working in partnership and orientation to the agendas and work at
hand. Johnston.P (2003) notes that when the system sees the tangata whaiora and
Whānau as inferior, it is in conflict with the process of Manaakitanga.

Aroha ki te tangata, the next principle, is about being open and honest on engagement
from ones physical, mental, spiritual and Whānau bases. It is often understood as our
code of conduct from a professional basis (a practice of being true to who you are).

Despite these commonly held views that Māori knowledge can stand alongside western
knowledge frameworks, and that a functional Whānau is an important factor to well-
being, the reality is that a lot of our Whānau, hapu and iwi are dislocated as a result of
past disenfranchisement of Whānau. Consequently, the upsurge in understanding the
importance of Whānau has seen a recent drive to have the concept of Whānau-driven
frameworks incorporated in policy. This lead to service delivery models which are now
seen and referred to as evidence based models. This begs the question, though, as to
how much these evidence based practice models are underpinned by Māori ways of
knowing, seeing and doing. To understand what these practices may look like, it is
important to understand the interface with the tangata whaiora and Whānau. At the
point of referral, the process of drawing on a range of knowings begins for the clinician
and Whānau. Being evidence based in your thinking happens from this point forward.

We are always thinking, in this manner in terms, of the fine balance between being
Māori in an environment that is of western origin. Smith (1998) highlights these as key
points to understand in finding the balance between Kaupapa Māori and evidence based
practice.
The following table identifies key themes that capture Kaupapa Māori theory and practice.

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### 2.4 Kaupapa Māori theory and practice variables

Thinking critically considers the use of Kaupapa Māori frameworks to understand the complexities of the issues we are working with in Māori mental health. Māori models of practice such as the Pounamu model provide a platform and visual cue to talk to the complexities or issues that are being presented by the tangata whaiora and Whānau. Kaupapa Māori theory provides the standards for practice when working with Māori, for example, face to face is a key approach when working with tangata whaiora and Whānau. Face to face aides in the process of developing a rapport. Kaupapa Māori theory and praxis is based on a range of foundations that require the kaimahi to develop relationships to ensure effective access to services for tangata whaiora and Whānau. Kaupapa Māori theory is a framework derived from a range of teachings that span over the traditions of time, which provides a range of interventions to address the complexities or layers we are working with in Māori mental health. Multidisciplinary
research involves a process of wananga with many disciplines, not necessarily those who are qualified in the mainstream system, but also acknowledges the more traditional healer, such as our Kaumatua. It is through the process of wananga that the disciplines gather to review what the best intervention is. Kaupapa Māori theory and praxis is the method in identifying and framing the enquiry to identify the issues of concern. Kaupapa Māori allows for flexibility in practice that creates a space where both practices from a mainstream and Kaupapa Māori ideology can be worked in partnership in the interest of the tangata whaiora and Whānau.

2.5 **Kaupapa Māori theory and praxis in health: strategies for moving forward**

Manna (2002) noted that a key issue that continually arises in working with Māori is the issues of identity. It is evident that identity is a key factor that contributes to the mental unwellness of Māori people. Durie. M (1999) highlighted strategies to improve Māori mental health, the first of which was the development of a secure identity. The loss of identity is a symptom of colonization evidenced through the loss of land, language and ways of knowing. What we see in mental health services is that there are those of our Whānau who do not want to associate with being Māori for whatever reason and so choose to access mainstream services. Durie (1994) writes that an identity continuum illustrates this issue; there are those who have a compromised sense of identity and there are those who have a notional sense, that is, they are Māori and are learning more about who they are. Then there are those whom have a positive sense of their identity in that they know who and where they come from, and consequently spend a lot of time with Whānau, hapu and iwi. Identity is not only an issue for tangata whaiora and Whānau but also becomes a dilemma for those kaimahi who have little or no knowledge of who they are and where they come from. Not only are they attempting to provide the services and do the mahi, they too are learning about themselves. Kaupapa Māori theories and frameworks provide the space for this to happen safely, however it may be problematic for those kaimahi who require more from the therapeutic relationship from the Whānau. Manna (2002) highlights the starting point in working with Māori is the assessment phase. Cultural assessment is another process that is floated around, redrafted into different shapes and forms, but that continues to sit in isolation from the clinical
interventions when, in actual fact the Māori models of practice we use as cultural assessment should be seen as cultural assessment tools that cover the clinical deliverables as a natural progression of the assessment. Māori models cover key Māori tenants of working in a Kaupapa Māori way which are holistic, applicable to not only Māori but, if things improve for those whom have the highest statistics we get bashed with in the research and academic writings, things would be better for all as a natural consequence. Key Kaupapa Māori values that a cultural assessment tool incorporates and interweaves are WhakaWhānauungatanga (getting to know who one another is), Korero (talking), Aroha (Respect for one another), Manaakitanga (making sure Whānau are well informed, cared for at all times, and that we provide access to the appropriate expertise), Tīka (doing what is right), Pono (being transparent), Tautoko (creating a pathway that supports Whānau) and Wairuatanga (spirituality).

The principles of the Treaty of Waitangi are often overlooked and greatly misunderstood in terms of how to operationalize these principles in practice. Manna (2002) writes about the importance of these principles in light of the relationship building that comes from working in partnership with tangata whaiora and Whānau, and therefore being able to understand the way in which we all participate in the mahi (work) at hand. Manna (2002) also highlights how, through our professional practice, we enact safety with respect to protecting those tangata whaiora and Whānau we work with in making sure that all documentation of the presenting picture is interpreted correctly, and not on different pages in understanding what the concerns / issues are. The processes of Karakia (prayer) and Mihimihi (introductions) clear the way for the rapport building and orientate the relationship to the working environment. The working environment includes practices such as clarifying written material and discussing the legal aspects of the mahi, for example discussing confidentiality. The process of the session works more effectively when approaches which are visual are used to collate and map back the relevant information. The visual cue becomes, in a sense, a third person which provides for some case of the issues being put forward, looked at and discussed, and which then provokes some whakaaaro (thinking). It also allows a process of examining what the level of insight is into their issues and the mahi at hand.

Health is ultimately about safeguarding the mauri (life force) of Māori people to find its full expression; access to cultural identity is fundamental (Manna, 2002). It has
historically been a story told over and over again of how colonisation has contributed to the loss of language and way of knowing. This has been an on-going issue and a struggle that service providers are faced with in terms of using Māori models to work towards our people finding their ultimate expression. This is how globalization continues to erode our identity, through the constant change and evolution of trying to understand who we are and where we come from. The activity of daily life makes this complicated, especially our own. The struggle also includes needing to know who you are as a clinician; working towards best health outcomes in practice and understanding the fine line of integrating both the clinical and cultural deliverables in any given environment, as well as applying these in practice accordingly. Access to this genuine giftedness is a gem that is rare to find. This giftedness is a combination of childhood knowing, life exposure to both the Māori and Pakeha realities, educational experiences and skill with the insight into the clinical and cultural issues in a mental health environment, a strong sense of being Māori and clarity about understanding and sorting out of your own backyard before helping others. It is these attributes that contribute to the genuine giftedness; and it is this giftedness that filters out kaimahi who work within Kaupapa Māori and those who work as clinicians in the field of Kaupapa Māori mental health.

2.6 A Kaupapa Māori framework

Manna (2002) noted that a key issue that continually arises in working with Māori is the issues of identity. It is evident that identity is a key factor that contributes to the mental unwellness of Māori people. Durie (1994) highlighted strategies to improve Māori mental health, the first of which was the development of a secure identity. The loss of identity is a symptom of colonization evidenced through the loss of land, language and ways of knowing. What we see in mental health services is that there are those of our Whānau who do not want to associate with being Māori for whatever reason and so choose to access mainstream services. Durie (1994) writes that an identity continuum illustrates this issue; there are those who have a compromised sense of identity and there are those who have a notional sense, that is, they are Māori and are learning more about who they are. Then there are those whom have a positive sense of their identity in that they know who and where they come from, and consequently spend a lot of time with Whānau, hapu and iwi. Identity is not only an issue for tangata whaiora and Whānau but
also becomes a dilemma for those kaimahi who have little or no knowledge of who they are and where they come from. Not only are they attempting to provide the services and do the mahi, they too are learning about themselves. Kaupapa Māori theories and frameworks provide the space for this to happen safely, however it may be problematic for those kaimahi who require more from the therapeutic relationship from the Whānau.

Many presentations to the mental health system highlight presenting issues which can either allude to two potential formulations. The first mock scenario may be as follows:

*She is paranoid as a result of poor sleep; the Whānau member has not slept a full eight hours over the past few months and has only had one to two hours a night because she is being tormented by her paranoid thought. The Whānau member is depressed from the grief and loss of a Whānau she was close to. The burdens of daily life have burnt her out and so are stressed from the pressures of Whānau life, and the Whānau have no insight into what’s going on.*

All these issues can also be potentially contributing to lack of sleep due to work and her perception about the Whānau expectations, which is complicated by her intuitive senses (she has visits with those who she continues to grieve over). Her childhood trauma of abuse complicates how she manages these emotions and thoughts. The second scenario may be that;

*the issues have manifested into poor sleep and distorted thinking due to the underlying grief associated with her grandparents death, who brought her up and probably provided her with an environment that nurtured her intuitive senses and allowed free discussion and learning from these experiences. This is not helped by the burden she feels in caring for the Whānau because she has a responsibility to do so and this makes it harder in terms of the demands of work. The lack of sleep is possibly due to her severe grief and mokemoketanga (loneliness). With her wairua being out of sync, it has had a roll on effect and affects the other four corners of her wellbeing.*

This highlights a number of issues. Firstly, that Neoliberalism, the notion of individualism, has impacted on us as reflected in the cycles that we are working with in the mental health environment. The individual approach has been a subtle process and so layers of issues contribute to our presentation. Not only do we have to address the
ills of life, but also the on-going colonial contamination which we call globalization. The challenge is that eventually we come to realize what is going on and some come to this through recovering from their experiences within the health system. For some of the Whānau we have contact with, they come to this understanding through education. Some develop understandings through their relationships in which they are surrounded, and some of us go and learn about being who we are. The Whānau we see in the mental health system who present with feature’s that are misunderstood, such as wairua (spiritual) presentations, are often misdiagnosed, poorly treated or continue to be isolated from the appropriate expertise, as we don’t yet have a skilled workforce that have a sound sense of their own identity.

Smith.L. (1998) asserts ‘bona fide theory of transformation’ as an interchangeable theory. Every layer of engagement has a different framework but the basis of the engagement is based on Kaupapa Māori. This provides the framework by which we can apply the tools to intervene and address some of the consequences of dominant western frameworks. Kaupapa Māori provides the platform by which we can re-identify where we are positioned and find tools to move past the struggle to live a more meaningful life. It is a movement that will be well placed for the next generations; it is our platform. Rata (2004) claims that Kaupapa Māori is a ‘they and we approach’ that serves to protect Kaupapa Māori ideas. Walker (1974) explains that Kaupapa Māori equals Kaupapa tangata, as evidenced by the following whakatauki:

He aha te mea nui o te ao, he Tangata, he Tangata, he Tangata,
(What is the most important thing it is man, it is man, it is people)

Bishop (1998) refer to transformative practice as a revolution, in that we give ourselves consent to write our own story and write how we interpret research and what that looks like for us. The transformation of this in today’s reality is understanding ourselves and our own struggle but, more importantly, having the space to describe how it is for us through our own knowing, thinking and writings which legitimize and validate our place. This practice is a golden resource that sits within each of our stories and experiences of the impact of the discourse, of practice in research from western knowing versus our own as Māori. Johnston (2003), in dialogue with Pratt, talks about how ‘ways of knowing’ become research when subjected to processes of scrutiny.
The mere fact that we are of ethnic origin means that we are positioned by western frameworks as inferior. Smith (2008) exposes these unequal relationships and demonstrates how Kaupapa Māori challenges these inequities. The funding arm requires that we are able to demonstrate the use of evidence based models of practice in order to get funding to meet the needs of Māori, and yet, Kaupapa Māori approaches are not even recognized or considered as models of intervention that would be effective in meeting the needs of Māori.

The unequal power relationships are not only about the fact that our ways of knowing and Kaupapa Māori theories are seen as primitive or not research based or clinically equivalent, it is almost seen as a second cousin, or taken for granted that it is not of any use (a recyclable resource), a waste! If you happen to be a Māori who comes from a significant history of clinical experience, as well as being very comfortable with Māori knowledge, you are constantly battling to be recognized as an equal partner, you are always seen as the ‘other’. If the challenges that are being posed create conflict for the dominant framework, you are told that they struggle to understand what our philosophy is. What is our model of evidence? This demonstrates that Pakeha exclusion of Māori preferred interests continues to oppress holistic ways of working. Rata (2004) sees that Kaupapa Māori creates processes of unequal and economic division.

The testing and interrogation of Māori theory over the years has been reflected on and continues to be tested and evaluated by Whānau, hapu and iwi to this day Smith, L (1997). Smith.L (1997) poses a challenge in regards to asking whether Kaupapa Māori / Kaupapa Tangata can be achieved in dominating Pakeha institutional structures. The unequal relationships oppress the ‘other’ into being plastic, giving the browning effect, which makes us ill and increases our workloads. You are taken for granted ‘being Māori’, therefore there is no remuneration of skill mix. You manage the multiple roles but are one person, you are seen as the second class citizen, doing the nigger dance to create the safe space and get the buy in, having to perform to the standard behaviour of practice and being held accountable because that’s what the system and legislation demands of us in meeting the needs of Māori in a system that is dominated by Pakeha.

Royal (1998) defines collective responsibility as part of Māori survival and achievement where we all take responsibility. We have become so used to being boxed in our fragmented areas, that we now say it is inconsistent having more than one person
working as a Whānau with a Whānau. We see complexities of issues but the system only allows one on one, and yet the layers of intervention require a number of hands to contribute to the healing. The collaboration of all parties is about being in the same position of power and being seen as equally valid in terms of roles and contributions that then provides a process where Whānau can be Whānau.

A system by Māori for Māori is seen as anti-colonial, so the fight for this space is long and hard (Smith, L 1998). The transformation is to create this space so that the fight is not so long and hard for our future generations. Freire (1993) writes that the oppressed must also participate in freeing themselves, understanding the revolution and elements to make the change or the transformation and how we might apply that in our working realities and our lives. These struggles are compounded by the different realities we have as Māori. It is because of these concerns that Māori continue to access mainstream services rather than Kaupapa Māori services. Kingi (2005) explains that contemporary Māori health problems call for a multi-faceted and integrated approach, as the issues are complex and not easily treated with narrowly targeted programmes. It is important that options are made available in terms of access to services and that Māori discuss the options of services that are available for Māori by Māori, as we are better able to talk to the realities and anxieties one may present with. The developments should ultimately be towards encouraging Māori who access mainstream services to seek out Kaupapa Māori services and interventions, and work through their issues they have. A Kaupapa Māori framework that meets and addresses these challenges can be summarised in the diagram below.

The option of mainstream or Kaupapa Māori mental health services creates concern in that such services are seen as a separatist approach and racist because they are for Māori only. We must question what is it then called when you have mainstream only services that operate, and have operated, in such a way that it meets the needs for non-Māori more so than those who are of a different ethnic origin. The argument then becomes why we are not a society that accommodates to the multi ethnic groups that exist within our communities. Applying holistic interventions can be difficult, and consequently, some service providers do this well, but most do not (Kingi, 2005). There is a wealth of writings that now highlight our poor health statistic, and so if Māori are at the bottom of the wellbeing scale, we need to be a priority if things are to be better for Māori. As a
natural progression, things will be better for all. The Western infrastructures, by which we operate, are obsolete and Māori are now determining what our own ideological space looks like. There is a growing pool of evidence that suggest that culture has little place in a health setting unless it contributes to the health gains (Kingi, 2005). Kaupapa Māori theory and praxis has created this space for Māori to think and be Māori in a world that is littered with ways of knowing that are of western origin.

Evidence based practice includes the use of operational procedures, guidelines, protocols and programme pathways. This has been part of our practices for decades. Kaupapa Māori theory and praxis is driven by traditions of practices that have survived the rigor of intergenerational debate, and survived the many changing faces of the western system by which we live. The knowledge could not be static because of the evolution of time and the need to adapt the traditions according to the time. The research has been done by our ancestors; they have lived these practices for generations using the same method of application, observation and integration.

Kaupapa Māori theory and praxis, such as the Pounamu model, is a tool that allows us to unshackle ourselves from the hegemonies (Smith, 2008) by exposing the underlying agendas and creating an opportunity to discuss the strategies, and to then manage those issues. This helps to move on and past the struggle, where we are then better placed to work with wider Whānau to address these hegemonies and influences on every one of us. We all have a story to be told because we are being born into an environment that is oppressive. We need to understand our own story and know where it comes from and how we continue to perpetuate the cycle of intergenerational abuse. The following chapter will provide an introduction to the Pounamu model. Following this will be some case studies of how evidence based practice works through the practical application of the Pounamu model. First though, I will provide a background to the Pounamu model (Te kakano14)

The Pounamu model provides a framework that allows us the space to work in a meaningful way with Māori, keeping the bureaucracy of the system at a distance. Manna (2002) writes that the Pounamu Model is a tool that has been developing over the last 12 years. It is a model that was inspired by a session with a fellow colleague while working with a rangatahi (young person). At the time, aged 23 and quite young still, we soon

14 Te Kakano: The seeds
learnt that the rangatahi we were working with perceived us as being health workers who
did not know about her world. The Pounamu was visual, so provided an opportunity to
feedback the insights into her world which contributed to the buy in in building the
relationship. This was a glimpse into the “light being switched on” and how powerful
that was for this rangatahi. There have been many interesting travels with the Pounamu
model over the years, and it is a way of knowing that has been implemented in practice
in a number of treatment facilities such as Māori mental health, non-government
organisations providing primary Māori mental health services, Lower North Severe
Conduct Disorder Programme; stage 1, 2 and 3 (a collaborative venture). The model
has been implemented by the multi disciplines within the mental health sector,
psychiatrist, psychologist, nurse, social workers, programme assistants, kaumatua, non-
Māori, Māori and in acute, specialist mental health treatment environments, community
mental health teams, across the mental health sector, in the District Health board
environment and the non-government sector. The Pounamu model is always being
modified, developing and adapting and out there for clinical and cultural integration in
health, in meetings, at a strategic level, in workforce development, in supervision and
training with groups, individuals, students, clinicians, kaumatua, at noho marae, in
practice on the floor with tangata whaiora and Whānau, and with my own immediate
Whānau and wider Whānau.

The Pounamu provides a framework by which to live life, a tool to korero with Whānau,
a tool to keep honest and grounded, and a way of knowing to manage the challenges of
the new subtleties of colonization, which continue to erode our identities as indigenous
peoples. There are many hands that have contributed to its development over the years
and so it truly does belong to us all. If the quality of life is better for Māori then, as a
natural progression, life will be better for us all. Māori mental health workers tire from
being part of a working environment where you constantly are challenged by the
majority whom continue to remain concerned about these issues and remain ignorant.
Then we have the sideliners (those who side with the management of the time), whom
sit and say nothing because of their own issues. There are those whom are focused on
their own needs and are there in the interest of themselves, and there are those whom
work themselves to death and are driven by the passion to make things better for Māori
people.
Manna (2002) advises that the Pounamu model is a visual cue in that it allows tangata whaiora and Whānau an opportunity to talk to the issues that we are often burdened with. Every time we have to recite and tell our story and talk to the layers of issues, and come away not feeling burdened by them but to some degree relieved from the heaviness and offloading, we are better able to see what the issues are and what they look like, and to truly grieve through them which takes shape in a number of differing forms. The visual tool becomes the strategy to revisit the cycles of abuse, address the manipulation, denial, and level of insight in a therapeutic manner, and it provides a consistent approach which is easily revisited when using the same approach during one on one.

The Pounamu model is based on the notions of Te Tiriti o Waitangi (Durie, 2001). Participation, Protection and Partnership are principles that, when implemented in anything we do with Whānau, ensure that access to the best service delivery is going to be appropriate in respect to being accountable.

Chapter two provides understandings of evidence based practice definitions, and poses the challenge that Kaupapa Māori theory and praxis is evidence based practice. Through these definitions of evidence based practice from a western perspective, we continue to see how Māori knowing is marginalised. Chapter three considers the ethical issues needing to be understood and addressed in the process of engaging in this research. The writings go further and look at the literature in understanding the struggles practitioners face as Māori kaimahi in mental health.
Chapter Three:
Methodology

3.1 Limitations of study
A qualitative approach involves talking to those involved in the research about their lives and observing their world view (Radnor, 2002). The Pounamu model is a Māori model of practice that I have developed over the time spent in mental health. The identified Whānau were working with the model and using this approach to manage their realities and the model was used to capture how this approach worked for them as a Whānau. There were some ethical issues that needed further exploration when undertaking the interview with this family, which included my role and relationship with the family. I have an existing relationship with this family and a working history with the family member who was implementing the Pounamu model within the identified Whānau, so my influence on the family in regards to the model having been developed by myself needed to be kept in consideration. I also needed to have preliminary discussions with the Whānau about the proposed idea.

3.2 Location of case study
It is important to engage in transactions with the participants in their own natural environment (Radnor, 2002). Two Kaupapa Māori mental health services were identified who implement Kaupapa Māori theory and praxis in their service delivery. This gave an overview of providers who work towards the same outputs, but who work in different sections of society and sit in different regional catchments.

3.3 Data collation
Oliver (2003) mentions that interviews need to involve all participants, to ensure the information being gathered avoids any value judgements. A key technique used was observation; a process of watching, listening, asking and recording which assists in fine tuning the data collated, allowing my own knowledge and experiences to sit as part of the proceedings (Radnor, 2002). Other techniques included an observation of service provision, review of archival service information, and interviews with other sources.
3.4 Informed consent

I have used the term participants to talk about the persons and groups involved in the study. Oliver (2003) defines a participant as a person who is involved in decision making, planning and execution of the plan. All information and processes were transparent and those involved were engaged at all stages of the research. All details of the research such as the process, the aims, purposes, findings, intent and details of the researcher’s background, qualifications and experience were outlined in an information sheet that was provided to all involved. Anonymity was also noted in the information sheet, where those involved signed to remain anonymous throughout the research. This process involved a face to face discussion of the research to ensure that all involved are fully informed, therefore giving informed consent. Copies of the research consent sat as part of the research documents, and copies were held by the participants.

3.5 Analyzing the data

Radnor (2002) states that, as researchers, we are required to revisit the participant to feed back the findings. Following the interview with all participants and collation of the research material, information was transcribed and scripts were given to the participants to ensure that all material had been recorded accurately. On editing of the material, the common themes and key findings were identified.

3.6 Privacy and confidentiality

A key factor that was considered throughout the research was ensuring whatever was promised needed to happen (Fogelman, 2002). All participants involved in the research were informed about what happens with the information, where this information was stored, who had access to the material, who will own the information and who will be supervising the research project. All the research material was saved to a memory stick which was kept in a locked filing cabinet housed at my workplace, and only I had access to the cabinet.

3.7 A critical analyses and review of the literature

In contemporary mental health practice, the expectation is that some form of evidence based practice is used.
Māori mental health kaimahi are faced with different struggles in comparison to non-Māori kaimahi working in mental health. Māori kaimahi are required to provide the clinical deliverables and, because you are Māori, assumptions are made that you are positioned to provide the cultural deliverables. However, that is not always the case. In contrast, our non-Māori colleagues are only positioned to provide the clinical deliverables, while the cultural deliverables sits as part of their on-going professional development. In most cases, these deliverables are provided by their colleagues who are Māori. It is important to understand these issues, as it allows Māori kaimahi to challenge the status quo and manage the hidden agendas of how working in mainstream erodes our cultural identity, which in turn results in burnout.

Qualifications and the number of letters after your name are seen by the western world as important; they give you status but give no recognition of the life experience and the qualities of lifelong knowing. Often these people are in positions of authority, are the ones making the decisions and are removed from the realities of the ‘coal face’. This sometimes causes the decision making to be flawed and not necessarily appropriate. In contemporary society, the expectation is to research and perform using evidence based practice. In understanding critical theory and looking at matters more broadly, Carpenter et al (2001) suggest theory as being a knowledge base that provides an ability to explain our practice. However over the years we have seen that the theory and the knowledge base is used to the detriment of our people. An example of this occurs during the discussion between the practitioner and the Whānau around appropriate treatment. Often the explanation is not culturally specific, so the consent to treatment is not informed from the perspective or knowledge of the Whānau. Consequently, the Whānau member does not really understand what the treatment is for and how it will contribute to their wellbeing. Sometimes the practitioner’s knowledge is underpinned by theory instead of practice and this will make the treatment explanation difficult for Whānau to comprehend. Bargh (2007) highlighted that this is evidence of how those with money are infiltrating the infrastructure by which we are governed. Kingi (2005) brings to our attention to the fact that professionalism is being seen as another model of health, and therefore professionals are being seen as the experts in providing health care. The health system in which we work therefore continues to be infiltrated by thinking
that focuses on the self or the individual approach rather than the collective and the whole being, which includes Whānau.

The mindsets that continue to subtly colonize our ways of knowing, as an indigenous peoples, is a pattern seen through the unspoken expectations to perform double standards, to be experts in our field, to be qualified, to build relationships to create ease of access to services, and to work holistically in a system that is fraught with individual set ups and practices. There is a need to become familiar with the range of languages, so that we are not done over by the hidden agendas, the submerged issues that come with a structure that promotes Neoliberalism\textsuperscript{15} and Colonialization\textsuperscript{16} (Smith, 2008). We are more vulnerable as a people to being colonized into practices of Neoliberalism as a result of the erosion of the collective ways of knowing. This is due to the promotion of individualism and structures such as promoting one’s self that supports this notion (Hohepa, Williams, & Barber, 2005).

Within the context of this thesis, three critical issues have come to light that are pertinent to the role of Māori mental health kaimahi (practitioners). In reviewing the readings regarding critical theory, Kaupapa Māori, indigenous matters and education, there are three concepts that are relevant in terms of how they influence the work ethic and practices in the New Zealand mental health area. Firstly, how the subtle structural changes (moving from the collective to the individual) impact on us as individuals and how it contributes to the on-going struggles of strengthening our identity and to poor mental health. This is often couched in Neoliberalism theory. Secondly, looking at biculturalism and its place in today’s mental health realities, and how we contribute to these developments as Māori mental health kaimahi in working towards seeking better mental wellbeing. The third concept is looking at how Kaupapa Māori contributes to the better wellbeing of our mental health, and how such tools can work towards enhancing the way in which we practice as Māori mental health kaimahi within such infrastructures.

Manna (2002) discusses biculturalism in practice, by investigating the Māori mental health model ‘Te Pounamu’ within traditional clinical assessment processes. Manna suggests that a newly devised and supported framework be implemented for Māori that

\textsuperscript{15} Neoliberalism: processes and practices that are driven for the purpose of making money and not necessarily in the best interest of the health and wellbeing of the people.

\textsuperscript{16} Colonialism: The domination of the western system at the detriment of indigenous people.
supports Māori ways of thinking, doing and seeing. Manna also discusses the need to continue with research that assists this model in becoming an accepted model of practice alongside other models of practice. Hirini (1997) focuses on counselling situations including client identity, social context and ideological assumptions, examining one particular counselling perspective: cognitive behavioural therapy and its application in working with Māori. Hirini’s work provides an opportunity to the extent thinking around Māori mental health may have changed since 1997. These two writings are important to understanding different disciplinary perspectives in response to the integration of the clinical and cultural realities from a practice perspective.

Globalization and the rise of individualistic ways of thinking bring with them an ongoing destruction towards the wellbeing of indigenous peoples (Carpenter, Dixon, Rata & Rawlinson, 2001). The impact of such societal infiltrations (an environment that is all about money and making money) adds to the struggles we face in dealing with the demands of daily life. Mental health workers talk about such influences in the context of the immediate district health board environment, but we do not necessarily consider how the wider societal infrastructures contribute to these health board environments and continue to reinforce colonial influences. Carpenter et al (2001) write about state restructuring, and transforming the business of health into a business model. Such infrastructures continue to erode Māori identity. Not only do we have struggles of learning about whom and what makes us, and who we are as individuals, but also what makes us who we are as a people. Erosion of identity further challenges our place in society. Ethnicity is an agreement of identity that becomes part of who we are, which is strengthened or weakened by the way we live our lives (Carpenter, Dixon, Rata & Rawlinson, 2001).

Also prevalent in determining our identity is the concept of biculturalism. Carpenter et al (2001) wrote about biculturalism being a browning approach, where most often Māori are providing the deliverables for predominantly Pakeha frameworks. This creates an environment where Māori kaimahi are in a position of disclosing those things that are traditionally Māori and applying them within a medical legal infrastructure. Māori continue to utilize mainstream so at the end of the day non-Māori are working with our own. Biculturalism has a place in today’s society in respect to Non-Māori enhancing their understandings about working with our people safely. Clarke (2006) writes about
marginalization, alienation and exclusion and asserts that assimilation is a fine line that we walk when developing Māori models that non-Māori can work with in terms of them being used against our own. Bargh (2007) maintains that Neoliberals look to create efficient societal practices through the expertise of other countries. There is a thinking that evidence based models are best practice and a drive at the funding planning level to have these evidence based practices sit as part of service delivery. Bargh (2007) goes further to say self-determination, self-management, and service delivery by Māori, rather than actual policy formulation or decision making by Māori, are promoted within neoliberalist policy in an attempt to reflect wider issues. The strategy Māori use against these policies is through the implementation of traditional concepts such as Kaupapa Māori frameworks. Cultural identity in a self-determined sense confronts neoliberals thinking and can be seen as successful resistance (Bargh, 2007).

Kingi (2005) maintained that, during the twentieth century, health was oriented towards a medical model and is the business of health professionals and specialists, and that mental health still engaged in institutionalized practices. Māori models of health were expected to meet the holistic needs; however, funding did not accommodate this, and remains an on-going battle. Bargh (2007) indicated that applying holistic interventions is difficult for most mental health providers because of the cost of resourcing the holistic demands. Manna (2002) and Hirini (1997) write about identity being a key issue and contributing factor to our high rates of poor mental health. Identity is not only an issue for tangata whaiora and Whānau, but also becomes a dilemma for those kaimahi who themselves have little confidence in their own identity as Māori. This not only means they are attempting to provide the services and do the mahi, but also are learning about themselves. Te Rau Matatini has been a lead agency in Māori workforce development within mental health that works towards addressing cultural pathway development for Māori health workers. Kingi (2005) noted that a fundamental principle that Maui Pomare understood was that a by Māori for Māori approach was best.

Jenkins (2000) coined the term and concept of Aitanga, which allowed for a framework by which relationships between Māori and Pakeha could be used to strengthen the participation of both worlds and provide endless possibilities. The principles of the Treaty of Waitangi are often overlooked and greatly misunderstood in terms of how to operationalise these principles in practice. Manna (2002) writes about the importance of
these principles in light of the relationship building that comes from working in partnership with tangata whaiora and Whānau and therefore being able to understand how it is we all participate. Carpenter. et al (2001) writes about a culturalist approach being Māoritanga theory, stating that Māori and Pakeha are considered different and that the treaty redress is about recognizing Māori. Manna also highlights how, through our professional practice, we enact safety with respect to protecting those tangata whaiora and Whānau we work with. This entails making sure that all documentation of the presenting picture is interpreted correctly and understood so everyone understands what the referral concerns. Manna goes further to elaborate how the model can be implemented in practice as a tool. The processes of Karakia (prayer) and Mihimihi (introductions) clear the way for the rapport building and orientates the relationship to the working environment.

Hohepa (1990) talks about enculturation being about cultural values that are systematically related to guide routines and interactions. The working environment includes practices such as clarifying referral material, and discussing the legal aspects of the mahi such as discussing confidentiality. The process of the session is explained through the Pounamu model, which becomes the visual cue used to collate and map back the relevant information. The visual cue becomes, in a sense, a third person and provides for some ease of the issues being looked at and discussed. This provokes some whakaaro (thought) and the kaimahi get to check out what the tangata whaiora and Whānau level of insight is into their issues and the mahi at hand. Hohepa (1990) goes further to say that enculturation is about routines that work to affirm cultural values, and that such activities reflect the value of holistic health and the wellbeing of the person.

The case scenario that is demonstrated in Manna’s article shows her working insight into ‘the Pounamu’ model. Through her writings, you get a feel for the dialogue she writes in linking it back to the case scenario formulation. A crucial and important aspect of the model that is often neglected when being implemented is acknowledging the arrows. Manna clearly articulates that they demonstrate a cycle where each aspect has an impact on one another. The arrows also generate discussions about the fact we are not only working with the individuals presenting issues, but also the Whānau and potentially the wider Whānau in respect to the issues of intergenerational cycles of abuse. An issue that is often debated is whether the layers are features of post-traumatic stress disorder as a
consequence of being colonized. The case scenario that Manna (2002) writes about tells a story that is common with our Whānau: poor sleep pattern, increased stress, disrupted sleep pattern, having fleeting suicidal thought, and significant grief and loss. She was raised by her grandparents, and was experiencing feelings of being detached from the physical world. Manna was extremely burdened by the expectations of her Whānau and isolated in terms of no one really showing any understanding about what was happening for her. This was also impacted by her successes in life and that the process of interactive drawing helped her communicate her struggles and allowed her to express the hurts. Clarke (2006) mentions that storytelling provides for an effective methodology and a means that may also effect social change. Māori achievement is complex and multi-layered; there are multi factors and causes (Carpenter, Dixon, Rata & Rawlinson, 2001). Health is ultimately about ensuring the Mauri (life force) of Māori people is allowed to find its full expression; access to cultural identity is fundamental (Manna, 2002). As a result of colonization and loss of language and ways of knowing, there often remain on-going issues. Coupled with that, service providers are faced with challenges from non-Māori systems with regards to using Māori models.

3.8 Kaupapa Māori

Hirini (1997) and Manna (2002) write about the establishment of a rapport as imperative in making any attempts to engage. This is a process that is managed over a number of sessions. An initial assessment may happen over three sessions, in which it may be solely focused on orientating the tangata whaiora (person seeking wellbeing) to the referral material, environment, understanding and knowing of what your role is and the relationship to them. Understanding the tangata whaiora and Whānau identity starts from the initial engagement, and the basis of how well you get to understand this depends on the rapport you build at the introductory stage. The insight into the tangata whaiora and Whānau identity allows you to have a better understanding of what pitch to take in regards to access to the appropriate clinical and cultural expertise in response to the tangata whaiora and Whānau needs. Whānau are an important in working with Māori. Carpenter et al (2001) identified that Whānau are a fundamental cornerstone of good health. Whānau in more contemporary times has been extended to be those whom are not only blood, but also those whom we see as significant supports, those whom we
are related to through affiliation from a kaupapa of shared interest. Hirini encourages counsellors to give careful consideration into enquiry regarding ones identity. As a result of the diverse realities we experience as Māori, one needs to be flexible in how we work with tangata whaiora and Whānau. Manna (2002) asserts that the starting point in working with Māori is the assessment phase. Cultural assessment is another process that is promoted, redrafted into different shapes and forms but that continues to sit in isolation from the clinical interventions, when, in actual fact, the Māori models of practice we use as cultural assessment should be seen as cultural assessment tools that cover the clinical deliverables as a natural progression of the assessment. Māori models cover key Māori tenants of working in a Kaupapa Māori way, and these models are holistic. The assessment of the holistic being is the cornerstone of effective therapy. Traditional therapeutic practices, such as the implementation of Karakia\textsuperscript{17} to open and close sessions, is one solution to the multi layers of complexities. These require a multitude of interventions which ensure access to the appropriate expertise, such as psychiatrist, social services, cultural advisers and consultants, and case managers, and can only enrich therapy. Cultural competence involves more than a health professional being qualified in their respective fields. It requires an understanding of the contributing factors that underlie poor mental health for Māori, and a gaining of working knowledge of best practice guidelines such as Kaupapa Māori mental health models of intervention. This at times creates some ethical issues, as we may be seen as breaching boundaries through the disclosure of one’s own whakapapa (which is unique to Māori) or story telling in working towards developing a rapport.

When the tangata whaiora and Whānau are provided with these opportunities it ensures we access the necessary interventions to cater to the multi-layers of issues. Māori mental health services are not only for Māori but for all who would benefit from a range of cultural interventions. Māori mental health services were set up to ensure that Māori tangata whaiora and Whānau had access to the appropriate cultural specialist to reduce the concerns of misdiagnosis and, most importantly, that Whānau were included as part of the treatment process. However, Bargh (2007) identifies that the goal post is always shifting so we are never really able to achieve better outcomes. A key issue that arises is

\textsuperscript{17} Karakia; a process of opening and closing therapy sessions with prayer, words of wisdom or thoughts that are meaningful for that particular time, place and person.
how safe it is for non-Māori to be working with Kaupapa Māori frameworks or models. Cultural safety or kawa whakaruruahau provided health professionals with insights into the history of our people and traditions and practices, which has been seen as cultural safety training. Over a period of time, a number of terms and projects have been implemented to provide for application of this theory into practice. This insight compliments the rapport building phase. The application of Māori frameworks, such as Te Matarau (Kingi, 2005), work towards achieving tangata whaiora and Whānau insights into what they perceive their issues to be or not to be, (the health workers involvement) and provides an opportunity to feedback and to provide clarity and address any issues. This assists with the process of informed consent. Therefore, Māori needing mental health services are provided with the space to understand what is happening, to heal and move forward and not be burdened with the emotional negativity.

Māori must operate from a united stance in what we do to find strength in one another, to strengthen ourselves to resist the colonization of our minds, hearts and souls as indigenous peoples. It is through the teachings of our forefathers that we will find opportunities and refreshing ideas to strip away at the layers of Neoliberal contamination which, in turn, has contributed to the disparities of poor mental wellbeing amongst our people. Manna and Hirini writings about the concepts of Neoliberalism, Biculturalism and Kaupapa Māori provide an understanding to further explore how these tools can be used for and against us. Neoliberalism, as I see it, is a mix of everything and so more than one strategy must be utilized to counteract the impact on our health. Biculturalism has its place in attempting to free the minds of our people who are trapped into colonial ways through the implementation of Māori models. Kaupapa Māori provides us with this advantage and a platform to bring about this change, which has been used as the strategy over the years by many of our Māori leaders who are driven by the desire to give back to the people (Diamond, 2003). A quote from Nga Tama Toa; *A landless Māori is a lost Māori, a lost Māori is a lonely Māori, a lonely Māori becomes a ruthless Māori*, na kuri a wharei, nga tama toa tuarua, nga tama toa kirikiriroa, nga tama toa tuatoru (Harris, 2005).

Chapter three takes a particular focus on an article written by Manna, a Māori clinical psychologist, and how she has implemented the Pounamu model in her practice within a Kaupapa Māori setting. This allows for some understanding of how Māori practitioners
integrate both clinical and cultural deliverables in their practice when working in a Kaupapa Māori environment. Chapter four takes a deeper look at the Pounamu model and its application in practice.
Chapter Four
The Pounamu Model

He mihi kia Ranginui me Papatuanuku
Ki ā rāua tamariki huhua –
No ratou nei nga ahuatanga katoa
Kei a tatou – e tātāea ana i
roto o te ao hurihuri o inaianei -
Mihi atu, mihi mai
Mihi haere
Mihi rongo ko te hinengaro rā
Nga whakapūtanga kōrero-
I te aro ngā ake o ia, tatou te
Tangata-
Tēnā
Tēnā
Tēnā ra katoa nga ahuatanga -
O mua – o inaianei o Āpopo
He taonga tuku iho no rātou
Ma- he mihi he mihi he mihi
Kia ora te whakāro Rongowhakāta

It is from who they are, we inherit who we are.
Buffeted in a world of confusion, we acknowledge the time of “atu mai, haere Rongo”. Mental reality is about korero and listening – hearing, caring, of knowing who we are as people, as humankind.
We acknowledge the treasures from our past thoughts which lead to our enlightenment.
4.1 Development of the model

I graduated as a registered nurse in 1993. In 1995, I was a team member of Oranga Hinengaro, a Kaupapa Māori mental health service in Palmerston North. Over the next four years, many pātai would come to light in my own professional development as a mental health clinician, but also as a Māori mental health clinician. Many Māori tangata whaiora and Whānau did not seem to be able to relate to Pakeha and medical models that we were taught in our nursing training. It often seemed that we would spend lots of time trying to diagnose the problem, but not much time on sharing our ideas with Whānau and coming to an agreed understanding with them about what was going on for their Whānau member. For many Whānau, it seemed that being given a diagnosis on its own did not help the Whānau make sense of the predicament they were facing. As a direct result of this, medication compliance would often cease as soon as they left hospital and, for those with severe psychotic illnesses, this would lead to prolonged periods of disabling symptoms. During this period, we had an opportunity to pull together clinical ways of knowing, including diagnostic frameworks, principals of assessment, and understandings about the impact of trauma and loss, combined with my cultural ways of knowing. Drawing these understandings together led to the development of the Pounamu model. Many hands have contributed to the development of the model over the past 20 years.

In 1999, my Whānau and I moved to Porirua, Wellington and I started a new position at Te Whare Mārie, a Kaupapa Māori mental health service in Porirua. During that time, a series of hui were facilitated in which kaimahi were introduced to the model. These wananga led to further rich korero; reflection from Māori clinicians on how the model could best be adapted to the practical realities of clinical practice with Māori whānau. This resulted in further development of the model.

During that period the model was given its name “Pounamu” by kuia Ani Sweet, who is a Kaumatua from Te Whare Marie. The name Pounamu is symbolic of the precious nature of the Whānau we work with and as taonga of their tupuna. The name reminds us to treat the often painful personal stories that Whānau share with us as taonga that we hold on trust. This name also alerts Whānau to the value of this model in helping

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18 Diagnose; to identify the presenting problem in line with the DSM-4, a diagnostic manual used to categorise mental illness.
them to understand their troubles. In many cases, having a visual representation to understand the intergenerational cycles of abuse has helped Whānau members understand where some of these patterns of abuse have arisen in earlier generations. The values symbolised by the name Pounamu also relate to the fact that individuals and Whānau are able to take this taonga away with them, and continue to share their stories and experiences with their own Whānau, therefore imparting this way of knowing to their wider Whānau. This process has the potential to help the wider Whānau tell their own stories and continue to break their own immediate Whānau cycles of abuse, and perhaps also break the intergenerational cycles of abuse that have been part of their lives for many years.

The picture in the centre of the Pounamu diagram has its origins in an analogy that was shared in 1995 by Tangi Hepi who worked as an alcohol and drug counsellor at Oranga Hinengaro. Tangi used the bottle analogy in his work with young tangata whaiora. He would describe the bottle as likened to that of a person who has all this mamae (Hurt) anger and pain stored up inside them. When the bottle is full to a point and you shake it, the pressure causes it to explode or break open.

Tangi Hepi, a fellow colleague, used this as a metaphor with a teenage Māori kotiro that we were working with. She was angry about having to meet with us and dismissed us as yet more adults who had no idea of how things were for her. Even though she gave us little information about herself, Tangi used this analogy, of the pressure in the bottle, to talk to her about the kind of painful memories and experiences many young Rangatahi are coping with. Often, alcohol and drugs seem like the only way they can cope with this mamae. Using the bottle metaphor allowed Tangi Hepi to let her know that we actually did have some understanding of what was going on for her. It helped considerably in engaging with this young person. Not only that, but we noticed that seeing her story drawn up on the whiteboard made an impact on her. Seeing the story in black and white; and out there.
4.1.1 The visual cue

The figure is visual, so it provides an opportunity for the discussions with Whānau to be mapped back to the diagram. This reduces the issues of Whānau constantly feeling burdened by having to retell their story over and over. As kaimahi, we are not only dealing with the individual and the issues of concern they present with, but on most cases this also reflects the issues that sit within that Whānau and the wider Whānau or intergenerational issues that have continued through the generations of the Whānau. The ngakau\(^\text{19}\) is to remind us that it is a privilege to be part of the life experience of the life breath of another person. Whatumanawa\(^\text{20}\) touches on issues of Māori for Māori services, therefore being able to utilise our own ways (Māori models) to create a space in facilitating the sharing of deep seated hurts.

The bottle figure represents the young person themselves and the ngakau, or heart, is symbolic of their relationships and wairua. The figure also reminds us, as kaimahi that it is a privilege for us to be part of that experience and we must treat that information as we would expect our own personal material to be treated, with safety and with confidentiality.

\(^{19}\) Ngakau; the heart of a person, the emotional state.

\(^{20}\) Whatumanawa; the issues that are deep seated, that we often only disclose to those close to us, or to our own.
From a Māori worldview, the putiputi (or flower) in the puku (stomach region) is where a person holds their whatumanawa (deep-seated hurts), stored within and hidden from view or suppressed but seen through the physical distress. This distress is a reflection of the underlying issues, and of all those painful and traumatic memories which tend not to get addressed in our mental health services. Many of the Whānau do not have an opportunity to access the appropriate people to be able to work through those issues. Te Pounamu offers Whānau a way of understanding the place of these underlying issues in their lives, which may encourage them to start such a journey of healing.

Figure 2: Māori Psychology

4.1.2 Māori Psychology

Figure two acknowledges that we learn, understand, heal, grow and process our experiences and ‘knowings’ (understandings and lived realities we bring with us into our

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21 Māori Psychology: This power point was developed by Gill Hawke, a clinical psychologist who was working in EIS. This was part of a Pounamu training package, provided by Gill in demonstrating the application of a bicultural approach.
practice, that we have inherited through teachings from Whānau and traditions of practice we have been brought up with) in our head, heart and stomachs. Pehi (2011) highlights that psychological practices over the years, have opposed these ways of understanding. The Pounamu model provides a framework that acknowledges the range of understandings and ‘knowings’, therefore is more meaningful for the Whānau we are working with in mental health.

Following the early wananga at Te Whare Mārie, a training programme (Ruha, 1999) was developed to assist Pakeha mental health clinicians to use this model with Māori clients and Whānau. The aim was to help understand and take account of the complex range of psychosocial and cultural realities faced by many Māori tangata whaiora and Whānau, and the model provided a tool to help non-Māori clinicians’ feedback material to the individuals and whānau. Pounamu also provided an example of a model considered to exemplify best practice when working with Māori. It was both comprehensive from a clinical point of view and also from a cultural point of view. For example, as described below, it is aligned with the principals of Te Whare Tapa Wha, as described by Dr Mason Durie.

This development introduced the model to mental health professionals from all disciplines in the local mainstream mental health services. The positive and constructive feedback from these hui with both Pakeha and Māori mental health professionals led to further refinement of the model. In 2001, the project, which became known as Whakapai, was expanded to include improved service delivery to Māori across the Capital Coast Health mental health sector. One of the key tools used to demonstrate best practice, in terms of service delivery to Māori, was the Pounamu model. Clinicians from 26 different mental health services in Capital Coast Health participated in group training forums, case reviews, and group or one-on-one supervision using this approach. The clinicians included psychiatrists, nurses, psychologists, social workers, occupational therapists and other health workers from a range of multi-disciplines. Using the Pounamu allowed for sufficient depth of discussion in regards to the clinical and the cultural ways of knowing, without feeling culturally unsafe. In the course of the Whakapai project, the Pounamu model was presented to over 350 Pakeha clinicians through monthly cultural supervision sessions with all the mental health teams in the

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22 My role was to implement Whakapai moemoea and vision, at an operational level.
4.2 Components of the model in practice

Talking therapies refers to talking with trained individuals in exploring and understanding a person’s thoughts and issues. In a Kaupapa Māori context, we would consider the wider Whānau aspects as part of the talking therapy and, more importantly, provide a cultural platform that acknowledges the importance of the wairua or spiritual realities one may be experiencing. He Pou o Te Whakaaro Nui (2010) highlights that engagement and rapport building is important in working with Whānau Māori. The Pounamu model provides a framework for kaimahi to explore aspects of these realities through korero or talking therapy. The following sections elaborate and explain key themes of enquiry that sit within each component of the Pounamu model. The themes of enquiry become the basis of the assessment we undertake when working with the Pounamu model to elicit the information we require to understand what is happening for our Whānau. The approach allows for effective feedback of information using the key themes and allows for korero to flow in acknowledging the story that sits within each theme.
4.2.1 Nga Rorirori23 (Presenting Issues)

Under this heading, we usually consider four categories. The first is mental health symptoms that have led the tangata whaiora and Whānau to present to a mental health service. They may have been given a diagnosis which could be added here. This would be the appropriate place to include a DSM (Diagnostic and Statistical Manual of Mental Disorders) diagnosis (Pilgrim, 2009). However, it may be that they relate better to a list of their symptoms using expressions and descriptions from their own korero. The closer the words are to their own experience, the greater the likelihood that the feedback will resonate with their own understanding. The second category is safety; including

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assessment of risk to self-harm (the intent to inflict harm to self in order to release tension) verses suicidal intent. Suicide is now a leading cause of death for young adults aged 15-34 for both sexes (Frydenberg, 2008). This is usually a key focus of clinical attention, and it is important that tangata whaiaora and Whānau have a clear idea of the clinical team’s assessment here in order that they can then participate fully in helping manage these risks. The third aspect listed under presenting issues is social stressors. Māori Whānau have many types of social adversity to deal with, including poor or unstable accommodation, poverty or financial stress from loans or commitments to extended Whānau, and legal problems. Too often in the past, the significance of these stressors for our families has been ignored or downplayed in mental health settings (Durie, 2003). The fourth category we focus on here is physical problems. Again, our whānau frequently have a major burden of physical ill health, either in the tangata whaiaora themselves or close whānau members. Common physical problems include diabetes, asthma, and head injury. Increasingly recognized also is that complications/side effects of antipsychotic treatment may add to problems like obesity and diabetes for Whānau members with psychotic illnesses (for example, Lithium).

4.2.2 Nga Roritanga (Coping Strategies)

Moving across to the top left of the Pounamu diagram (figure 3) we come to coping strategies. Coping styles are methods that characterize the individual’s reaction to stress across different situations over time, manifesting as co-existing disorders (Frydenberg, 2008). These coping strategies can take the form of, for example, alcohol and drug use, withdrawing from whānau, friends, school or work, and violent behaviour. For example, young people often self-medicate with whatever substances they have access to. Other coping strategies include ‘acting out’ behaviours, such as running away, lying and manipulation. Sometimes gang affiliation, as a type of alternative lifestyle, can be seen as a type of coping strategy.

Referring to these behaviours as coping strategies helps Whānau to start thinking about what is behind their young person’s difficult behaviour and encourages the young person to make a link between what they are doing and what else is going on. It also

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24 Antipsychotic; medications that are prescribed for the treatment of tangata whaiaora who present with symptoms of mental illness
takes away any negative and evaluative judgement of their choices to date. This approach opens up questions about other ways of coping that may suit them better, that fit better with their goals, hopes, and moemoea (the dreams that they may have for their life). The focus here is therefore on more adaptive or positive coping skills that the tangata whaiora and Whānau may have. These skills may include being able to korero about their problems or feelings with others, church connections or other such ways they have of nurturing their wairua (for example, being able to walk away from a fight).

4.2.3 Nga Rorirori o te Whānau (Whānau Dynamics)

Next we move down the left hand side of the Pounamu diagram to look at Whānau dynamics. The young person's whakapapa or genogram is recorded in this space. Dynamics refer to sustained patterns of interaction that are characteristic of this Whānau as they affect their Whānau member. A key focus here is on Whānau strengths and exploring dynamics early on in assessment with Whānau, as this helps Whānau members to become more engaged with the assessment and these ideas. Durie (2001) has described a number of Whānau capacities which may enhance cultural identity and resilience of Whānau members. These include manaakitanga (the capacity to care), whakamana (the capacity to empower Whānau members), whakapumau tikanga (the capacity to transmit culture, knowledge and values), and whakaWhānaungatanga (the capacity to reach consensus).

Acknowledging more distressing or difficult Whānau dynamics that are having an impact on the young person concerned is also important. There may be patterns of anger, aggression or violence by other Whānau members that impact on this young person. If such a dynamic is present, the origin of these features is also important to understand. Usually young people have not invented the dynamic for themselves, and there is almost always an intergenerational pattern that can be traced back by Whānau members. Identifying this pattern can be an opening for whānau members to begin to address such intergenerational patterns.

The Whānau dynamics may revolve around past unresolved conflict and hurt between Whānau members or parts of extended Whānau. Figley (1998) notes that families are greatly affected by the trauma of another family member, for example, jealousy or other raruraru (problems) may exist between Whānau members. Sometimes patterns of
interaction are dominated by a parent’s mental illness or physical ill health. Styles of parenting or care giving can also strongly influence the emotional tone of a Whānau. Parenting practices which emphasise rigid patterns of control may contribute to a climate of fear. Alternatively, a lack of boundaries or lack of supervision from parents who are working long hours to provide for their Whānau may contribute to a dynamic in which young people increasingly spend time away from their Whānau and may end up in trouble as a consequence.

For tangata whaora who have experienced prolonged mental health problems, isolation is often a strong theme in their patterns of interaction with Whānau. Isolation may occur because they have moved away from where most of their Whānau live, or from where they were born. This shift could have happened for a number of reasons. For example, psychotic symptoms, such as persecutory beliefs, could have led to them pulling away from whānau. Relationships may have been strained with Whānau over the years as a consequence of not being well and Whānau frequently may not understand what is happening for their whānau member.

### 4.2.4 Nga Rorirori o nga moetahi (Relationship Issues)

There are a number of key relationships to bear in mind from a Māori world view, based on the basic tenet that relationships are of the utmost importance. Tuakana-teina relationships have a major function in determining roles and responsibilities amongst siblings in our Whānau. For example, as the teina in my Whānau, I take the lead of my older sister /tuakana when it comes to managing the kitchen on the marae. Isolated Whānau might not be aware of the significance of these relationships. A point of view that may be taken about their older siblings may be seen as intrusive and controlling when, from Te Ao Māori, it is about being a tuakana. Describing these cultural ways of understanding sibling relationships may help individuals put words to some of their experience and can help to address the sibling conflict. Tuakana-teina relationships are also important for understanding who is looking out after this young person, and who are their closest sibling supports, especially under difficult Whānau circumstances.

An even more important relationship for many young people may be their relationship with their grandparents. Many of our young people may grow up with their primary attachment relationship with their koroua or nan. A particular example of this type of
relationship is young people who grow up as taura moko. My daughter is a taura moko. At birth, she was given over to her grandmother (my mum), who is a native speaker. Having the opportunity to live with her grandmother fostered a strong relationship, not only physically, but also through love, aroha, manaakitanga, role modelling and te reo. The language provides all of this and can transmit the aroha and manaaki, and the other values that are handed down. A taura moko is not only nurtured physically, but also mentally as they learn to understand the world of the old people. They learn to listen, observe, and learn from just being with their kaumatua (grandparents). They learn that it is good and right for them to be true to themselves. An example of where problems occur is that, as their grandparent’s get older, these young people are frequently faced with the early loss of these loved ones and may be ill-equipped to cope with their grief. The burden of care of an active teenager becomes greater on an elderly grandparent and the Whānau may decide that the young person needs to move to live with their parents, perhaps for the first time. If the parents do not have the strength of relationship needed to exert their authority over their young person, this may result in conflict and rebellious behaviour by the young person. Another example of problems that occur is the peer relationships, and the influence they have for individuals also need to be considered. Many teenagers seek most of their emotional support from peers and are vulnerable to falling out with their friends (Berger & Thompson, 1995). Intimate relationships with girlfriends and boyfriends are frequently a source of support, conflict or stress, depending on the circumstances. Key considerations also need to be given to those who identify as being homosexual and encouragement and support given to this disclosure rather than using ignorance to deal with these preferences.

4.2.5 Pumanawa (Strengths)

Whānau who have been part of a mental health assessment, whether in adult or Child Adolescent Mental Health Service (CAMHS), often comment that all the focus seems to be on ‘what is wrong’. The young people and their Whānau feel hohā (annoyed) about this, especially when they have experienced a similar negative korero (talk / discussion)

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25 Taura Moko: a mokopuna brought up by a native speaker, Ruha I (1995)
with schools and other agencies. This part of the model reminds us to devote time to understanding and feeding back pumanawa (or skills) that the young person may already have. These skills may include their fluency with te reo, kapa haka, mau rakau, or in sport. This part of the assessment is an opportunity to note the person’s hopes and dreams for the future, their perceived purposes in life and what they give value to in life (for example, spirituality may give them strength). Certain relationships with Whānau members, friends or others who strengthen them could also be included here. An example may be that they have strengths in the way that they carry out their roles and responsibilities as a tuakana to a younger sibling, or as a mokopuna to their koroua. Their strength could also be the korowai (cloak) of their whānau around them.

4.3 Components of the Psychotherapeutic process

Māori models of practice work immediately on suppressed issues, and Kaupapa Māori provides the space by which we can do this (Milne, 2005). The implementation of these approaches assist in the gathering of korero using mediums of engagement that are meaningful for the tangata whaiora and Whānau. During this phase of engagement, the information is being shared as a natural progression of understanding the Māori model of practice. An example is that, when using the Pounamu model, the visual cue acknowledges what the underlying issues are, but provides a space for the tangata whaiora and Whānau to discuss those issues when they are ready to disclose the detail around those features of concern. The psychotherapeutic aspect of the process is the understanding of one’s story and making the links regarding the intergenerational cycles of abuse. The korero that is shared in dialogue is the therapeutic aspect of the process. Breaking cycles of intergenerational abuse starts with the underlying issues and understanding the history of these features. The common themes we see that underlie the range of presenting issues we are dealing with are elaborated further below.

4.3.1 Nga Rorirori hohonu (Underlying Issues)

A unique feature of the Pounamu model is the ability to work therapeutically with deep seated hurts that have remained suppressed over the generations. The implementation of Māori models of practice, such as the Pounamu model, creates a space that allows for a natural discussion around these issues. This part of the Pounamu model includes such
matters as unresolved grief and loss, past emotional, physical and/or sexual abuse, underlying attachment insecurity or disorganized attachment; as well as Māori related issues such as problems of cultural identity, and Māori spiritual issues such as matakite, or spiritual difficulties such as mate Māori. These areas can be very sensitive for Whānau to explore as they often touch on hara27 and hurt that are deeply painful for all Whānau members and may be intergenerational. Another aspect may be that most Whānau do not know these histories in the Whānau, or have access to wider Whānau members who have these understandings or knowledge of the Whānau background. It is at these times in an assessment when people often rely on karakia28 and other rituals for spiritual protection, to look after the wairua (spiritual) side. Although Whānau may experience these underlying issues as painful, if they are not included as part of the formulation, Whānau may experience the explanation offered as superficial and irrelevant to their lives. This is also an opportunity to bring their issues to a consciousness for the first time.

4.3.1(a) Grief
A key underlying concern is the grief tangata whaiora and Whānau are dealing with for a range of reasons. Whānau who present to mental health services regularly retell stories of loss of close Whānau members and peers, and other members of their community. Grief also arises for young people who are in Child, Youth and Family Services (CYFS) care and lose contact with siblings, parents and extended Whānau through care and protection processes. The grief may also relate to a loss of quality of life as a result of experiencing a mental illness.

4.3.1(b) Abuse
Furthermore, issues such as physical, emotional and sexual abuse continue to remain an on-going underlying issue that may have remained a secret and, as a result, have led the tangata whaiora on the respective paths they present with. As Māori kaimahi, Whānau members frequently entrust us with their most painful stories. These may include their early memories as children growing up and stories of abuse they experienced. Te Pou o

26 Māte Māori; a Māori illness that affects the spiritual wellbeing of a person
27 Hara; the hurt that one carries.
28 Karakia; offerings to a higher being for guidance through the practice of prayers.
Te Whakaaro Nui (2010) notes how psychotherapy has a focus on interventions that are used to help children work through their emotions and major childhood trauma. An example may also include early experiences of separation from primary attachment figures resulting in attachment disorder, or perhaps inadvertent trauma as a result of hospital treatment for a chronic health problem, as a result of access and engagement issues with the hospital services (Te Pou o Te Whakaaro Nui, 2010). Such experiences can help shape our sense of identity. In cases where abuse experiences have occurred across several generations, often adults have been constrained by their own whatumanawa, hara and pain from finding resolution to their own abuse issues. These adults therefore frequently find it difficult to guide their own children in finding a healing path.

4.3.1(c) Identity

Many writers, such as Durie (2001), have talked about the search for identity as a key task for adolescent development which continues into adulthood. For rangatahi Māori, this task is complex as they struggle to make sense of their identity in the context of their whakapapa and early Whānau experiences. Basic assessment information from a Māori perspective would include the young person’s iwi and hapu affiliations on both sides of their Whānau; awa, waka and marae connections; as well as their key relationships with kuia, koroua and kaumatua. This information could be included here or in the section on whānau or relationship issues. In meeting with tangata whaiora and their Whānau, we often hear stories of people not knowing who they are and where they come from. There are many reasons for this. Durie (2001) has written about a link between secure cultural identity and mental health and wellbeing. He has also talked about identity in terms of the different life experiences we all have that shape what it means for us to be Māori. Today, there are those of our whānau who know they are Māori but who have absolutely nothing to do with it for whatever reason. Durie referred to this as a ‘compromised sense of Māori identity’. Then there are those of us, who know who we are and are learning about what that means for us. He referred to this as a ‘notional sense of Māori identity’. Then there are those of us who know what it means to be who we are as Māori, so have a more positive sense of being Māori. Many of us

29 Whatumanawa: deep seated hurts that have never been addressed or worked through therapeutically
have been developed this sense of identity through wananga, training, peer groups and/or whānau. Finally, there are those of us who have a secure sense of what it means to be Māori. This group is more likely to include our kaumātua; however there are tamariki and rangatahi now coming out of the kura kaupapa and kohanga reo who have a very secure sense of what it means to be Māori. The whānau we are working with may be sitting anywhere along that continuum. Likewise, for Māori kaimahi, we too can sit anywhere along that continuum.

Identity is important information for us to consider as part of the assessment. For example, a young rangatahi with a compromised sense of his Māori identity (perhaps due to early experiences of abuse that the rangatahi may associate with his Māori Whānau), may initially reject the idea of working with a Māori therapy model, and he may even wish to be seen at a mainstream or non-Māori service. But at a later stage in therapy, when the therapeutic relationship is strong, it may be possible to begin to explore the origins of the hurt and pain. Considering Māori concepts that may be somewhat familiar to him may contribute to a healing process for this young person. In contrast, when working with a young person with a secure sense of their Māori identity, they may be fluent in te reo and have a strong sense of belonging to their Whānau. They may well have a good understanding of their whakapapa connections and a rich awareness of concepts from Te Ao Māori. They are likely to have ready access to kaumātua and plenty of contact with their marae, even in an urban setting. They may feel confident about stepping into a Māori therapeutic paradigm, such as Te Tuakiri O Te Tangata. In fact, it may be that their secure Māori identity raises issues for kaimahi who are working with them, if kaimahi are not so confident in te reo or comfortable in their knowledge of concepts from Te Ao Māori.

The point here is not that all Māori kaimahi should have a secure sense of identity, but that it helps us as kaimahi if we know where we sit on this continuum and if we have a degree of comfort with this. If they are a kaimahi who has a notional sense of Māori identity and actively seeking to find out more, then they are potentially able to do useful therapeutic work with a young person who is positioned at the secure end of the continuum. For example, when working with Te Tuakiri O Te Tangata,

30 Te Ao Māori (The Māori world)
acknowledgements are made early in the session, that the rangatahi and kaimahi will work together on the model. This provides an opportunity for both kaimahi and tangata whaora and Whānau to grow and learn from each other.

In choosing to use a Māori model, this information can be used to understand how this person is positioned on the identity continuum in a number of ways. It is important, when engaging with tangata whaora, to be able to start by getting alongside them at the level that they are at. Understanding where they are on the continuum will provide information on how open they may be to ideas that might extend or make use of their understanding of Te Ao Māori. It may also give useful information about how they might evaluate possible spiritual experiences they may describe, and whether they might adhere to traditional Māori understandings of mental ill health and associated attitudes to seeking services.

4.3.1(d) Matakite

Frequently when working with rangatahi, they describe experiences that suggest that they may be, to some degree, attuned to the spirit world. This is a gift that our people call Matakite\(^{32}\). These kinds of experiences may or may not be connected to their presenting problems. Although they may superficially resemble psychotic experiences, the belief is that there are differences in the quality of these experiences that help us distinguish them, because the belief in tapu and spirits deviate from the norm of the dominant pakeha culture (Lyndon, 1983). Young people with psychosis may also have had some spiritual encounters, however may be interpreted as having a form of mental illness due to not having had vital nurturing and teaching on how to look after their gift. For rangatahi who have spiritual encounters, it can be a very lonely hikoi. Karakia, and access to kaumatua and other elders who understand this reality, are very important. These practices keep you grounded in today’s world and keep your wairua grounded in your physical being. In addition, where a young person sits on the identity continuum can be very helpful in understanding how they may deal with a spiritual experience. For example, a rangatahi who has a secure sense of Māori identity, and is describing seeing the spirit of their deceased koroua at the end of their bed at night, may well have a

\(^{32}\)Matakite: a person who has the ability to see into the spirit world. An ability that is seen as a gift from our ancestors.
traditional way of understanding their experience. This interpretation would render these spirits as meaningful and therefore may reduce their anxiety and others about it. The youth might also have other Whānau members to talk to who could help them make sense of this experience culturally. For a young person with a compromised sense of Māori identity, such an experience could be more anxiety provoking, and they may have less access to Whānau members who can help them understand such an experience from a cultural point of view.

4.3.1(e) Māori Related Issues / Spiritual Distress

25 years on, we are still hearing stories of features of “Māori sicknesses”, that mimic all the commonly accepted psychiatric syndromes, however the task is to distinguish those cases of culturally induced illness from the genuine psychiatric illnesses (Lyndon, 1983). One reason that Māori mental health services are so important is that these services should be able to ensure that our whānau get access to the appropriate expertise, whether that be tōhunga33, kaumātua, or qualified Māori practitioners who have an ability to add a traditional perspective to the assessment and diagnostic process (Mental Health Commission, 2011). This is particularly the case with tangata whaiora who present with symptoms that could be interpreted either as psychosis from a western perspective or as wairua/spiritual experiences from a Māori viewpoint.

There are many presentations of this nature of probable Mate Māori34. Te Pou o Te Whakaaro Nui (2010) highlights that spirituality continues to play a key role in the increase in poor mental health for Māori. The concern being raised by Māori mental health kaimahi is the issue of misdiagnosis by western trained practitioners who are likely to have had little awareness of traditional Māori understandings. For example, we see significant concerns being raised by Māori consumer advisors in the DHB sector regarding psychiatrists who are from overseas and have no understanding of the cultural realities of Māori (Bennett, personal communication, 2011). Kaupapa Māori services provide an opportunity for Māori related issues to be acknowledged and for Whānau to have access to the appropriate expertise, such as tōhunga and kaumātua. This ensures

33 Tōhunga (Experts, Specialist)
34 Mate Māori (Māori illness)
that Whānau have the option of addressing Māori related issues with appropriate cultural protocols if they wish to.

4.4 Tohunga

Moon (2003), during his time journaling experiences and life knowings of Hohepa Kereopa, refers to a tohunga as an expert in the realms outside of the physical being and one who understands the intimate connection to all realms of our environment. For Māori people, mental and spiritual distress was traditionally understood as being caused by breaches of tapu. Such tapu were always placed there for the purpose of cultural protection. Breaching tapu was likely to bring serious consequences, often thought to be mediated via the spirit world. These consequences could be as serious as an accident or death, or could consist of frightening spiritual experiences that might serve as a warning. Such mate Māori could be brought about by means of a curse or makutu. In these cases, resolving this spiritual problem would require a skilled tohunga, “nga mahi tohunga” the Karakia and Waiata associated with healing (Lydon, 1983, p. 7). They had rigorous training in specific wānanga focused on fields of knowledge such as agriculture, the arts of navigation, fishing, and healing arts such as rongoa (herbal treatments) and mirimiri (massage). The appropriate use of karakia was an essential training in all of these areas of expertise. Hence, it is appropriate for us to call on the skills of a trusted tohunga when there are concerns about possible mate Māori with tangata whaiora and Whānau.

Further considerations need to look at the impact of colonization on our people down the generations. When we talk about mate Māori, it might be sometimes more appropriate to refer to Mate Pakenga. For example, this applies when there are intergenerational problems of loss of identity and loss of mana that can be traced back, for example, to land confiscation or loss of te reo through processes of colonization. The idea of mate toto also needs to be raised. Are some of these mental health problems in our bloodlines (i.e. are they hereditary)? When I think about this patai (question), the reality that we see in mental health is that it is a combination of all these things. The

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35 Makutu (witch craft)
36 Wānanga (learning forums)
interplay between these processes has gone on for so long that we have seen generations of our families coming through the system.

4.5 Te Pounamu and Te Whare Tapa Wha

Figure 4:

<table>
<thead>
<tr>
<th>Coping Strategies:</th>
<th>Presenting Issues:</th>
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<tbody>
<tr>
<td>Te Taha Tinana</td>
<td>Te Taha Hinengaro</td>
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<tr>
<th>Whānau Dynamics:</th>
<th>Underlying Issues:</th>
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<tr>
<td>Te Taha Whānau</td>
<td>Te Taha Wairua</td>
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4.6 The Pounamu and other health models

The Pounamu is closely aligned to Māori models such as Te Whare Tapa Wha. For example, the Pounamu encourages us to look at the four dimensions of Te Whare Tapa Wha in our assessment and treatment planning with tangata whaiora and their whānau. The four dimensions are Te Taha Tinana, Te Taha Hinengaro, Te Taha Whānau and Te Taha Wairua. Te Taha Tinana is particularly addressed as part of the presenting issues. Te Taha Hinengaro is addressed with psychological presenting issues and also in the coping strategies tangata whaiora and Whānau develop in response to their situation and life experience. Te Taha Whānau directly attends to relationship issues and whānau dynamics. Perhaps most importantly, the model makes sure that we are acknowledging and accessing the appropriate expertise in terms of Te Taha Wairua; when we are dealing with the underlying issues and the deep-seated hurt, the whatumanawa which sits deep in their puku, facets of Te Whare Tapa Wha.

4.6.1 Biopsychosocial model and the Pounamu

The biopsychosocial model developed by George Engel (1980) is commonly used in psychiatry to make sure that a clinical formulation is taking different aspects of a person’s

37 Whatumanawa (deep seated hurts)
situation into account. More recently, it has been suggested that this model does not emphasise culture sufficiently. Hence, it is also referred to as the bio-psycho-socio-cultural model. The Pounamu covers the same key areas (see figure 5).

Figure 5:

4.6.2 Predisposing, Precipitating, Perpetuating and Protective factors

Te Pounamu also allows kaimahi to consider the “4 P’s”, namely: (1) predisposing factors (underlying issues/grief, abuse, childhood issues, identity issues, Māori related issues), (2) precipitating factors (presenting issues, coping strategies, which may include substance abuse, Whānau dynamics, relationship issues), (3) perpetuating factors (same categories as 2) and (4) protective factors (strengths, Whānau capacities etc) (see Figure 6 below).

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38 The 4P’s an adaptation added to the Pounamu model presentation that Gill Hawke (2007) developed.
4.7 The Pounamu model and Te Tiriti o Waitangi.

A key concern that is raised constantly is about the application of the Treaty of Waitangi in practice and how trainings that are provided do not provide tools for integrating these understandings into a kaimahi clinical practice. Clinicians, whether they are Māori or non-Māori, often say, "yes, I've done heaps of treaty training, and cultural safety training but I'm still not sure how to apply it in my practice". The Pounamu model provides a tool for clinicians to be able to apply these principles in practice.

This happens as a natural progression from clinicians feeding back and checking out the information they have just collated from Whānau they are working with. Checking out the information and using a visual cue to feed back to the Whānau how we have then interpreted this information allows a visual overview to the Whānau about the complex issues that have been raised. This practice allows the Whānau to then develop an
understanding of what the issues are, how they impact on one another and where (as a Whānau) they can address the issues for themselves or with the support of others. This is Whānau participating in the engagement. The clinician is then also working in partnership with the Whānau by checking out the information they have collated.

The Pounamu model provides a framework to feedback all the information captured during the initial assessment, considering Te Taha Tinana (the physical presentation), Te Taha Hinengaro (the mental wellbeing), Te Taha Whānau (the Whānau issues), and finally Te Taha Wairua (the spiritual considerations). More importantly, the space provided allows for discussion about the discourse and on-going suppression and undermining of Māori experience in the struggle to balance all four cornerstones of ones wellbeing (Turia, 2001).

4.8 The principles of the Treaty of Waitangi in practice

Figure 7: The principles of partnership, protection and participation in practice
4.8.1 The principle of participation in practice

When whānau get to participate in developing a shared explanation for their young person’s presenting problem, they are better able to participate in the areas that they then can work on as a Whānau (see figure 7). Te Pounamu helps us work with them to identify how it is that they can play a role in working through their own issues, including the often painful territory of underlying issues. The Whānau are provided with an approach that allows for an understanding of what the issues are and where they can manage the issues for themselves and/or with the support of wider Whānau. Participation allows the Whānau some shared Whānau management of the issues. This is the beginnings of Whānau Ora through the provision of information using meaningful approach to feedback the information, so Whānau are better placed to identify and manage the issues or better understand why the clinician may recommend the treatment they do. Linking the recommendations back to the Pounamu model allows for the development of the Whānau insight into the complexities of the issues the impact on one another, and how they should then ideally be supported. The implementation of a consistent tool allows for a way of working that uses the same framework to work through the complexities of the issues. In turn, you are also addressing issues of inconsistency with the Whānau. Participation of the Whānau ensures that we are working in partnership.

4.8.2 The principle of partnership in practice

The other key principal that we are talking about is partnership. If you are feeding back the information and checking out with Whānau the information that you are collating, you are making sure you've got the story right; you are making sure that they understand why things are the way they are for them at this point in time. Partnership is about feeding back and sharing as much information as possible to the Whānau in terms of informing them about the range of issues being presented. This also includes having discussions about the common themes we see in working with Whānau who are non-compliant, issues with the recovery process, the system, medication complications, issues with the mental health act, and all those issues we see presented in the Pounamu model. Partnership is a two way process; it is not only about the clinician doing all the work, it is also about the Whānau taking responsibility in working with the clinicians. Partnership
happens at all levels of the relationship and is not a one off process. This practice ensures we are safe and being accountable to the Whānau.

4.8.3 The principle of protection in practice
An initial assessment provides a platform of information to consider what the needs are for one’s physical, mental, Whānau and spiritual wellbeing. Based on the comprehensive assessment, we are well positioned to work with the Whānau to identify the most appropriate interventions, ensuring we have understood and recorded all information collated correctly. The Pounamu model assists clinicians in a practical way to apply the principals of Te Tiriti O Waitangi in our everyday work; feeding back information and communicating effectively with one another to ensure everyone is on the same understanding.

4.9 How to use the Pounamu model
The Pounamu model is used as a visual representation of a young person and/or their Whānau situation to feed back information to Whānau about how it is that they came to present to our mental health service at this time. There are a number of effective ways of using the model.

Step One:
Understanding the language we use in our practice.
The first aspect to understand is to do with jargon. While it can be helpful to use mental health jargon at times to educate whānau, generally it works better if feedback of the information is couched in language they understand. In this way, the visual cue tells their story. For example, when feeding back the information collated from the assessment the visual cue allows for discussion about what each part of this figure symbolizes. The themes of each heading can be written up, which allows for korero with the Whānau and/or whaiora. Comments can be filled in under the different headings, and further feedback gathered for each aspect using their words as much as possible during the assessment process. As the dialogue progresses, it is important to check out with the Whānau the accuracy of each aspect, and whether they have other words that might be closer to their experience of the issues.
It is important to consider using key headings in terms of pulling together a shared formulation of the key issues for this young person and their Whānau. By reflecting the korero in their own words and in their own story, this ensures the tangata whaiora and Whānau are able to stay with the korero being fed back and the history they have given. The end point provides a platform of engagement to ask if you understood the information correctly: This reduces the risk of misrepresenting the young person’s predicament, which could damage rapport and get in the way of a shared explanation of the problem. The shared understanding supports the Whānau engaging with a treatment plan much more. This process also reduces the risk of misdiagnosis.

Step 2:
In this process, discussions are had about what this formulation of issues is in terms of being able to develop a treatment plan. For example, with a young tane who has a history of repeated admissions to hospital for a recurrent psychotic illness, who is not keen to keep going with medication treatment after discharge, the Pounamu may be used as a tool to try to come to a shared understanding of the history with him and his whānau. The Whānau are better placed to then understand why we might say: (1) “this is why the medication was prescribed, to help with your sleep”, (2) “this is why you have got to see the psychiatrist”, (3)”this is why you were in seclusion for that period of time when you came in because these were major issues for you in terms of your safety”. The aim of this stage is for a natural progression from a shared formulation to collaborating on psycho-education and treatment planning and to come to a shared understanding about the ‘revolving door syndrome’ that they may be caught up in (how this is maintained and what they might do to escape from this vicious cycle). By using the model, the aim is that they will go away with a real understanding such as "aah is that why that keeps happening to me?", or “is that where that emotional distress comes from”. It also allows the Whānau to be part of this shared korero. If past mental health treatment has been a traumatic experience, then this korero offers a chance to explore that and understand it in new ways.

It is not always the Whānau who hold all the detail of the history, so checking out wider Whānau supports is imperative. The whānau can often say, "you know when you were

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39 Tane (male)
four years old, you were a little hangman and you were accident prone”, and so as a kaimahi you will be considering potential contributing factors, such as “ohh, a head injury?”. You will often hear more stories from the Whānau which help fit pieces of the puzzle together. For example, in our korero around the Pounamu, the Whānau may begin recounting further stories, "oh he was close to his Koroua, and that's when we noticed that things started changing for him, when his koroua died”.

Sometimes Whānau dynamics are a tricky subject and Whānau can feel threatened by a suggestion that family therapy is needed. Using Te Pounamu allows korero about Whānau issues to be included as part of the big picture in a positive way and the Whānau involvement in articulating this may help them feel more open to the idea that this area needs to be attended to in the treatment plan.

4.10 Using the Pounamu therapeutically

In the assessment phase, it is critical to check out that we have understood about the lived realities of Whānau and tangata whaora accurately. This should not be done once; we need to do it continually. In later sessions, kaimahi can repeatedly refer back to the original Pounamu diagram to revisit korero that has been discussed in relation to each issue. It provides an opportunity to make links between issues that are not immediately apparent to Whānau. For example, an individual may have a major issue in trying to understanding why they were a whangai40. As a consequence of being adopted out, they now do not know who Dad is and because of this, have little or no contact with their Māori side. There is an opportunity to link these aspects of their life story to their current issues of identity and help them to understand where they see themselves in terms of the continuum and where they would like to be. The kaimahi are then better placed to work with them to identify other Māori approaches that may help them develop that sense of identity and do so safely. These matters may well link into feelings of grief that they have previously found hard to put into words, which may link to acting out behaviours that have damaged relationships with other Whānau members. These links could only be made when Whānau members are ready to hear them. The Pounamu picture on the whiteboard is a great visual cue for enhancing therapeutic work, well after the assessment.

40 Whangai (adopted)
phase is over. By revisiting it in later sessions, this tool can allow them the opportunity to
tell their story again and gradually work through past trauma.

4.11 How Whānau respond to the Pounamu model

Whakapai means ‘to seek better wellbeing’. If things are better for those who have the
poorest health statistics, as a natural progression, things will be better for all. The
feedback from Whānau about the Pounamu has been overwhelmingly positive. For
example, comments such as "now I understand why you people want us to do what you
do"; "now I know what our picture looks like, I now know what I have to do to help
break this intergenerational cycle". As mentioned above, the visual representation is not
only a reflection of the individual but often a reflection of the Whānau and the wider
Whānau. Hence, the importance of using this model with whānau. As kaimahi, you are
not only working with that individual Whānau member but also educating the wider
Whānau. The opportunity is there to take that korero out to their Whānau to help them
have a better understanding of how is it that they might break their cycle of
intergenerational abuse, or how is it that they might help themselves as a Whānau, or
seek better wellbeing. That’s what Whakapai means.

Chapter four provided a working understanding how the Pounamu model can be
implemented by Practitioners who are non-Māori or Māori, when working across the
mental health sector. This leads into chapter five where two Whānau demonstrate how
they have implemented the Pounamu model in their recovery to Whānau ora.
Chapter Five

Method

5.1 The researcher
As the researcher, I come with 20 years experience working across the mental health sector. The utilisation of Kaupapa Māori as a framework provides a platform whereby my own personal work experience and indigenous knowledge base allows for these knowings to be recognised in the writings. The fine line is understanding one’s own ethics of practice or knowing how to integrate the cultural and clinical deliverables in one’s practice. As the researcher, I bring those experiences of walking in both worlds and a lived knowing of the fine line of what it means to have a practice that is culturally and clinically integrated, a workforce skill mix that is unique to Kaupapa Māori. As a Māori clinician, I am not only accountable to my ethics and code of conduct as a nurse but also have a responsibility and accountability to the Whānau, hapu and iwi. Kaupapa Māori frameworks allow me as a Māori clinician to maintain my accountabilities to my professional body and to the Whānau, hapu and iwi.

5.2 Ethical approval
The providers on the first instance were approached face to face to discuss the proposed research; the thesis topic, hypothesis, and request to interview individuals of each kaupapa. The research ethics were then completed submitted and approved by Te Whare Wananga o Awanuiarangi ethics committee. The providers were then emailed a copy of the interview questions, abstract, and consent forms, following confirmation of the scheduled interview appointment times. The interviews were opened and closed with Karakia by the provider, followed with a process of mihimihi at the beginning and end. The interviews were held at the Kaupapa place of residency. The questions that were asked were both structured and semi-structured (see appendix three). The nature of the dialogue and interview was driven by a process of storytelling, sharing of genealogy, and experiences of working in mainstream services. Kaimahi also have an appreciation of the
unique gifts of working from a Kaupapa Māori approach and being privileged to be part of the lived realities of those experiences from our Whānau who access the services. The process of enquiry was through storytelling and sharing between the interviewee and interviewer. The interviews were dictaphoned and then transcribed, and the transcripts were returned to the providers to make any necessary changes. Through a process of face to face and wananga at every stage of the research, and transparency of all information collated, transcribed and stored, we are ethical in regards to our clinical responsibilities and Te Ao Māori.

5.3 The methods
The two methods that were used to undertake the research were through a process of interviewing two providers. The interviews were based on semi-structured and structured questions (see appendix three). The Whānau involved in the interviews will be identified as kaupapa one and kaupapa two. The providers were identified because they are providers who have worked in Kaupapa Māori mental health for at least five years. One is located in the upper north island and the other in the lower north island. One provider is predominantly made up of a staffing mix that are learning what it means for them to practice Kaupapa Māori, and the other provider comes with a team of kaimahi who are predominantly first language speakers of te reo Māori. Despite these differences, both providers are located in the major cities of New Zealand. The case studies are from two Whānau reflecting the practice of the Pounamu model. The Whānau involved in the case studies will be identified as Whānau one and Whānau two.

5.4 The interviews
The numbers of Whānau interviewed in kaupapa one were the team leader on the first instance, who then invited a tangata whaiora in the service to share his experience of the kaupapa to evidence how the concepts of Kaupapa Māori were being experienced as a therapeutic modality. In kaupapa two, the kaiwhakahaere, or leader of the kaupapa, was interviewed and was the voice for the kaupapa. This Whānau member had been involved in the kaupapa since its inception. Kaupapa Māori provides a platform whereby the individual is situated as the voice for the wider Whānau. The interviews for both providers happened in the workplace, which allowed for least disruption to the Whānau
involved and allowed for some insights into how they translated principles of Kaupapa Māori in practice.

Both providers have been operating for 10 years as Kaupapa Māori mental health providers for both Māori and non-Māori tangata whaiora and Whānau. Both providers service an age range from 17 to 60 years of age, and work with Whānau and referred cases. The providers have more than one service arm, which range from respite care, mobile services, residential care, day programmes and an educational / recovery component of service delivery.

The two providers who were interviewed were specifically identified for the following reasons. The first provider is based in Wellington (kaupapa one). The identified Whānau is a team leader for this kaupapa. This clinician has actively worked with the Pounamu model at a number of operational levels across the mental health sector, and is utilising the Pounamu model as an approach to develop an integrated cultural and clinical operation. The team is at the very beginning stages of the development of a Kaupapa Māori service. The second provider, kaupapa two, is based in Auckland. This service utilises a range of Māori models of practice, and they come from a very strong base of cultural understandings and practice in respect to tikanga Māori, including employing a significant number of fluent speakers of te reo Māori. Although both kaupapa are based at either end of the North Island and have come from two very different working histories, the commonality the services operate from is the use of Kaupapa Māori models of practice, which is reflected in the case study discussions.

5.5 The case studies

The Whānau who have been identified as case studies for this thesis are working with the Pounamu model, and have been working with this approach either in their practice or alongside other approaches. The model has also been used at a Whānau level to address a range of presenting issues within their own Whānau. The Whānau have found the tool useful as a framework in addressing the issues and supporting the Whānau to make change. The case studies will provide evidence of Kaupapa Māori treatment themes in practice. This Whānau had their first experience with this approach when their mother had supported her son in an interview. From that day forward, this Whānau have used the Pounamu model as a tool to contribute to their Whānau ora. The
Whānau are also caretakers of the Arahura River / the Pounamu, so it was fitting to ask the Whānau to carry the name Pounamu. It is with the blessings of this Whānau that the name can be carried and to have this Whānau actively using this as a tool for healing is a privilege.

5.6 Case Study 1: Cat

5.6.1 Whānau formulation of issues

Cat has had a number of diagnoses over the period of her mental illness, and is now being treated for bipolar since 1980. Cat and the Whānau are well versed with the mental health system, their mother’s symptoms and early warning triggers and signs. The Whānau have been the primary caregivers for Cat over the period of her mental illness. The Whānau have, in more recent times, been working with the Pounamu model. The approach has been a good fit for them, as a Whānau, in maintaining their well health. The Pounamu model provides a framework for the Whānau in identifying how and where they each contribute to the well health of their mother and, more importantly, understanding the cycles of concern that sit within the Whānau and their roles and responsibilities.
The Pounamu model provides the Whānau with an opportunity to identify the concerns and where they then as a Whānau sit in contributing to the healing for Cat, but, more importantly, for them as a Whānau. The following plan is an outline of the Whānau history of interventions both clinically and culturally.

1. At the heart of the Whānau, Pounamu assessment was the balance of strengths and weaknesses and a plan to reduce weaknesses and amplify strengths to increase the Whānau capacity. An individual Pounamu assessment was also carried out on Cat (separately attached), and the insights attained from this assessment led to a more searching inquiry into the current clinical care plan. The end result was the compilation of the most comprehensive care plan Cat had ever been a party to during over four decades of mental health services:
a. Since 2008, the care plan has been successful, both clinically and culturally. Appropriate financial and human resources have been allocated to Cat including:

i. Cultural input for the first time from the West Coast Māori Mental Health team; the service is new and in some respects struggles to deliver in-depth cultural services, however the support is welcomed by the Whānau as it has had to deal with a monoculture clinical pathway that is culturally insensitive to Whānau needs.

ii. Clinical Psychological counselling for the first time, paid through the current care plan by the West Coast DHB.

iii. Crisis respite plan, should there ever be a future need for an acute admission.

iv. A needs assessment that allocated human and financial services for day to day care needs for Cat and her Whānau.

v. On-going management by a community psychiatrist and local nurse/case manager.

vi. An advanced directive contract signed between Cat as one party and her Whānau as the other party.

5.6.2 Whānau ora conclusions

The Pounamu model provided a window of opportunity for the Whānau to identify what has worked well and, more importantly, provided a platform of engaging and integrating the need for both the clinical and cultural interventions required by Cat.

1. Items i to vi could be seen by some as standard practice. However, all six components of the working care plan are novel and have never been used by the Wellington and Christchurch Mental Health teams subsequent to Cat’s four acute admissions, two each for both DHBs. The reasons for this historical vacuum are a mystery and one day Whānau may concern themselves with some analysis as to the poor direction maintained by successive mental health teams. The difference with the West Coast care plan that incorporates all six interventions is the heads up Whānau had from
the Pounamu assessment of themselves and Cat personal Pounamu assessment.

a. The West Coast mental health team was regarded by Whānau as historically the best of a bad bunch to try and deal with. They were under resourced through budget constraints and had arranged to discharge Cat at an early stage of her recovery. However, the Whānau began to hold the mental health team to account and to due process. It was felt by Whānau that the obscene haste to discharge was economically driven. In the end, the DHB Operations Manager became a party to final deliberations between Whānau and the clinical team to authorise expenditure for the final care Māori plan. 6/10

b. The care plan has been engaged actively over the last two years. The most progress in terms of recovery for Cat has been through ongoing counselling and assessment by the clinical psychologist. 7/10

c. The cultural interventions from the Māori mental health team have been by way of well-meaning support but little else. 5/10

d. Cat before, during, and following her acute admission, had been on a strengths programme to amplify talents that she was aware she possessed. These included art, as in painting, gardening and watching sports. The talents for amplification were identified in the Pounamu assessment, and the strengthening of talent forms the foundation upon which all other interventions sit. 8/10

e. In October 2010, Cat met with her community psychiatrist and reached agreement that she will experiment with a substantial reduction in her daily medication of Epilim from 1000 mg per day down to 600 mg. The reduction was agreed first by the heads of Whānau, with Cat, following a review of her advanced directive (copy attached). Further, the reduction is programmed to take place in late January 2010, at a time when Whānau can focus on caring for Cat should she need crisis respite care. A successful negotiation
between three parties, Cat the patient, the clinicians and the Whānau – all working together at last.

f. The presentation of Cat is as good as it has ever been since 1970. There is better empathy and understanding between Whānau caring for Cat and Cat herself. Whānau support decisions made by the clinical team and there is no longer any opportunity for Cat to be splitting information between Whānau and clinical teams.

g. It is unlikely there will be any further acute admissions.

5.7 Case Study 2: DR

The case study on DR provides an overview of how the Pounamu model has been used as a model for Whānau ora in response to the question of ‘where to from here’? DR is my nephew and I have used this approach to support my nephew’s transition from a path of destruction into a Whānau ora plan, where we as a Whānau can take responsibility for the rehabilitation of our nephew while he is on home detention. The opportunity to give back to your own Whānau is an important aspect of the process of backyard and front yard. Through all my life achievements, the sense of giving back to your own Whānau is the most satisfying and rewarding sense of achievement I have ever had. The Pounamu model is the tool that has been used to report the Whānau ora progress and the strategy being used to work through the issues as a Whānau.

5.7.1 Whānau formulation of issues

DR is a young man who came from a very privileged childhood and upbringing and, yet, was enticed into walking a path of methamphetamine use for at least eight years of his young adult life. DR come from an immediate Whānau who were well resourced, so was able to hide his methamphetamine use until a pattern of lies, unemployment, transiency and crime exposed the realities of his lifestyle.
The implementation plan for DR has been mapped against a Whānau ora framework, an approach that captures the roles and responsibilities of the Whānau. The plan also demonstrates how the interventions link to the identified formulation of issues and notes how the Whānau propose to work with DR therapeutically.

### 5.7.2 Whānau Ora Plan

The Whānau ora plan has been drafted by DR Whānau. It outlines where DR is to be placed and what is required of DR and the Whānau during his placement. The Whānau provided the Whānau ora approach as an option of rehabilitation other than detainment in prison. The details of this plan are as follows:

DR to be based at the homestead in the care of his aunty, a younger sister to DR father. Aunty has recently relocated home to Kawerau; her training base (nursing) and work history have included working across the mental health sector in the lower north island; recently managed the Lower North Severe Conduct Disorder Unit for rangatahi with severe conduct disorder. All Whānau have been engaged in...
the development of this plan. The following is a matrix of activity that will be undertaken across all Whānau environments.

<table>
<thead>
<tr>
<th>Key Tasks</th>
<th>Particulars</th>
<th>Expected outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibilities as a Dad</td>
<td>To maintain on-going contact with his two year old son</td>
<td>An opportunity to maintain his responsibilities as a parent, this allows for contact with his son.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs to places of residence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interior Renovation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repairs</td>
<td>Painting</td>
<td>All activities to be completed will be managed by the Whānau. This will be a shared Whānau responsibility to ensure that Whānau do not burn out.</td>
</tr>
<tr>
<td></td>
<td>Sanding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Replace ceilings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fix property damage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Renovations to Homestead</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demolition</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Labour hand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Installation</td>
<td></td>
</tr>
<tr>
<td>Exterior Renovations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painting</td>
<td>Paint windows and roof</td>
<td>An opportunity to develop practical skills while contributing to outcomes that will benefit the wider Whānau and community.</td>
</tr>
<tr>
<td>Fencing</td>
<td>Build new fences</td>
<td></td>
</tr>
<tr>
<td>Landscaping</td>
<td>Clean yard</td>
<td></td>
</tr>
<tr>
<td>Building</td>
<td>Build Gardens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Build BBQ area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Garage</td>
<td></td>
</tr>
<tr>
<td>WORKFORCE DEVELOPMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete Mahi Ora and Mauri Ora papers</td>
<td>Supervision and management of papers to be completed by his aunty, who also lives at the homestead.</td>
<td>This can happen at any of the prosed Whānau placement options. This is a mobile learning package.</td>
</tr>
<tr>
<td>Activity</td>
<td>Support Description</td>
<td>Related Information</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Learn about Tikanga and Te Reo Māori</td>
<td>Will be supported by all Whānau members to korero Māori.</td>
<td>Key topics of discussion will be in regards to his offending, behaviour and in particular regarding decisions he makes and the consequences for us all.</td>
</tr>
<tr>
<td>To spend time with his Kuia learning about Tikanga.</td>
<td></td>
<td>Aunty to follow up with a referral.</td>
</tr>
<tr>
<td>To assist and support his aunt’s weaving business.</td>
<td></td>
<td>Aunty to follow up.</td>
</tr>
<tr>
<td>A &amp; D counselling</td>
<td>To complete an A &amp; D programme.</td>
<td>As directed by the courts.</td>
</tr>
<tr>
<td>Therapy</td>
<td>To meet with his Probation team as required.</td>
<td>Aunty to follow up.</td>
</tr>
<tr>
<td>To participate in a monthly Whānau wananga.</td>
<td></td>
<td>Aunty to follow up.</td>
</tr>
<tr>
<td>To identify a suitably qualified therapist.</td>
<td></td>
<td>Aunty to follow up.</td>
</tr>
<tr>
<td>Long-term Study</td>
<td>To undertake some home correspondence schooling in studying a topic of choice.</td>
<td>Will be supported by all Whānau and relevant Whānau with the appropriate skill mix.</td>
</tr>
<tr>
<td>Complete his community service in accordance with offending outcomes</td>
<td></td>
<td>Probation team to advise.</td>
</tr>
</tbody>
</table>

**COMMUNITY SERVICE**
5.7.3 Whānau ora conclusions

The above plan ensured that DR was engaged in productive and meaningful activity while under home detention, should this option have been considered. Given Whānau support available and DR current responsibilities as a father, it was believed that the Whānau and community outcomes of undertaking such a plan would far exceed those of other sentencing options, and would be much more economical for society and DR himself. At the completion of my thesis 12 months on, DR has completed his Whānau ora plan while under home detention and has been methamphetamine free.

Through chapter five, we are privileged to share the life experience of two Whānau ora stories, where the Whānau have used the Pounamu model as the framework for navigating through the complexities of the health and justice system. Chapter six outlines the process of analyses. The two identified Kaupapa Māori mental health providers share, through the transcripts from their interviews, how they have implemented Māori knowing in practice and the common themes of Kaupapa Māori theory and praxis that sit with both providers. The results take a closer look at the comparisons of these findings between the two case studies and the two Kaupapa Māori providers.
Chapter Six

Results

The results from the interviews and case studies highlighted that, in practice, the themes are often seen at different times and different stages of engagement when the providers are working with the Whānau that is constantly changing. This requires a practice that is flexible within the parameters of Kaupapa Māori and theory and that can change to suit varying circumstances and cases instead of being rigid.

6.1 Process of Analysis

Through a process of reviewing, reading the material and then deciding from the interview scripts, key themes emerged. The themes that emerged were based initially on knowings that are evident in my own practice and practices that I have seen over the past 20 years working in Kaupapa Māori mental health. The storytelling was grouped into the identified Kaupapa Māori concepts, drawn on from Māori readings as identified in appendix two. In undertaking this process of analysis, it becomes apparent that not only are these concepts that we may see in one’s clinical practice, but they are knowings that we live, in our everyday lives. It is important therefore to reflect on how these concepts are demonstrated in our clinical practice and how these knowings then translate into our daily lives. It is on this basis that we challenge the definitions of evidence based practice. It is a knowledge that has survived generations and evolutions of time, which can be translated into practice and act as a remedy for wellbeing which we live in our everyday lives. Kaupapa Māori also provides a framework that recognises the dual accountabilities we hold as Māori kaimahi, to our clinical profession and our Whānau, hapu and iwi. In taking the Kaupapa Māori themes that emerged and separating the knowings from practice, those who operate from different realities can understand these dual accountabilities and interpretations of evidence based practice.
Step 1: The foundations of practice
An important aspect of practice when looking to work within the field of mental health is that it is crucial to understand what your own story is and understand what this looks like within your wider Whānau. This is about healing yourself in understanding your own story. As a practitioner, you will have a better understanding of how colonisation has impacted you as an individual and the impacts for your Whānau. As Whānau, we are better placed to heal from these realities by strengthening our identity. Understanding ones identity is the basis of one’s foundation of practice. This foundation of understanding who you are strengthens your ability to integrate both your clinical and cultural knowledge in practice.

Step 2: A foot in the door
Kaupapa Māori is the space that allows practitioners the ability to engage with our Whānau so that it is meaningful. The space is the Māori knowing that we call on when engaging with our Whānau. The lived knowing of aroha and whakaWhānaungatanga allows these opportunities for getting a foot in the door and developing a rapport. The relationships we have through geneology or kaupapa allows the practitioner the ability to locate those of our Whānau who are transient. Practitioners who are Māori have a lived knowing of the realities of Kaupapa Māori and so are better placed to call on these knowings to strengthen our clinical practice. Māori models are the tools from the traditions of the past that we implement in our practice to compliment the therapeutic milieu. Evidence based practice must therefore be an inclusive approach and acknowledge both western and cultural realities.

Step 3: The windows of opportunity
The relationships I have built in Kaupapa Māori mental health with the Pounamu model over the past 20 years has provided the opportunities to meet with many Whānau and kaupapa. Through these relationships, this field study has been able to be completed. The relationships are built on whakapapa, trust and understanding of walking both world views but, more importantly, on having an ability to translate Kaupapa Māori in the many realities in which we live. Through the process of whakaWhānaungatanga, I am provided with the windows of opportunity.
Table 4: Data Analysis

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Reflecting and working through my own story</th>
<th>Understanding intergenerational cycles of abuse, within my own Whānau</th>
<th>Knowing the outcomes of decades of colonisation</th>
<th>Capturing 20 years of practice across the mental health sector</th>
<th>A consolidation of cultural and clinical knowing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>Understand what Kaupapa Māori is</td>
<td>Identify what Kaupapa Māori looks like in my own practice</td>
<td>Understand what Māori models of practice are</td>
<td>Demonstrate an integrated practice through the use of Māori models of practice (The Pounamu model)</td>
<td>Define and understand what is evidence based practice</td>
</tr>
<tr>
<td>Step 3</td>
<td>Identify two Kaupapa Māori mental health providers and 2 Whānau to present their case</td>
<td>Capture their korero through a process of storytelling face to face</td>
<td>Data transcribed and returned to participants for sign off</td>
<td>List of themes identified and linked back to themes identified in Kaupapa Māori theory and praxis readings</td>
<td>Key themes defined and linked into sub themes, that link to step 1 &amp; 2. Examples of how they then translate In practice and</td>
</tr>
</tbody>
</table>
6.2 The House of Integrated Approaches

The model below provides an understanding of the weaving of the many relationships (theoretically, physically and spiritually) that are integrated throughout the process of analysis from step one to three. The House of Integrated Approaches is a model that provides a critical lens by which we can understand Kaupapa Māori theory and praxis as evidence based practice. The House of Integrated Approaches is a model that shows a matrix of engagement and how Kaupapa Māori sits as a foundation for defining evidence based practice outside of western realities, validating indigenous pedagogy. A foot in the door is about developing a rapport so the relationship fosters hope. The window of opportunity is about the need to develop resiliency because of the nature of the work involved in working with Whānau. The qualitative research is a reflection of the research that is involved when making decisions about treatment and expected outcomes. The use of the language has its place, and to use this in a meaningful way is to first have a foot in the door with the Whānau. The relationship otherwise misses the opportunities for therapeutic engagement.
A Foot in the Door | The Windows of Opportunity | Qualitative Research | Language
---|---|---|---
Māori models of practice | Clinical and cultural integration | Indigenous knowing | In practice, in application, recovery
Evidence based practice | Evidence based medicine | Evidence based thinking | In teaching resiliency

Eclectic ways of knowing | Keeping it real, hope

The Foundations of Practice
Rangatiratanga, Manaakitanga, Kaitiakitanga, Matauranga, Whānaungatanga, Kaitiakitanga, Wairuatanga, Tikanga, Kaupapa, Whānau, Whakapapa.

6.3 Findings
The key themes that emerged during the interviews and are evident in the case studies were Rangatiratanga (being Māori), Manaakitanga (giving without expectation), Kaitiakitanga (access to the best possible services), Matauranga (knowledge from all sources), Whānaungatanga (strengthening relationships), Wairuatanga (knowing who we are), Tikanga, Kaupapa, Whānau and Whakapapa (the contribution of self). These themes are further defined below and explained with regard to using the Pounamu model in its application in one's clinical practice and how it is translated into our everyday lives.
Rangatiratanga

Rangatiratanga is a practice we see in regards to providing an environment that allows Whānau to be who they are in a comfortable environment. Working with the Pounamu model acknowledges the privilege to be part of one’s experience. When working with the Pounamu model, it is important to support the Whānau in accessing the appropriate expertise. In the following example, we see how these core Māori values can be applied when working with non-Māori in response to our values acting as a foundation of practice that not only applies to Māori but for the betterment of all. For example, we see evidence of these themes with group one and two as follows.

In Practice

Group one talked about the fact he came into the Kaupapa a stranger (Tauiwi\(^41\)) who was unwell, suffering from an addiction with severe emotional distress. It has been four weeks and I don’t ever remember feeling like a stranger, but recall being treated like family.

Knowing

Group two talked about the Kaupapa in reference to talking about the Whānau and the foundations in which the organization is absolutely entrenched. This allows for Whānau thinking: Kaupapa a Iwi, a Whakapapa, a Whānau. It is about the mokopuna, it is about working through our experiences with everyday people. We are blessed.

Manaakitanga

A second Pounamu variable is Manaakitanga, which is about everything we do and how we practice. In other words, it is about giving unconditionally. In working with an approach such as the Pounamu, this provides a framework to work through issues of counter-transference or transference, in being honest to who we are in making the necessary changes for ourselves, and therefore truly being there with the Whānau. This is evidenced by the following comments with group one and two:

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\(^{41}\) Tauiwi: an individual who is non-Māori
In Practice
Group one talked about an example from a tangata whaiora who highlighted that many (Kaimahi) had given a listening ear and never told me what to do, but instead, have shed light on situations in helping me to find my own solutions and understanding what’s best for me. Another kaimahi highlighted what was paramount in working with our Whānau and the first thing we do is establish our rapport, “it’s like being on the Marae”, and (we practice what we know).

Knowing
A tangata whaiora from group one acknowledged the he could not possibly express enough his sincere gratitude for the genuineness and sincerity that the kaimahi have shown me. Further to this, a kaimahi went further to mention that “the Kaupapa unites us” and we sit across all that it is we do; this strengthens the resiliency of the Whānau, kaimahi and the Kaupapa. Group two went further to elaborate on how we integrate our knowings into our practice and daily lives “I treat my tamariki as human beings” not tamariki, I teach my tamariki how to carry the responsibilities of the choices they make, it is about real people having, seeing the inner most person and connecting genuinely, in fact we are wairua first.

Kaitiakitanga
The Pounamu variable, kaitiakitanga, is the navigation tool for working through the mental health services. This ensures that Whānau are informed throughout their contact with the mental health services, and provided with insights into how the mental health system operates. The Pounamu provides a framework that allows for a visual insight and a tool for discussing the relationship between treatment recommendations, service delivery and treatment outcomes. We see evidence of this practice in the following examples:

In Practice
Group one talked about the Whānau, kaimahi and Kaupapa being one in the same, we are Whānau in response to having had an experience within the mental health system. Group two talked about how the Kaupapa was their life, and that we are finding ways for better wellbeing for us all, it is about strengthening our Whānau and Whānau is where it is at.
Knowing

*We see this theme in the conversations with group two who talk about the Kaupapa belonging to the people, but how we practice belongs to us solely. Group two go further to challenge the importance of relationships and without understanding relationships, how we will connect with people, our traditions teach us these understandings, that’s why face to face is important for us.*

Matauranga

The Pounamu, in practice, provides a tool to address the clinical requirements, but is flexible in allowing one’s own storytelling to be told so that the process of sharing the story does not become abusive. It also allows for the relevant material to be captured while safeguarding the deep knowings that Whānau bring safe. This is called Matauranga and is reflected in the following comment.

In Practice

*Group one highlighted that kaimahi contribute their own knowing’s to the Kaupapa. They go further to mention that evidence based practice is about working with tools that work for our Whānau, tools that work at the grass roots. Group two talks about how our learned knowings from being good listeners and observers make us uniquely different and stand out in terms of being Kaupapa Māori.*

Knowing

*Group two talks about the learning’s kaimahi receive from the Kaupapa and how the kaimahi provide their learning’s and feedback into the Kaupapa, a process of reciprocity. Having the knowledge and knowing when the time is right, so our Whānau understand how to help themselves, rather than others doing for them.*

Whānaungatanga

The next set of questions concerned how indigenous knowings were applicable in contemporary times. The practice of Whānaungatanga provides the understandings for engaging and finding the window of opportunity to have a range of discussions as Whānau stories are told. We see this in the practice of linking the issues when talking
through how one issue may impact on another in understanding the potential impact and its history. Group one referred to this as being likened to how you would manage your own Whānau.

**In Practice**

*Service provision with group one involves the support for those with significant risk of relapse and recovery from acute episodes of unwellness, and the kāimahi see it as a responsibility to work (110%) to ensure the safety and risk management and wellbeing for all the Whānau.*

**Knowing**

*Group two referred to the relationship of linking our understandings through the following story; I teach my tamariki how to hiki (carry) the responsibilities of the choices they make. An example is talking with my kotiro about having a cigarette and the choice she made to take the puff, and talking with her about the decision she made and accepting responsibility for that decision, and then how does she carry that decision she made, to bring about an understanding of knowing the difference.*

This example captures how, as a mother, she linked the choice her daughter made to the responsibilities of that decision; for example, it cost to smoke cigarettes, and challenges her to consider how she would pay for her cigarettes. As a mum she maintained the relationship with her daughter by talking with her about the other issues that needed to be considered in making the decision to have a cigarette. The opportunity was about addressing the issue but, more importantly, allowed for the building and strengthening of their relationship as mother and daughter.

**Wairuatanga**

The groups were then asked the question; ‘why is Kaupapa Māori important?’ There were a number of variables discussed at this stage. One of which was wairuatanga. Wairuatanga sets the scene for all that it is we do in one’s practice. This begins with our own understandings of who we are and where we come from. The loss of identity is a number one factor that underlies our poor mental health. The Pounamu model provides a pathway to acknowledge the underlying issues, surrounding the loss of identity.
**In Practice**

Group one noted that they see evidence of this through the following comments; we are a *Kaupapa A Whānau*. The *kaupapa* unites us, as part of the healing. This strengthens the resiliency for both the Whānau and kaimahi. Group two go further to say that during the process of Powhiri, the practice of hongi unites everyone through the sharing of one’s own personal space. It is through this practice of meeting and greeting that allows us to engage at a spiritual level.

**Knowing**

Group one talked about the inspiration, innovation and motivation, and that there is a spiritual element that connects human wellness to the environment of Māori culture. This development is interconnected to our development. Group utilise karakia and waiata as a vehicle to build the relationships and nurture the connections of the many senses.

**Tikanga**

Group one raised key themes such as how tikanga is observed in respect to being evidenced in what we bring with us as kaimahi into our practice. The Pounamu highlights the key issues that have been disclosed by the Whānau, so it provides a starting point to talk to the complexities. For example;

**In Practice**

Group one acknowledged the many hands that had contributed to the developments of their *kaupapa* in understanding who they are, they must acknowledge those who have treaded the *kaupapa* before our time. The many hands have contributed to the *kaupapa* current status, we will do the same, and we will continue to add to the developments for those yet to come.

**Knowing**

Group two highlighted when people are ready for knowing, you see a transformation, it is this privilege of being part of this that makes up for all the struggles and keeps you in the *kaupapa*. That is when you see *Kaupapa Māori* in practice.
Kaupapa Māori allows for understandings and experiences to be shared by the kaimahi and the Whānau. We see evidence of this from the following comments;

1. *We plant seeds in those who want to take on board those understandings and those who are ready for this knowing, you can grow and nurture this knowing, that is now so much part of who we are. When people are ready for knowing, it is the privilege of being part of this that makes up for all the struggles and keeps you in the kaupapa.*

2. *We are part of the maunga and the maunga is us. We are connected to our environment. It is the source of that environment that has enriched us to become who we are, we have bathed in the waters of our river, and we have left footprints in the whenua and enjoyed the Mauri of the maunga. The essence of the maunga has moulded and strengthened our connection to the higher realms; therefore we are children of that environment. I am the river and river is me, I am the maunga and the maunga is me, we are one, which is the ultimate. This is understood as the practice of psycho-education in mainstream mental health.*

### 6.4 Case Study Findings

From the case studies, both groups were asked about the Māori models they were working with. One of the models used was the Pounamu model, which is a key reason why these case studies have been included. Two aspects that were highlighted were about the Kaupapa and the Whānau. The responsibility to give back to your own people was paramount. The Pounamu provides a framework that allows kaimahi to feed back as much information as possible to Whānau, to shed light on the complexities but strengthening the Whānau to move forward. An example is presented of a report for the initial assessment where the treatment outcomes and recommendations are given to the Whānau. If they move to different services, they have a report that explains their situation without having to repeat the storytelling constantly, therefore stopping the repetition and the process becoming abusive.

*Group two highlights the responsibility of translating the many viewpoints, role-modelling what that then looks like and then knowing how to articulate these different perspectives. The Pounamu as a framework provides this opportunity.*
The case study groups were then asked to discuss what makes Kaupapa Māori different from mainstream. One key difference that was highlighted is that everything is underpinned by whakapapa. Whakapapa links all that we do, for every issue tells its own history and comes with its own complexities. The Pounamu allows for the chance to talk to the different layers that sit within that issue and work through where, what, why and how. Group one refers to this notion of whakapapa through the following comment. They acknowledged the need to draw on a range of knowings to address the complexities of the issues.

_The kaupapa cannot be governed by one practice, otherwise we start conditioning our Whānau into boxes of (A) or (B) and if the person is neither, do we say “sorry you don’t fit the (A) or (B) kaupapa. Kaupapa Māori opens up a reciprocal approach for everyone. Group two states we are channels by which conversations and relationships connect people, you whakapapa all the time, the struggles keeping the traditions of practice alive, this is the driving life force, mainstream refer to this as the passion for the mabi._

The healing in the Kaupapa Māori themes is evidenced in the above case study examples. Rangatira is a reminder to us to be true to we are; knowing who and where you come from is imperative to healing. To be able to manaaki is to be pono, tika and aroha in your practice. Kaitiakitanga is about ensuring our Whānau have access to the best and most appropriate services at all times, wherever possible. Matauranga is about the utilisation of all resources for the betterment of our people. Whānaungatanga is the strengthening and building of relationships for the wellbeing of all. Wairuatanga is reaching our fullest potential in everything we do with our Whānau in the interest of our future generations in breaking cycles of intergenerational abuse. Tikanga, Māori kaupapa, Whānau and whakapapa is about being Māori.

The discussions, however, from group one and two interviews highlighted key themes evident in the application of the Pounamu model in case study three, four and five. The case studies provide for evidence regarding the common Kaupapa Māori treatment themes that emerge from all case studies (Rangatiratanga, Manaakitanga, Kaitiakitanga, Matauranga, WhakaWhānaungatanga, Wairuatanga and Tikanga). Case study evidence
will be provided looking at two of the Kaupapa Māori treatment themes (Rangatiratanga and Manaakitanga) across case study three, four and five.

Rangatiratanga

Case study one captures a similar essence of self-determination/ rangatiratanga in the following example;

*At the heart of the Whānau Pounamu assessment was the balance of strengths and weaknesses and a plan to reduce weaknesses and amplify strengths to increase the Whānau capacity. Also an individual Pounamu assessment was carried out on Cat (separately attached) and the insights attained from this assessment led to a more searching inquiry into the current clinical care plan. The end result was the compilation of the most comprehensive care plan Cat had ever been a party to during over four decades of mental health services:*

Case study four assessment notes mention the following findings in response to self-determination/ rangatiratanga;

*I detected a strong love for one another in the whole Whānau. I am concerned with Kuia eldest daughter Toko wellbeing, given the load Toko has undertaken as a caring committed parent attachment for her siblings during times of family stress overload. This brings into account the need to plan for the spill over effects from Kuia presentation that can adversely affect children in the home. I am reassured by the Whānau strength. I plan to introduce Sir Prof. Mason Durie’s Whānau framework to help with supporting and strengthening Whānau. The key for a Whānau ora practitioner is to help Whānau bridge the gap in understanding between themselves and community agencies, to bring about better outcomes for all concerned.*

Case study two captures self-determination/ rangatiratanga from a Whānau perspective;

*DR is of Ngatiawa and Te Arawa descent. He is one of five siblings and one of 45 grandchildren. He is a young man with a very active mind and he thrives in an outdoor environment. A young man who was well schooled, but not necessarily a strong academic, however, should be focus, would go far in terms of achieving whatever he put his mind to. He comes from a very loving immediate Whānau, as I would say, “had everything they could possibly want growing up”. Their parents ensured that they had a childhood that would teach*
and nurture them to live healthy adult lives. Their upbringing was not one like a “once were warriors” environment but one that was filled with Whānau and loving parents. They were well clothed, fed and well disciplined, and given parental nurturing in knowing how to live off the land. DR is one of the mokopuna who is very skilled in outdoor activities: particularly in diving and hunting. As a Whānau, it is unfortunate that we have to live through this period of DR’s life (a man with his own mind). Although he had great advice, he made his own decisions and so we are where we are at now, a time where we need to undertake such activities to help him remain in our care and not in prison.

Although DR knows it will be much easier to go to jail than remain on this Whānau plan, we have also considered how we will manage this process as a Whānau, keeping everyone well in support of DR at this point of his life. Our hope is that this material will plant some opportunity for DR to remain in our care. We are putting our hands up as a Whānau and are prepared to take responsibility, rather than jail being the only option.

Case study three clearly indicated how the Pounamu model was implemented as a tool for making an assessment, formulating the key issues and identifying a treatment plan in moving forward with the issues. Case study four has taken further steps in its application with the Pounamu model and has made links to a range of Māori models of practice, in highlighting what are the areas for priority treatment, the roles and responsibilities for intervention from a Whānau ora perspective and, more importantly, provides an outcome measures plan in measuring the effectiveness of the assessment, interventions and progress. Case study five demonstrates how the Pounamu model has been applied in response to a crises intervention measure (home detention verses jail) that provided the Whānau a platform for taking responsibility for their own Whānau member.

Manaakitanga

In case study three, the relationship with this Whānau is through personal relationships with a wider Whānau member, also through having an opportunity to work with an elder sibling of this personal friend and then being involved with their developments of Whānau ora, alongside their journey with the support of their mothers mental illness. In turn, I have a responsibility to support this Whānau, and give as much support as
possible through sharing what I know and helping whenever required. This is evidenced in the following case study notes;

2. The Pounamu Model entered the consciousness of the Whānau when Cat attended a job interview in 2002 as Whānau support for one of her sons, for a job in the Forensic unit at the Porirua campus of Capital and Coast DHB.

   a. An interview panel asked questions of the son, and Whānau in attendance could participate. At that stage, Cat spoke about her thirty year experience in mental health and her clinical diagnosis, as well as doubts that she was diagnosed correctly and that her medication was redundant. At that point Peta Ruha (part of the interview panel) drew a white board diagram of the Pounamu model and explained how it worked, to give better understanding to Cat dilemma. The importance of the model was understood by Whānau present, as in a simple clear concise way, light was shed on the clinical pathway that Cat had journeyed through, with the understanding that there were cultural deficiencies in the clinical pathway. There was no interconnection between the two pathways (clinical and cultural) in Cat life experience.

In case study four, the assessor was initially a neighbour who, years later, completed an initial cultural assessment with this Whānau. A copy of the initial assessment was completed and given to the Whānau from the onset. The Whānau options for support from this initial assessment were then discussed as a Whānau in regards to access to a cultural pathway that could be provided from the Whānau ora provider (Te Ahukura). The Pounamu model was deployed as the framework to complete the Māori Assessment and is outlined below.

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<th>Māori Assessment:</th>
<th>Pounamu model</th>
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**Presentation:** Flakey – up and down with no balance. Can’t sit still, laid back with family, kids chill Kuia out. Cannot cope with how she is feeling and being overwhelmed by it all.
Coping Strategies: Argues with partner.

Whānau Dynamics: Detaches from kids, short and blunt with korero, has assaultive behaviours and moods.

Relationships: Friends – smothers at start when first forming friendships then relationship breaks down through lack of understanding of boundaries (note self-report of this insight). Partnership is psychologically volatile, seemingly due to perceived age difference between Koro and Kuia that includes generational differences in upbringing and personality.

Underlying Issues: Self-reported an historical trauma event but at this stage was not asked to describe event.

Strengths: Enjoys singing, with last opportunity for singing about a month prior to contact triage, during attendance at church. Kuia enjoys writing poems and philosophy.

Application: From a Māori world view, it would appear there are elements of mate Māori present within Kuia and her Whānau. There has been disclosure and observation of information that points to a cultural distortion. Normal day to day transfer of social learning within the Whānau grouping has not been handed down intact from one generation to the next. Values and beliefs from Te Ao Māori that kept our society strong have been affected at some stage of the generational transfer. Whānau normally pass on its value and beliefs through love and affection. When this process is disrupted it can introduce values and beliefs that are not only foreign but also counterproductive to a balanced Whānau in its social setting and context.

Formulation:

- Encourage Whānau framework for Whānau support, healing and development (capacity building)
- Refer mate Māori issues to Whānau (cultural issues)
- Liaise with agencies for appropriate psychological counseling to deal with the emotional trauma event in the underlying issue
- Liaise with agencies included in support plan

In case study five, a presentation was noted that came about as a result of a Whānau member being on a path of destruction, fuelled by methamphetamine use and abuse.
This was a cycle which had been in motion for at least the past five years, and which had greatly impacted and affected many people; a cycle that could have only been stopped by detainment, despite the many Whānau attempts to change the course of this scenario.

Pounamu Assessment was used as the tool to complete a comprehensive report on DR and his wider Whānau. The assessment collated and captured the Whānau story of events. This aided in a number of ways; the framework was used to formulate the comprehensive Whānau ora assessment for the judge to be considered as part of DR sentencing.

Feedback and commentary with the judge in response to document; Aunty what a great report, however I have a number of questions to ask; this young man is out of control, how come it has taken this to happen for the Whānau to come forward? You’re Honour; “our nephew has not been able to hear the Whānau, it has taken for this to happen, for him to bear us, we are putting our hands up to take responsibility for our Whānau member. Judge; How are you going to manage him? You’re Honour; I have recently returned home so am better resourced to call on the appropriate resources to support us as a Whānau in taking responsibility for our nephew.

The interviews on Kaupapa Māori theory and praxis (in a Kaupapa Māori NGO environment) and case studies of the Pounamu model and its application in practice across the continuum of intervention, from an early intervention phase to a more acute and crises approach, highlight the flexibility of the Pounamu model. Furthermore, the evidence shows that the Pounamu model can be applied in both the clinical environment and the community to provide a foundation for the Whānau to take responsibility in moving forward.
Chapter Seven
Discussion

7.1 Analysis
The aim of this research was to provide evidence that Kaupapa Māori theory and praxis is evidence based practice that originates from generations of debate, tradition and lived realities over time, and show that it can stand alongside imported counterparts as an ideal Māori mental health model. This research has demonstrated that Kaupapa Māori provides the framework that allows us to work in a meaningful way with our own people, in understanding one’s own positioning and story. The Pounamu model provides a framework that creates a safe space for storytelling that not only sits with the clinician but a parallel process that also sits with the tangata whaiora and Whānau. As Māori clinicians, we are a reflection of these traditions of evidence and the counterparts that stand in today’s contemporary world. There is little to no literature on evidence based approaches and their effectiveness for Māori, but the literature that exists clearly highlights the move towards the importing of these practices into New Zealand, and the role Kaupapa Māori theory and praxis plays in addressing the poor health statistics for Māori.

Thyer (2004) states that “evidence based practice is not a static knowledge”; it is constantly evolving information that provides a formulation and critical appraisal of evidence, with the clinical expertise and client’s perspective taken into account. Kaupapa Māori theory and praxis is not a static knowledge, it is constantly evolving. The Pounamu model provides a formulation and critical appraisal of evidence through the integration of cultural and clinical practice. Kaupapa Māori evidence based practice provides a framework by which we can have meaningful engagement, using knowings, understandings, models and frameworks as a means of healing. In practice, the Pounamu provides a window of opportunity to see how such understanding can be integrated as a means of evidence based practice that makes a difference and fosters
hope, recovery, and resilience using Kaupapa Māori knowledge. To do this, you need to step outside the boxed thinking that the system nurtures.

Kaupapa Māori theory and praxis as a Māori centred model of evidence based practice has been researched over generations of time, which is evidenced in Māori models of practice such as the Pounamu model. The Pounamu model can be applied in any clinical or Whānau environment that allows for an integration of clinical and cultural knowings. It keeps tinorangatiratanga intact when navigating through a clinical/mental health environment, but captures the essence of holistic needs. The case studies provide evidence of key themes of Kaupapa Māori theory and praxis through the application of the Pounamu model to demonstrate that indigenous knowing counts.

The research hypothesis that Kaupapa Māori theory and praxis is evidence based practice summons a number of questions such as; what is Kaupapa Māori theory and praxis? These have been answered throughout the course of the thesis to provide an understanding of the definitions of what is Kaupapa Māori theory and praxis and what constitutes evidence based practice. This enquiry provides a framework to understand how Kaupapa Māori and theory is defined from an indigenous scientific perspective. The understanding of definitions that form evidence based practice from a western perspective allows the research to highlight the marginalization of indigenous knowing that continues to disturb the lenses we wear as kaimahi.

The third question asks: What are Kaupapa Māori models? This question provides the context for this thesis, where I maintain that Kaupapa Māori models are formed from a foundation of knowing based on an integration of knowledge from the older Māori generations and from more contemporary times. The Pounamu model is one of many perspectives of the strategies of evidence based practice we utilize in improving service delivery to Māori who interface with Māori mental health.
7.2 Where to from here.

Tuputuputuwhenua
Ki runga I te moana, ki raro I te moana,
Ki runga I te whenua, ki raro I te whenua,
Ko au te whenua, ko te whenua ko au
Ko au te awa, ko te awa ko au
Ko au te maunga, ko te maunga ko au

(B. Kereopa, personal communication, 2011)

The proverb refers to the depth within the realms of the ever-changing world in which we live. The many layers and complexities on the sea and under the sea, on the land and under the land. It refers to man and land, man and the free flowing river waters and the mountains being one. There is depth within the depths of understanding. We understand these knowings through our traditions of practice. Kaupapa Māori provides a foundation of knowing that helps us to navigate through the complexities of the contemporary times and keeps safe the traditions of knowing that survive within each of us.

The aim of this research was to prove that Kaupapa Māori theory and praxis is evidence based practice that originates from generations of debate, tradition and lived realities over time. The House of Integrated Practice is built on foundations of practice that originate from generations of time, that capture the lived realities we experience today in a manner that allows Māori to navigate a path for recovery. The House sums up the idea of Kaupapa Māori as evidence based practice and moves the Pounamu model to the next level. It has been tested as reflected in the case studies and is now ready to be considered as part of the overall practice and application in Māori mental health.

Māori models of practice provide a pathway for navigating through the complexities of issues we may present and face when needing to engage with the secondary sector or district health board services. The implementation of Māori models contributes to opening the door and allowing for a foot in the door with regard to building a therapeutic relationship. Māori models are a compilation of knowings that derive from
Kaupapa Māori theory and praxis that is a knowledge that has been scientifically tested and debated over generations of time in response to evidence based practices. One Kaupapa Māori model that is an example of evidence based practice built from a Māori way of knowing is the Pounamu model. The Pounamu model is a lens by which we can detect colonization and a tool for managing the risk of western society. It allows us to tell our contemporary experiences, capturing it so we can make sense of the complexities of colonization and then move forward in bringing re-dress to the shady lenses we experience in Māori mental health. The Whānau ora case study for DR demonstrates how the Pounamu model is used as a tool for identifying what the issues are that DR is presenting with, where they stem from and their impact on the Whānau. The Whānau ora plan is the name given to the practice that has stemmed from generations of tradition. This practice has allowed DR and his Whānau a platform to take responsibility for the issues at hand while, in turn, bringing about wellbeing for the Whānau. The Pounamu highlights the issues, provides a formulation of the concerns so the Whānau are better placed to identify the best strategy for movement forward and healing. It is a tool for practice that allows Māori to work in a meaningful way with our own people, calling on practices that have survived generations of time and adapted to the changing environment. It allows indigenous people to keep those sacred knowings safe without being marginalized in the western environment.

Group one utilized the Pounamu as a framework for developing the team’s clinical and cultural integration of practices as a tool for developing the team. Group two highlighted the Māori models of practice that they worked with in particular self-determination and how that is then used as a tool for recovery and instilling hope. The Pounamu model is a framework that allows a space where the clinician can feedback the information that has been collated in a meaningful way in assisting in the recovery process, allowing one to then determine what that recovery will look like for them. Case study three clearly highlights how the Pounamu model was used as an assessment tool by the Whānau in assisting them to navigate their way through the complexities of the issues and maintain their tinorangatiratanga. Case study four provides further evidence of how the Pounamu model is applied in working with Whānau and demonstrates how Whānau then facilitate their own path for recovery. Case study five demonstrates how the Pounamu model is then used across the continuum of intervention in response to a
crises situation, and in managing acutely high risks behaviours, while allowing Whānau to determine their own path for recovery and maintain accountabilities to both the Whānau and mainstream systems.

Through the reflection of 20 years practice across the mental health sector, Kaupapa Māori provides a space to challenge the current boundaries of evidence based practice and provides leverage for more lateral thinking in defining evidence based practice for indigenous peoples throughout the world.

Critical theory provided a lens by which the definitions of evidence based practice could be challenged. The Pounamu model is a tool that creates a space for Māori clinicians to work with Māori in a meaningful way and keeps the bureaucracy of the system at bay, ensuring the process of engagement is safe for both the Whānau they are working with and for themselves in response to the many lines of personal and professional accountability.

The case studies clearly reflect the evidence of how practices of tradition that have been debated over generations of time continue to prove that Kaupapa Māori theory and praxis is evidence based practice, in that it is a better way in working with Māori in mental health. The case studies recorded in this thesis provide evidence that demonstrates how approaches unique to Māori are a better way in working with Māori clients.

In concluding this thesis, the position that is being taken throughout these writings is that Kaupapa Māori models, such as the Pounamu model, are formed from a foundation of knowing based on an integration of knowledge from the older Māori generations and from more contemporary times. The writings provide an understanding of evidence based practice definitions, and pose the challenge that Kaupapa Māori theory and praxis is evidence based practice. Through the definitions of evidence based practice from a western perspective, we continue to see how Māori knowing is marginalised. The application of the Pounamu model in practice provides an understanding of how Māori practitioners integrate both clinical and cultural deliverables in their practice when working in a Kaupapa Māori environment. Finally, through the privilege of having a foot in the door with two Māori Whānau and Kaupapa Māori providers, we are given the window of opportunity to understand how Māori knowing contributes to the wellbeing of all peoples. The House of Integrated Approaches is a model that provides a
critical lens by which we can understand Kaupapa Māori theory and praxis as evidence based practice.

Inoi Whakamutunga

Kia tau ngā manaakitanga o te wāhi ngaro ki runga ki tēna, ki tēna ō tātou
Kia māhia te hua mā kihikihi kia Toi te kupu Toi te mana Toi ngā tikanga Māori
Kia tūturu ō whiti whakamaua kia tina hui e taiki e.
Appendix One

Glossary of Terms

Assessment
Ahuatanga Māori (Māori elements)
Aroha (love)
Awhi (helpfulness)
Awa (river)

Ballet of concepts (using concepts all the time)

Cultural identity
CAFS (Child Adolescent and Family Services)

Evaluation
Evidence Based Practice

Hikoi (walk)
Homelessness; the borders of cultural difference and different
Hoha (annoyed)
Intervention

Kaitiakitanga (guardians, care for natural order)
Kaupapa Māori Theory and Praxis
Kaumatua (grandparents)
Kapahaka (Māori dance)
Kotahitanga(unity, sense of group belonging)
Korero (talk / discussion)
Korowai (cloak)
Māori Model of Practice
Mahi (work)
Manaakitanga (hospitality)
Manaakitanga (kindness, generosity, hospitality, care, support)
Mamae (Hurt)
Mau Rākau (Māori weaponry)
Moemoea, the dreams

Nga Rorirori (presenting issues)
Nga Roritanga (coping strategies)
Nga Rorirori o Te Whānau (family dynamics)
Nga Rorirori o Te Moe Tahi (relationships issues)
Nga Rorihohonu (underlying issues)

Pedagogy
Post colonialism
Pukengatanga (repository of higher learning)
Putiputi (flower)
Pumanawa (skills)

Rangatiratanga (chiefly dignity)
Raruraru (problems).

Tangata whaiora (person seeking better wellbeing)
Te Reo Māori (Māori language)
Tiaki (guidance)
Taura Moko (a grandchild brought up by their native speaking grandparents)

Ukaipotanga (nurturing mother and nurturing earth)

Wananga (cultural vehicle in the transmission and reproduction of Ahuatanga Māori)
Waka (canoe)
Wairua (spiritual)
Wairuatanga (spirituality locating man within and not above the natural order)
Whakatauki (words of wisdom)
Whānaungatanga (kinship, relationships)
Whakapapa (geneology of knowledge, Māori epistemology)
Whānau (family)
Whānaunga (relatives)
Whatumanawa (our deep-seated hurts)
Whakamana (strengthen)
Appendix Two

Ethical values framework

Research associated with collecting data brings with it certain responsibilities and raises questions about how people should be treated and, in particular, those whom are most affected will have a vested interest (Oliver, 2003). The following framework, developed by the Australian Institute of Aboriginal and Torres Strait Islander Studies, has been considered in undertaking this research as it provides guidelines for conduct of research for indigenous communities (AIATASIS, 2000).

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<tr>
<th>Research Ethics Approach</th>
<th>Kaupapa Māori Ethics of Practice</th>
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<tr>
<td>Consultation</td>
<td>A process that is ongoing</td>
</tr>
<tr>
<td>Negotiation</td>
<td>All participants involved which is ongoing</td>
</tr>
<tr>
<td>Mutual understanding</td>
<td>Everyone has the same information and understandings</td>
</tr>
<tr>
<td>Good faith, free and informed consent</td>
<td>Providing all the information using meaningful processes</td>
</tr>
<tr>
<td>Respect</td>
<td>Working with Whānau, hapu and iwi</td>
</tr>
<tr>
<td>Recognition of diversity and uniqueness</td>
<td>Māori models of practice, integration of eclectic ways of knowing</td>
</tr>
<tr>
<td>Rights of the indigenous must be preserved</td>
<td>Māori determining what is right for them</td>
</tr>
<tr>
<td>All parties should be involved as collaborators</td>
<td>The integration of cultural and clinical knowledge</td>
</tr>
<tr>
<td>Benefits / outcomes / agreements</td>
<td>The right fit at the right time</td>
</tr>
<tr>
<td>The use of and access to results should be agreed</td>
<td>Providing the information at all times</td>
</tr>
<tr>
<td>Research benefit to indigenous communities</td>
<td>The best outcomes for the Whānau, hapu and iwi</td>
</tr>
</tbody>
</table>
Appendix Three

Kaupapa Māori Theory and Praxis Definitions

Kaupapa Māori theory and praxis evidence based practice models are understood through 10 values of ahuatanga Māori (Hohepa et al., 2005). We understand these ways of knowing through practices of;

**Manaakitanga** (kindness, generosity, hospitality, care, support). Durie (2003) highlights we all have a critical role we play, the capacity to care, share, guardianship, to empower and to plan forward. An issue that comes to light when one operates from indigenous knowing in a western environment is the fact that we carry these ways in all that we do and, yet, there is no reciprocity from our partners. If so, is often driven by a commitment they are obligated to as part of their workplace values or Māori strategy. The act of kindness and care is a practice that originates from our common descent.

**Rangatiratanga** (chiefly dignity and behaviour marked by nobleness oblige). The 1835 Declaration of Independence recognizes indigenous rights and sovereignty. How is it that we reflect these practices when those imported approaches do not recognize the place of indigenous knowing as evidence based practice.

**Whānaungatanga** (kinship, relationships) A group who descend from a common descent. In more contemporary times, Whānau, as described by Durie (2003), includes those whom we may associate with through our workplace, therefore through association they become Whānau a kaupapa. Durie (2003) refers to such incidences as Whānau facilitating the pathway into the community as a contribution to building Whānau capacity. The skill in building relationships is facilitated through the traditions of practice of mihi (disclosing who we are and where we originate from).

**Kotahitanga** (unity, sense of group belonging). All Māori Whānau are connected to a whakapapa (Durie, 2003). One’s identity provides access to a oneness that we share as indigenous peoples or the tangata whenua of this land. It is through this
unity we find freedom from the hegemonies of our society. The united acts that we as Māori have in common descend from our forefathers.

**Wairuatanga** (spirituality locating man within and not above the natural order). Kaumatua (older Māori) provide a look into the realms beyond the physical; a generation of Māori who hold significant knowing’s about traditions of practice; a generation who are few. A time that is fast approaching, where the younger generation are in positions of having to pick up those responsibilities, and in doing so, they may not necessarily be well prepared in carrying those responsibilities (Durie, 2003). Kaumatua are the holders of evidence based knowing, practice and medicine. Kaumatua provide access, support and nurturing to the spirit world.

**Ukaipotanga** (nurturing mother and nurturing earth). The relationship to land, being one in the same, the people of the land. The Whānau are linked to the land (Durie, 2003). How is that we nurture the land when we are not in a position to nurture ourselves? Māori models of practice stem from strategies that our ancestors used to fight for our place, our survival and knowing’s.

**Pukengatanga** (repository of higher learning). The multiple layers, a principle of integrated action (Durie, 2003). Many facets contribute to the ill health of Māori and so all sectors are required to work collaboratively. It is through the integration of all sectors that the layers of intervention that are required can truly benefit Māori. It is through the integration of practice, education, sectors of provision that outcomes for Māori will be improved. Māori ways of knowing provide the pathway for integration.

**Kaitiakitanga** (guardians, care for natural order). We are the guardians of the traditions of practice of our ancestors. The face of our forefathers, who contribute to the wellbeing of the earth and all living things. Likened to that of our forefathers, we have a responsible to ensure that our tamariki and mokopuna enjoy the giving’s of our atua (Gods).\(^{42}\)

**Te Reo Māori** (Māori Language). The survival of Māori language, the survival of the many indigenous languages, a common story of how colonisation has attempted to inaialate a practice of communication. Through these lessons, indigenous peoples

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\(^{42}\) Nga Atua; Māori gods, the children of Ranginui and Papatuanuku; such as Tanemahuta, the god of the forests.
are reframing these injustices. Language is key; we see the jargon that frames and defines what is evidence based practice and how this language excludes indigenous knowing.

**Whakapapa** geneology of knowledge, Māori epistemology). Leadership in the integration of the indigenous knowing and the global knowing provides an opportunity to show what positive outcomes can benefit all, in particular indigenous peoples (Durie, 2003).

**Wananga** have become a cultural vehicle in their own right for the transmission and reproduction of ahuatanga Māori. The wananga provides an environment where celebration of indigenous knowing takes place, it is key to spiritual wellbeing and cultural identity.
Appendix Four

Interview Questions for the research project titled
“Kaupapa Māori Theory and Praxis as Evidence Based Practice”.

Semi-structured Questions
1. What makes your Kaupapa; Kaupapa Māori?
2. How do you define evidence based practice from a Kaupapa Māori perspective?

Structured Questions:
1. What Kaupapa Māori models do you work with?
2. Why is Kaupapa Māori important?
3. How is indigenous knowing applicable in contemporary times?
4. What role does Kaupapa Māori theory and praxis play in your Kaupapa?
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