KAUPAPA MĀORI MODELS OF PSYCHOLOGICAL THERAPY & MENTAL HEALTH SERVICES.

A LITERATURE REVIEW

TE WHĀNAU O WAIPAREIRA
KOKIRITIA I ROTO I TE KOTAHITANGA
Progressively Act in Unity

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Kaupapa Māori Models of Psychological Therapy & Mental Health Services. A Literature Review.
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ABSTRACT

This literature review intends to examine current kaupapa Māori models of psychological therapy for the purpose of informing the potential development of a new Māori mental health service by Te Whānau o Waipareira Trust (Waipareira Trust). Published literature was sourced, read and summarised in order to ascertain consistent findings and gaps in the current research using online databases and the Philson Library.

The results of the review show that there is a large body of knowledge regarding Māori and Western perspectives of wellbeing, how they differ and how this affects the clinical care of Māori patients with mental illness. It is clear that current models of therapy are not well suited to indigenous populations and Māori patients are better treated using processes that stem from an understanding of the Māori worldview.

Practical applications of these therapies are covered less vigorously in current literature. The existence of services that attempt to utilise kaupapa Māori models of care is known, however there is limited evidence regarding the exact principles behind these services and their efficacy. Gaps in the research have been identified – these include limited references to urban Māori and little to no randomised clinical trials that assess the effectiveness of Māori models of therapy.

The overall evidence presented here proves that provision of mental health care to Māori populations is necessary and there are a number of theories regarding how best to do this - through modified conventional treatment, through traditional Māori healers, using CBT (Cognitive Behavioural Therapy), in hospitals, in the community, using rongoā, using conventional medication, in specialist mental health services or in holistic services. All possibilities are covered by the literature and conclusions have been drawn regarding the effectiveness of each and their applicability to the Waipareira Trust's proposal.

INTRODUCTION

The high incidence of poor mental health outcomes among Māori living in New Zealand and low rates of service utilisation, potentially due to a lack of culturally appropriate programmes, has prompted interest in the potential development of a kaupapa Māori therapy service within Te Whānau o Waipareira.

The unmet needs of Māori with poor mental health are well documented in literature. Statistics indicate that Māori experience the highest prevalence of serious mental disorders among all ethnic groups in New Zealand (Baxter, Kokaua, Wells, McGee & Oakley Browne, 2006a). According to the Ministry of Health (2014), Māori carry a disproportionately large burden of psychological distress, mood disorders, anxiety disorders, bipolar disorder and depression. Disturbingly, the prevalence of mental illness among Māori has been increasing since the end of the Second World War, resulting in psychological issues being identified as the "single most insidious threat to the health status of Māori in the 21st century" (Hirini, 1997). Durie (2001) suggests that the establishment of new public health measures and interventions specifically targeting Māori mental health is necessary to improve the current outlook.

Additionally, research suggests that Māori make fewer visits to mental health services despite their higher needs (Baxter et al., 2006a). Low utilisation rates have been proposed to stem from a combination of two things: reduced access to services and a lack of services that are appropriate for and effective in treating Māori patients. This indicates the possibility that mental health services currently fail to provide treatment that is relevant to or effective for Māori (Baxter, Kingi, Tapsell, & Durie, 2006b), something that will be explored further in this review.

The establishment of a therapy service that aims to use Māori models of psychological therapy to treat patients with mental disorders has been suggested by Te Whānau o Waipareira as a means of improving health outcomes in this area. Prior to the execution of such a project, or indeed even its planning, an assessment of the effectiveness of kaupapa Māori frameworks in psychological therapy must be undertaken. Reviewing the relevant literature appears to be a natural starting point. Therefore the aim of this literature review is to investigate current Māori models of therapy and their efficacy and also to provide recommendations to the Waipareira Trust in regards to developing their own mental health service.

METHODOLOGY

This review has been organised thematically, in order from general themes to more specific considerations. The literature covered includes relevant information on Māori models of health and therapy and examples of services that utilise such models. Due to the limited amount of prior research completed on Māori mental health services, literature published over a number of years has been reviewed.

While there are a number of kaupapa Māori initiatives in many different areas of health, this review will focus on frameworks and services that are applicable to mental health. The searches made were directed towards literature that is specific to Māori in order to limit search terms and highlight only relevant information, but where valuable material was found that related to other indigenous cultures it was included in its own section.

When reviewing existing literature, attempts were made to exclude from this report the bulk of statistics related to the incidence and prevalence of mental disorders and dysfunction in Māori. Aside from indicating that the burden of such issues is both high and increasing (Durie, 1994; Baxter et al., 2006a) and including other data where it is relevant, I will not be reviewing epidemiological data as its own theme in the discussion.

A consistent theme in current literature is the importance of recognising alternative models of health in improving service delivery for indigenous populations. The integration of Māori health models such as Te Whare Tapa Whā (Durie, 1994) into health services has occurred with increasing energy since the 1980s, based on the understanding that the inclusion of Māori cultural concepts will advance the quality of clinical care and therefore outcomes (Ihimaera, 2004). Many models have been developed and a number are accepted as useful within the literature. These models include Te Whare Tapa Whā (Durie, 1994), Raranga, Te Whare Pora (Fletcher, Green, MacDonald & Hoskyns, 2014), Te Wheke (Pere, 1991), Pōwhiri Poutama, Te Ao Tūtahi, Ngā Pou Mana and Ko te Tuakiri o te Tangata (see Ihimaera, 2004 for a discussion). While such frameworks are supported by many authors, others argue that there is no significant difference between Māori and Pākehā in the way that they perceive health and wellbeing and thus the impact of such models on health literacy is minimal (Marie, Forsyth & Miles, 2004; Sanders, Kydd, Morunga & Broadbent, 2011). Some questions remain about the usefulness of Māori models in reducing ethnic disparities in health and there is a potential for further research in this area.

DISCUSSION
BACKGROUND INFORMATION

Most of the literature reviewed begins with information on the current state of mental health among Māori. Before the literature surrounding therapeutic techniques and current mental health initiatives can be adequately reviewed, it is important to understand the past trends in the provision of care to Māori with mental health issues and what these trends indicate about current and future health services. There is agreement among the literature regarding the rationale behind the development of kaupapa Māori frameworks and clinics; – the epidemiology of Māori mental health as covered in this section would be reason alone to justify a kaupapa Māori service.

"Te Rau Hinengaro: The New Zealand Mental Health Survey" (Oakley Browne, Wells & Scott, 2006) was the most frequently referenced data source used by works published in the last 10 years and thus it can be inferenced that authors found this to be the most relevant epidemiological reference.

The published results of the survey contained a full chapter on Māori mental health statistics, written by Baxter et al. (2006b). Prior to Te Rau Hinengaro, health data lacked information regarding Māori in a community setting, as most research was conducted on hospitalised patients. This survey reflect lifetime, 12-month and 1-month prevalence of mental disorders including anxiety, mood and substance abuse disorders, as well as service utilisation and satisfaction of care. The most relevant data is listed below:

- 50.7% of Māori experience a mental disorder over their lifetime
- The most common disorder experienced by Māori were anxiety disorders, followed by substance abuse disorders and mood disorders
- Among Māori who experienced mental disorders, 32.5% had contact with health service providers. Most contacted general health services (20.4%) while others had contact with specialist mental health services (14.6%)
- Health care contact increased with severity of the disorder
- More Māori suffered from 12-month prevalence of all types of mental disorder when compared with Pacific and non-Māori, non-Pacific individuals
- 6.3% of Māori reported taking days off work due to mental health issues in the past 30 days
- 52.1% of Māori with a serious disorder and 74.6% of Māori with a moderate disorder did not make any contact with health services in the past 12 months.

It is possible to conclude from these findings that poor mental health is indeed, as Durie suggested in 1994, an enormous threat to wellbeing for Māori. In comparison to non-Māori individuals, Māori suffer higher prevalence rates, more involuntary admissions, more referrals to health facilities from law or welfare agencies, higher rates of readmission and even so are less likely to make contact with the health system despite the severity and prevalence of mental illness (Eade, 2014). The implications of this for Waipareira Trust is that there is certainly a need for better service provision; whether that involves increased access to care, increased quality of care, or more culturally appropriate care is discussed later.

A key issue outlined by many authors is that of late stage service contact among Māori (Eade, 2014; Ministry of Health [MoH], 2006; Baxter et al., 2006b). Māori tend to utilise services when their illness has become acute and the literature suggests that this is a result of poor provision of appropriate primary care (Eade, 2014; MoH, 2006). Additionally, Māori who are admitted as inpatients are most likely to be referred up from the law or justice systems. Another issue with late service contact is that mental illness that has progressed to an acute stage is harder to treat and is more likely to result in readmission (Eade, 2014). This emphasises the importance of early detection and increasing service contact at the appropriate time (i.e. before symptoms become severe). To facilitate this within future health services it could be suggested that primary care interventions are most important and that these interventions should emphasise early detection of psychiatric illness.

Another focus of the literature analysed for this review was the exploration of the reasons as to why Māori health is so poor. Ihimaera (2004) suggests two possible reasons: one being that there is an insufficient quantity of culturally appropriate services and the other being the incapacity of mainstream services to provide adequate care for Māori. Ryan (1998) concurs, noting that a lack of recognition of mate Māori (cultural illness) may be a barrier to earlier intervention and cure. Thus, adopting a more culturally competent method of care is seen by most authors to be central to improving health outcomes. In order to improve cultural competence, some reconfiguration of services may be necessary. Ihimaera (2004) describes four characteristics that may be of interest to Māori mental health services: a cultural context that fits with service users (tangata whaiora) and their whānau, optimal clinical care, outcome measures that are patient-focused and are understood easily by tangata whaiora and the intertwining of good mental health practice with other areas of Māori cultural development. Ihimaera also emphasises the importance of using tikanga models of clinical practice to develop kaupapa Māori mental health services. These models are discussed in the next section.

DISCUSSION
MODELS OF HEALTH

Māori models of health are mechanisms through which an understanding of wellbeing can be obtained, with particular reference to the Māori cultural perspective. Durie (1994) suggests that the differing world-views of Māori and Pākehā result in distinct areas of health knowledge between the two groups. Thus, Māori models can be used as a foundation from which service delivery can be improved on or altered in order to better reflect a certain cultural identity.

Though it is not frequently talked about, mainstream medicine in New Zealand also stems from a number of models of health - the biomedical model being just one example - and thus emulates the Western cultural identity (Fletcher et al., 2014). Western models of health are well covered in literature (Carvalho, Dantas, Rauma, Luzi, Geier, Caussidier & Clement, 2007; Engel, 1977; Sheridan & Radmacher, 1992) but are not frequently compared with kaupapa Māori models in terms of efficacy or application. McNeill (2009) argues that the most considerable difference between most Western models and most indigenous models is the inclusion of a spiritual component, which becomes particularly important in the field of mental health. This is well reflected in the literature reviewed for this report. Many of the Māori models described included some element of spiritual wellness as part of good health, while it is absent from Western frameworks such as the WHO health promotion model (McNeill, 2009).

There are a considerable number of models proposed by the literature. The most frequently mentioned was Durie's (1994) model "Te Whare Tapa Whā". This model compares wellness to the four walls of a house, the significance here being that all four components are necessary for total functioning. These components are taha tinana (physical health), taha wairua (spiritual health), taha hinengaro (thoughts and feelings/mental health) and taha whānau (family health). A second model that was regularly referenced was Pere's (1991) model Te Wheke, which uses an analogy of an octopus to represent total wellness. In Pere's model, the body and head represent the individual or whānau, with each of the eight tentacles representing Māori concepts that are required for wellbeing and the suckers on the tentacles representing the many unique facets to each dimension (Ihimaera, 2004). The eight main principles of Te Wheke are wairuatanga (spirituality), mauri, mana ake (individualism/uniqueness), tinana (the physical self), whānaungatanga (working together), whatumanawa (emotional development), hinengaro (the mind) and hā a koro ma a kui ma (heritage). Themes expressed by both Te Wheke and Te Whare Tapa Whā (as well as other less common models of Māori health such as Ngā Pou Mana) include the concept of holistic wellbeing and an understanding of the impact of spirituality and collective identity on health. The value placed on these concepts by Māori is proposed to be larger than the value given to them by Pākehā (Durie, 1994; Ihimaera, 2004), leading to a dissonance between Māori expectations of illness treatment and actual clinical practice - something that may be impacting on health outcomes.

The implication of Durie's and Pere's models is that the whole person is emphasised in clinical practice over treating individual maladies (Ihimaera, 2004). Durie argues that the mental, emotional, physical and spiritual aspects of a person and their whānau are inseparable and thus clinicians must consider all in their assessment and treatment of patients. Te Whare Tapa Whā is praised for being straightforward to apply and having the potential for universal benefit in that it could be applied to mainstream services that treat patients from any ethnicity (Fletcher et al., 2014; Ihimaera, 2004). On the other hand, it is criticised for lacking Māori epistemology and being too generic (McNeill 2009). A common complaint regarding these models is the assumption that the mental health perceptions of a Māori patient are fundamentally different from that of a non-Māori patient. Marie et al. (2004) argue that no such difference occurs and that non-Māori and Māori share many similar beliefs about health and ill health.

Marie et al. (2004) conducted a study investigating whether there are any fundamental differences in illness perception between Māori and Pākehā, with a special interest in health literacy regarding depression. The findings suggested that the well-documented and widely held assumption that Māori endorse supernatural frameworks (e.g. infringement of tapu) in explaining mental illness and the use of tohunga (spiritual healers) in treatment may not be accurate. The study found a very high level of congruity between Māori and Pākehā subjects in terms of illness perception and treatment preferences: both groups rated professional treatments as most effective. These findings are at odds with some of the other literature, which suggest that Māori rate tohunga as highly effective (Bush & Niania, 2012; Durie, 2011a).

Sanders et al. (2011) also rebuffed the idea that Māori and Pākehā attitudes toward health were radically different. Their study found that Māori demonstrated positive opinions towards conventional treatment and medication. Interestingly for the Waipareira Trust, Sanders et al. suggested that a likely reason for these similarities was that Māori living in urban environments had adapted to living separately from traditional iwi culture and that modern Māori may not continue to hold the same beliefs regarding mental health as their forbearers. This suggests that adopting an entirely distinct kaupapa Māori framework in a developing new health service is a decision that needs to be carefully considered; a better option may be to combine the knowledge of both the biomedical model and Māori models, or to adjust the traditional models in order to better provide for modern, urban Māori.

McNeill (2009) concludes that Māori cultural perspectives on health are highly complex and the application of Māori concepts to models of health and wellbeing require innovation and understanding of the existence of Māori in today's modern environment. Additionally, McNeill suggests that resistance to the application of Māori models (as expressed by Sanders et al., 2011 and Marie et al., 2004 is common within mainstream institutions. A potential reason for this is the impact of Western education on health professionals and researchers.

DISCUSSION
THE WORKFORCE

Evident from the literature is the importance of the labour pool in driving positive outcomes in the field of mental health, especially Māori mental health. Durie (2001) credits a rapid increase in the numbers of Māori medical practitioners with revolutionising the health workforce in the 1980s and 1990s. Other authors highlighted the role of culturally competent clinicians in improving the effectiveness of services such as the one proposed by the Waipareira Trust (Johnstone & Read, 2000; Eade, 2014; Evans, 2010).

Evans (2010) finds that cultural competencies form a significant part of the role of being a good mental health practitioner in New Zealand and are vital to effective care, however Johnstone & Read (2000) reported that 88% of hospital and clinical psychologists believed that their training had not prepared them adequately to work well with Māori clients. This section reviews the findings of multiple authors in regards to the health workforce and their role in kaupapa Māori mental health services.

Cultural competence is defined by Eade (2014) as "knowledge and information from and about individuals and groups that is integrated and transformed into clinical standards, skills, service approaches, techniques and marketing programmes that match the cultural experiences and traditions of clients and that increase both the quality and appropriateness of health care services and health care outcomes". It is related to the quality of care provision for all consumers of health services but is more usually referred to in relation to the care of indigenous populations, where the impact of cultural competence on health outcomes is of great significance (Evans, 2010).

Evans (2010) finds that the quality of service provision for Māori, especially in public hospitals, is poorer than the quality of care received by patients of other ethnicities. This is reported to be due to a number of issues including a lack of Māori professionals in the workforce, a lack of understanding of cultural difference and the limited capacity of non-government organisations (NGOs) in providing care. While the rapid growth and development of Māori service providers is praised (Evans, 2010), it is also reported that this spectacular increase in the number and range of Māori health organisations has led to a shortage of qualified Māori staff as they are spread out amongst the great number of new roles. This will cause issues for any potential new services. Proposed solutions that are alluded to in the literature include both short- and long-term interventions. Attracting Māori rangatahi (young people) to higher education in mental health will undoubtedly improve the situation (Evans 2010; MoH, 2006). However, this will require considerable effort and won't have a significant effect for a number of years as education programmes in the field are lengthy and so is the interval between promotion of mental health careers and the acceptance of such career pathways by youth. A second strategy that may be of use in addressing workforce shortages is to gear the training of health professionals towards biculturalism and culturally competent practice; a journey that has already been begun by many educational and clinical institutions (Evans, 2010; Eade, 2014; Brady, 1992).

A related topic of debate that presents itself frequently in the literature is that of whether non-indigenous clinicians are effective in providing care to indigenous populations; Johnstone & Read (2000) propose that non-indigenous clinicians are capable, but necessary to good clinical practice is a strong understanding of cultural frameworks and quality education regarding Māori perspectives of healthcare. Unfortunately this is not always realised (MoH, 2006). Johnstone & Read (2000) reported an uneven response from the mental health community to bicultural education initiatives and disappointingly only 40% of the psychiatrists who responded to the survey believed that they were prepared to work effectively with Māori. Furthermore, several psychiatrists - respected and well-educated members of the mental health workforce - made racist comments in their responses. The MoH (2006) emphasised repeatedly the necessity of having skilled Māori as a part of the mental health workforce in order to improve outcomes, a point that was stressed at the expense of endorsing the ability of Pākehā clinicians to reduce inequities in mental health.

A compromise suggested by Johnstone & Read (2000) that may be useful to the Waipareira Trust is to include a high level of consultation between Māori staff and Kaumātua (Māori elders) and Pākehā clinicians. Most psychiatrists felt that hiring Pākehā staff in dedicated Māori mental health facilities was appropriate given the current shortage of skilled Māori workers, so long as interaction with Māori staff was facilitated and advice could be sought.

DISCUSSION
THERAPY MODALITIES

An important question that came up frequently in the literature was "What therapies work for Māori?". It is well established that conventional methods such as CBT are effective in mainstream populations, but much of the literature surrounding the efficacy of CBT and other therapies lack applicability to indigenous populations (Bennett, 2009). The results of Te Rau Hinengaro showed that Māori who contacted healthcare providers in regards to their mental health needs were usually satisfied or very satisfied with the treatment they received however, rates of satisfaction did vary between types of providers (Baxter et al., 2006b).

For example, 32.3% of those who visited a psychiatrist reported being very satisfied while 30.8% were satisfied and among those who visited a spiritual practitioner, 76.3% reported being very satisfied and 17.3% were satisfied. These statistics open up debate regarding which providers and which assessment methods are most effective and most acceptable to Māori and therefore what should be used in future Māori mental health services.

Generally, within the theme of therapy modalities, there was distinction made in the literature between traditional Māori healing approaches and mainstream therapies that had been adjusted to better suit Māori. Parry, Jones, Gray & Ingham (2014) describe an altered form of the Calgary-Cambridge model of medical interviewing that utilises both the Pōwhiri and Meihana models of interaction and discussed its use in practice by medical students. The Pōwhiri process and Meihana model are two kaupapa Māori interviewing tools used in the clinical environment and are worth utilising as part of the new service proposed by Te Whānau o Waipareira. The reflections given by students involved in the study indicated that the new tools were successful. Parry et al. (2014) reported that the effectiveness of the interview was significantly improved through the use of the Meihana and Hui models. The suggestion is made that, due to the inequities between Māori and non-Māori in mental health outcomes, these culturally appropriate models have an important place in the clinical process for both mainstream and kaupapa Māori services and in the medical education system. Parry et al. (2014) conclude that, in today's multicultural society, it is no longer appropriate to retain a standard clinical interviewing format without reviewing its applicability to individual practice.

Bennett (2009) offered practical recommendations on how to effectively assess Māori in primary care who suffer from psychiatric illness. The DSM-IV diagnostic criteria is not known to suit the Māori worldview and results in difficulties for clinicians when diagnosing and treating tangata whaiora. For this reason, Bennett (2009) identifies several steps to assessment that assists both the patient and clinician in making the correct conclusions and beginning an appropriate treatment. The first of these is to define the self-identified cultural identity of the patient, followed by determining the views of ill health that are held by the patient and their whānau. These are critical steps to enabling the clinician to successfully combine concepts held by the patient and concepts central to Western medical practice. Bennett (2009) also stresses the importance of safety and feeling secure; it is recommended that patients who present to the interview alone should be asked if they would like a whānau member or cultural advisor present during the assessment process. As Bennett (2009) writes from the perspective of Pākehā clinicians accustomed to the mainstream health system, an explanation of whakawhanaungatanga is given and clinicians are encouraged to "get to know" their patient and allow their patient to learn more about their psychiatrist than just their medical background. Additionally, clinical staff need to ensure that their use of language is suitable and is well understood by the patient. The patient needs to feel comfortable enough with the interview process and with their clinician to be able to ask for clarification wherever needed and this requires respectful and careful conduct on part of health professionals. Hirini (1997) adds to this school of thought by emphasising the flexibility required when counselling tangata whaiora. This flexibility includes physical aspects of the service, including timing and provision for whānau to attend the therapy session and in aspects of the therapeutic alliance itself, including modifying what may be considered standard practice to suit the patient. Caution should be taken not to make assumptions about every Māori patient; while a patient may identify as Māori, it is important not to stereotype every Māori as having certain backgrounds or world views and instead to treat each patient as an individual (Hirini, 1997).

Some of the literature references traditional Māori healing practices and the effectiveness of such interventions (Bush & Niania, 2012; Hollands, Sutton, Wright-St Clair & Hall, 2015; Durie, 2011a). Bush & Niania (2012) investigated the utilisation of a traditional Māori healer in treating a young man with symptoms of psychosis and pseudoseizures and found that while the man's voice hearing was reduced by antipsychotic medication, the session with a traditional Māori healer helped enable the patient to understand his own symptoms and their potential spiritual origin. The patient reported feeling confident and uplifted after his session and he remained well at the 12-month follow up. The conclusion made is that collaboration between traditional healers and conventional psychiatrists could be encouraged as it can improve the care and treatment of tangata whaiora (Bush & Niania, 2012), but more research regarding indigenous therapists is necessary before these should be implemented in mainstream medical practice. Durie (2010) described the use of rongoā in a wider context of Māori healing in treatment of psychological distress. There has been very limited literature published on the effectiveness of such interventions, which is related to the effectiveness of Western health outcome tools in assessing traditional healing practices. Durie (2010) suggests the use of the Hua Oranga health outcome tool in further research regarding the efficacy of therapies such as rongoā in treating distress, anxiety and depression. Until this research is carried out, it is not known whether rongoā are useful in a clinical context and the decision should be made by individual healers and patients as to whether they would like to incorporate these therapies alongside other treatments.

An alternative mode of treatment that is described by Hollands et al. (2015) is the use of kapa haka and waiata in treating mental health issues. This type of therapy is known as sensory modulation and is used in mainstream health services as well as in Māori services, although the use of kapa haka is generally limited to kaupapa Māori treatment methods. Hollands et al. (2015) found that tangata whaiora who utilised a culturally-responsive sensory modulation activity reported feelings of safety, groundedness and connectedness to the Māori culture. Kapa haka being an established practice in New Zealand makes it useful to therapists and clients as the base of sensory modulation activities and may help Māori learn more about self-awareness and self-regulation: cornerstones of current sensory modulation therapy.

DISCUSSION
CLINICAL EXAMPLES

As part of this review, searches were made for literature pertaining to any existing mental health services that utilised a kaupapa Māori approach to treatment. Several initiatives have been undertaken that utilise kaupapa Māori psychological therapies, including Tu Meke PHO's Wairua Tangata Programme (Abel, Marshall, Riki & Luscombe, 2012), CAMHS' specialist mental health team He Kākano (Elder, Milne, Witehira, Mendes, Heslin, Cribb-Su'a & Kalra, 2009; Pomare, 2015), a culturally relevant adaptation of a cCBT programme developed by Shepherd, Fleming, Lucassen, Stasiak, Lambie and Merry (2015) and a primary care ultra-brief intervention designed by Mathieson, Mihaere, Collings, Dowell and Stanley (2012).

The conclusions drawn from the development and assessment of these programmes will be of considerable interest to the Waipareira Trust and may assist in guiding the planning and execution of a similar programme.

The Wairua Tangata Programme (WTP) is a primary mental health initiative based in Hawke's Bay general practices that was established by Tu Meke First Choice PHO in 2008 and assessed in scientific paper written by Abel et al. (2012). The initiative was funded by the MoH and targeted Māori residing in an NZDep Quintile 5 area and aimed to provide an effective tikanga-based mental health service. Abel et al. (2012) reported that existing providers were struggling with Māori services and recruiting a Māori workforce, as well as the complexity of mental health issues among underserved and over-stressed populations. The programme was accessible by GP referral and included between four and six sessions of free counselling or psychotherapy, as well as contact with a social worker if necessary. The entire programme was based in a Māori framework and tikanga-based clinical care was integral to its operation. Tikanga-based care, for this particular initiative, included whānau inclusion, whakawhanaungatanga (forming relationships), whakapapa (inclusion of ancestral origins), waiata (song) and whakanoa (creating safety). This was delivered by a multi-disciplinary team comprised of a Māori lead practitioner, a social worker and multiple therapists or counsellors, most of whom were Pākehā but who were selected based on both cultural and clinical competence and who were culturally supervised by the lead practitioner. An external evaluation undertaken by the Eastern Institute of Technology between April 2008 and June 2009 found the following:

- The programme successfully reached its target population and was characterised by high attendance and improvement in Kessler-10 (mental health assessment tool) scores.
- Service users provided highly positive feedback, with particular recognition given to the support of the therapists and social worker, the flexibility of the programme, the involvement of whānau, the lack of cost and the availability of Māori staff.

Some strategies were identified by Abel et al. (2012) as potential sites for improvement of the service. Firstly, they found that many of the patients referred required more than the four to six session package that was offered and thus, funding became difficult. Additionally, referring through a GP pathway reduced entry for Māori who did not actively engage with general practice services; during the second year of operation, the WTP began offering direct access through self or whānau referral. The authors of the evaluation offered a final key message: that it is undoubtedly possible to provide an efficacious tikanga-Māori based mental health programme to underserved populations, so long as it is delivered with demonstrable flexibility and cultural competence and by skilled providers.

A second initiative that was described and assessed by the literature was the services delivered by He Kākano, a kaupapa Māori mental health team working within Child and Adolescent Mental Health services in South Auckland. He Kākano deliver mental health care to Māori between 0 and 19 years of age in a culturally sensitive and tikanga-based way (Elder et al., 2009). The team found a number of elements of treatment that influenced the likelihood of strong, positive engagement in the service; these included the acceptability of the treatment, existing beliefs about treatment, stresses, barriers to accessing care, the therapeutic relationship, feelings of security, practitioner background and the location of the service (Pomare, 2015). The team also found improved engagement when performing arts (e.g. kapa haka), waiata and pūoro (traditional Māori instruments) were incorporated into the treatment process. An issue with the services provided by He Kākano and a likely issue for any potential service developed by Waipareira was reduced commitment to the programme by whānau due to fear, worry or mistrust. Pomare (2015) found that many whānau were concerned about becoming involved in a mental health service due to feelings of whakama (shame/embarrassment), fears of being judged and concerns regarding conflicting values between the mainstream health system and other whānau members. It appears that any efforts made by the Waipareira Trust to reduce stigma and increase feelings of safety will result in increased utilisation of services. Other significant barriers experienced by individuals and whānau were the use of overly technical/medical language in the therapy process and general aversions to psychiatric medication. Whānau who did engage with He Kākano noted a number of positive aspects including recognition of tikanga Māori, a positive environment and encouragement of whānau involvement (Pomare, 2015). Additionally, the team employed Taurawhiti (cultural advisors) who were very well received by the participants in Pomare's study and may be equally as appreciated by clients of a Waipareira service.

Pomare (2015) drew a number of relevant conclusions from his assessment of the services provided by He Kakano. Firstly, tikanga-based practices were praised as being useful for therapy and for increasing access and contact with services for Māori. The need for a strong understanding of mātauranga Māori among clinicians was emphasised and the use of cultural advisors throughout the entire therapy process was recommended for other services. Additionally, Pomare (2015) found that Māori tamariki prefer kinaesthetic activities or multiple-modality therapy to conventional interventions.

A third intervention covered by the literature was that of Te Ira Tangata, a trial of a treatment package that was designed by Hatcher, Coupe, Durie, Elder, Tapsell, Wikiriwhi and Parag (2011). The package included a combination of problem solving therapy, patient support, cultural assessment, primary care access, postcards and a risk management strategy and was delivered to Māori who presented with evidence of self-harm to hospitals. Unfortunately the literature

regarding this treatment proposal is not complete as the final follow ups are due in June 2016 however, the planning of this therapy may be of interest. Hatcher et al. (2011) proposed to meet three criteria of good practice from a Māori perspective, these three criteria being indigenous autonomy, clinical expertise and cultural competence. The package was delivered by researchers and clinicians to the patients utilising a pōwhiri model of engagement composed of a taki (challenge), karanga, karakia, whaikōrero, waiata, koha, hongi, hākari and poroporoaki. The pōwhiri model is described in the literature but no practical applications are cited except in this study, so when the results of this study are complete later this year it will be interesting to see if this model was effective for Te Ira Tangata and furthermore, if it could be used in a Waipareira service.

Another clinical application covered in the literature was an adapted CBT programme used for Māori patients with depression, piloted by Bennett, Flett & Babbage (2008) and developed and evaluated by Bennett (2009). The approach to CBT was utilised by Te Whare Marie (TWM), which is a current Māori mental health service provider located on the grounds of Kenepuru Hospital in Porirua. Te Whare Marie provide specialist kaupapa Māori care including cultural therapy, risk monitoring, referral/liaison with other mental health services and treatment planning. Self-referral is possible, as is referrals from the GP, schools and other government agencies. While there is limited published literature regarding the efficacy or service provision in general by Te Whare Marie, it would be useful for the Waipareira Trust to consult with the staff and clinicians involved with this service prior to developing their own because Te Whare Marie appears to operate in a similar way to the service planned by Waipareira, aside from the obvious exception being that TWM operates in the Wellington region. The CBT programme used by TWM was adapted in response to Hirini's (1997) concerns about cognitive behavioural therapy and its limited relevance to Māori and the lack of research supporting therapeutic techniques that benefit Māori (Bennett et al. 2008). The trial of the adapted CBT was undertaken by Bennett (2009), a Māori senior clinical psychologist and a second cultural clinical psychologist of Māori descent. Kaumātua were involved, as were the clinical staff of TWM. The adapted programme included five phases: initial whakawhanaungatanga (developing a positive therapeutic alliance), a second phase of ngā māramatanga (building a cognitive conceptualisation), a third phase of whanonga pai (encouraging positive behaviours), a fourth phase of whakaaro pai (encourage positive thinking) and a final phase of ora pai (staying well long-term). Bennett (2009) found that, on completion of at least seven sessions, the patients involved with the clinical trial experienced reduced symptoms of depression (sustained for the six month follow up), reduced negative cognition and improvements in holistic wellbeing across the four domains of Durie's Te Whare Tapa Whā model. An interesting conclusion discussed by Bennett (2009) was the finding that targeting one domain of Te Whare Tapa Whā (in this case, hinengaro) positively impacted the other three, despite there being no dedicated efforts towards such a result. This provides support for the concepts proposed by other authors of a holistic and interdependent model of wellbeing. An important conclusion for Waipareira, taken from this study, is that it is possible to effectively engage with Māori by employing unique treatment modalities, especially when this is undertaken within the framework of a kaupapa Māori health service such as Te Whare Marie. While analyses of TWM's work in areas outside of CBT could not be located in literature services, the knowledge and experience of the clinicians involved with TWM (such as Bennett) would be invaluable to the Waipareira Trust during the upcoming developments.

DISCUSSION
KAUPAPA MĀORI SERVICE CENTRES

There are other community services, in addition to Te Whare Marie, that target Māori mental wellbeing that are not covered in scientific literature but do exist and may be of use to the Waipareira Trust. These include the Porirua Whānau Centre, the Kelvin Road Preschool and Whānau Centre, He Waka Tapu and Purapura Whetu in Christchurch and Manawanui Oranga Hinengaro in Auckland.

The Porirua Whānau Centre markets itself as a community 'hub', providing whānau support in the form of counselling, social work, parenting programmes, holiday programmes and advocacy (Porirua Whānau Centre, n.d.). Additionally the centre contains a licensed multi-cultural Early Childhood Education Centre (common among the current services listed above), a WINZ clinic and family violence prevention services and endorses the HIPPY foundation programme for pre-schoolers and their parents. The Whānau Centre advocates for a holistic approach and in many ways embodies the goals of the Waipareira Trust in developing their own clinic. Unfortunately, the literature searched provided no measures of the efficacy of this service or information on the models and frameworks behind it, however this is something that could be explored further by contacting the Whānau Centre directly.

Purapura Whetu is a kaupapa Māori mental health and social services clinic run by a team of counsellors, community support workers and nurses in Christchurch (Purapura Whetu, 2014). They provide care to at-risk tamariki as well as adults and whānau who are affected by a mental health disorder or have a current diagnosis. The services offered include counselling, cultural assessment, anger management services, family violence prevention, alcohol and drug intervention, positive parenting programmes, facilitated access to legal and community services and healthy living programmes. Similar to the Whānau Centre in Porirua there is a gap in research regarding the background to and frameworks utilised by this service and this would be worth investigating on part of the Waipareira Trust in the future.

Manawanui Oranga Hinengaro is a kaupapa Māori specialist mental health service located on Whātua Kaimarie Marae in Auckland, run by the Auckland DHB (Healthpoint, 2015). This service utilises two specific teams - a cultural support team and a clinical team - and is predominantly staffed by Māori. Manawanui Oranga Hinengaro utilises the principles of Durie's Te Whare Tapa Whā holistic model of health and offers treatment for schizophrenia, bipolar disorder, depression and anxiety disorders. This service may be a good example for the Waipareira Trust of how to plan the mental health care aspect of their clinic, especially due to the use of Durie's Māori model of health in their service provision.

Kennedy (1994) noted several factors that influenced the success of services such as Manawanui Oranga Hinengaro, Purapura Whetu, TWM and other whānau centres. Firstly, the provision of a wide range of integrated services was recommended. This involves the care of all aspects of individual or whānau wellbeing with liaison between services to break down traditional modality boundaries and ensure a strongly holistic approach. The aim of Te Whānau o Waipareira to provide a 'one-stop shop' for whānau in need is supported by Kennedy (1994). Another factor considered critical to success was good outreach: the active marketing and promotion of services to community members who may need it and who may experience reduced access. A third factor was maintaining high quality care through professional leadership and provision of training and supervision by experienced clinical personnel. Culturally appropriate care is cited as another success factor alongside minimal user chargers and a strong community base.

DISCUSSION
OTHER INDIGENOUS EXAMPLES

It is an accepted fact that ethnic minorities outside New Zealand experience a similarly disproportionate mental health burden and also suffer from unmet health needs (Eade, 2014). Additionally, it is known that lack of cultural competency among health professionals and inappropriate service provision are major contributors to this issue among other indigenous populations as well as among Māori.

Durie (2011b) acknowledges that patterns of land alienation, social and economic disadvantage and health disparities are common to all indigenous groups in developed countries and therefore it could be of use to Waipareira to explore mental health services offered internationally that cater to the indigenous worldview.

Ihimaera (2004) found that the historical context of Māori holds many similarities with that of other indigenous populations. It is also suggested that conventional methods of diagnosis and assessment, such as the internationally recognised DSM-IV, limit the utilisation of cultural viewpoints in treating mental illness. Parker's 2003 report (as cited in Eade, 2014) endorsed Aboriginal mental health workers over other mental health workers in supporting indigenous populations in Australia for two reasons: one being Aboriginal clinicians' in-depth and personal understanding of colonisation and historical trauma and the other being the understanding of mental health and illness through an Aboriginal lens and using traditional models (as opposed to the biomedical approach that is supported by the DSM-IV).

As part of this literature review, services targeting indigenous populations in Australia and other developed nations were considered in addition to existing services in New Zealand, due to the applicability of cultural responsiveness across nations that were affected by colonisation.

In Australia, a number of organisations and services are described by Purdie, Dudgeon and Walker (2010). One of these is headspace, Australia's National Youth Mental Health Foundation which provides funding to improve integrated services for both indigenous and non-indigenous youth, but with a strong commitment to cultural competence. The success of headspace is attributed to its confidentiality and low service cost, as well as being community-based and staffed by multi-disciplinary teams that may include GPs, nurses, psychiatrists, psychologists, social workers, occupational therapists and youth workers. Each service provider is locally run and managed by a team that understands the local community. Another initiative covered by Purdie et al. (2010) is Indigenous Psychological Services (IPS), which is a private company founded by an Indigenous psychologist in order to reduce inequities in mental health service access. IPS provides whole-community intervention programmes including forums on suicide and trauma management for Aboriginal communities.

In the United States, the mental health of minority populations suffers due to barriers in organisational structure, diagnostic tools, cultural congruity and financing (Cheung & Snowden, 1990). Minority populations (such as Māori) are often over-represented in the most financially disadvantaged sections of society, which affects the utilisation of health services based on cost. If cost barriers are overcome, further issues appear to arise once minority populations find themselves in the health system. Some sources argue that symptoms reflecting poor mental health are underreported due to a mismatch between professional understanding of mental illness and the understanding held by indigenous groups, otherwise known as a lack of cultural congruity (Cheung, 1987).

Looking at the evidence presented above and in this section regarding international literature, it can be deduced that patterns of mental health service utilisation and service satisfaction is similar between indigenous groups. It may be of interest to Waipareira to investigate Aboriginal/Native American or other indigenous service providers to assess what their initiatives can offer as guidance.

DISCUSSION
FURTHER RESEARCH

A vital part of any review is to identify areas where the current literature is lacking. Many authors identified themselves where the research they conducted was not able to answer the questions they intended to; in other cases the gaps are visible simply from what is not covered by the literature at all.

Firstly there is a lack of literature specific to urban Māori, who are the target population of any intervention planned by Te Whānau o Waipareira. Most of the research undertaken on this topic took looked at specific populations, for example Māori living in Te Tau Ihu (Eade, 2014), or in only deprived areas (Abel et al., 2012), or exclusively children and adolescents (Elder et al., 2009). The limited knowledge regarding urban Māori may hinder the development of an effective service by Waipareira until sufficient research is carried out to ensure that the same conclusions drawn by the current literature can be applied to Māori living in metropolitan areas such as Auckland. It is possible and suggested by some authors (Sanders et al., 2011; Marie et al., 2004), that the worldview of urban Māori has evolved from that of the traditional iwi or hapū-based culture. This claim would be interesting to investigate and potentially very relevant to the project proposed by the Waipareira Trust.

Additionally, in the medical field, the 'gold standard' of research is the randomised clinical trial. Randomised trials form the basis of evidence-based practice and inform many of the mainstream treatments and therapies in use today. While there is ample literature covering the rationale behind using kaupapa Māori therapy models, there have been few randomised trials of the interventions that have been discussed in this paper. Shepherd et al. (2015) report that indigenous populations are not represented in efficacy research that make up the basis for clinical treatment in mental health, which is attributed to the small size of the indigenous population in comparison to other ethnicities. Baxter et al. (2006b) adds to this, highlighting the need for further studies regarding utilisation of indigenous health services, which has not yet been carried out. The limited amount of research around efficacy and utilisation of health services for indigenous people reduces the ability of minorities to become involved in development of interventions and may impact the efficacy of such interventions on indigenous populations, setting the scene for further inequities. Therefore, it is of great importance that researchers undertake these clinical studies with Māori populations and using kaupapa methods in order to better benefit the currently underserved population.

While these gaps are large enough to warrant further investigation, there is an additional lack of useful and reliable studies that would inform the development of a fully holistic, multidisciplinary service like the one proposed by Waipareira. There is some evidence towards the use of specific therapies e.g. SPARX (Shepherd et al., 2015), cCBT (Bennett, 2009) or sensory modulation (Hollands et al., 2015) and some additional evidence that entire

services exist that drawn on kaupapa Māori models, e.g. Te Whare Marie and the Porirua Whānau Centre, but little can be found from the literature regarding the type of 'one-stop shop' that would suit the service framework of Te Whānau o Waipareira. No literature exists regarding the efficacy of services that offer holistic mental health care alongside other services that fulfil the requirements of the other three domains of Te Whare Tapa Whā. Services such as the Porirua Whānau Centre and Purapura Whetu need to be investigated and researched in terms of their efficacy and utilisation and how the planning and execution of their programmes were achieved. Without research, it is difficult to know if these existing services are using kaupapa Māori models in practice or simply a Māori name. It is also difficult to determine how well these services are being accepted by whānau in the community. Looking into this appears to be an important next step in this project.

CONCLUSION

This literature review was undertaken in order to examine the current use of kaupapa Māori frameworks in mental health therapy. This review focused on the main themes drawn from the existing research and attempted to apply this knowledge to the potential development of a holistic Māori mental health service in an urban environment.

A number of key findings can be taken from this review. Firstly, there is a statistically-supported imperative to developing a service targeting Māori, seen in the dismal rates of mental illness prevalence and utilisation of services among Māori and indeed among other ethnic minorities worldwide. The literature agrees that the current status of Māori mental health is justification for the research presented here and the potential development of a new service by Te Whānau o Waipareira.

The literature suggests that a main reason for the poor mental health of Māori is the lack of therapies and services that cater to cultural contexts that differ from the Western norm.

The use of health frameworks such as Te Whare Tapa Whā is encouraged by many authors in order to integrate the Māori understanding of wellbeing into service provision. Current mental health care uses a biomedical approach to diagnosis and treatment that may not fit well with many Māori patients. One of the most analysed models and also one of the easiest to apply to clinical practice, is Mason Durie's Te Whare Tapa Whā model, a simple framework that emphasises a holistic view of health and the interconnectedness of the physical, mental, spiritual and interpersonal dimensions of health.

A common theme found in the literature was that of 'culturally competent care' and its importance when considering Māori mental health. Crucial components of culturally competent care include a well-educated and culturally safe workforce, effective and applicable treatment modalities that may be adapted for use in Māori populations and the use of assessment and diagnostic tools that are relevant to indigenous worldviews. In terms of a culturally safe workforce, most agreed that a long-term commitment to increasing numbers of Māori health professionals was imperative. Until the proportion of Māori mental health workers reflects the population need, it is recommended that Pākehā clinicians work in close contact with Kaumātua.

This review looked closely at existing services that utilise a kaupapa Māori approach to care delivery. It appears that the delivery of mental health services to Māori populations is a complex task fraught with barriers, although there are examples of promising clinics such as Te Whare Marie. Further research into the efficacy of therapies provided by these services and their utilisation is certainly needed. However, the themes discovered in this literature review are reflected in the architecture of many current

services, indicating that the development and day-to-day running of such clinics may be of special interest to Te Whānau
o Waipareira.

It is clear from this review that the provision of competent, effective mental health therapy to a Māori population is a complex task. Current research is limited in many areas and there are few examples of kaupapa Māori services that have been critically appraised in the literature. However, a number of common success factors - adapting traditional practices to better reflect Māori values, involving elders in care planning, broadening therapy to include traditional healers or rongoā, ensuring easy access and low service costs, supporting holistic wellbeing – can be identified and used as a base for extended research and planning.

Strengths of this review include the use of a wide range of perspectives and the assertion of a number of themes that are common to many publications and useful to Te Whānau o Waipareira. The number of services available within Māori mental health was surprising, even if critical assessment of these services was lacking in detail. An obvious limitation to this report is the time constraints; there is certainly more to be said about Māori mental health and the utilisation of kaupapa frameworks, but these could not be elaborated on due to the relatively short length of this studentship. Given more time and resources it would have been helpful to travel to the services described in the sections above in order to interview patients and clinicians to gain a more practical insight. However, the research team at Te Whānau o Waipareira now has a foundation to go from and future aspirations should include deeper investigation into how the existing services operate.

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