Te Whare Wānanga o Te Kurahuna:

Tēnei te Pō Nau mai te Ao - Transformation in Action

Be brave, be bold, be curious,
and embrace the potential of
Mahi a Atua and Te Kurahuna!

Diana Kopua, Mark Kopua & Michelle Levy
October 2021

Contents

1.0 Introduction

Before the separation of Ranginui (sky father) and Papatūānuku (earth mother) their children lived in darkness. All their children were Atua (Gods). Uepoto one of their younger children spotted a tiny speck of light. The light drew Uepoto towards it. When Uepoto went to explore what it was, an older sibling Whiro told Uepoto to get back. Whiro didn't like that, Whiro wanted the status quo, staying in the dark. Whiro fosters fear. Uepoto let curiosity take control and didn't listen to this older sibling, but kept pulling away and going to the light. Two other siblings started to follow Uepoto. Whiro was scared of it and threatened to get rid of the light. Tane, a much younger sibling stepped forward and said the only way to extinguish the light is to drown it in absolute light!

Te Whare Wānanga o Te Kurahuna is the kaitiaki of Mahi a Atua, a 'way of being' which privileges Indigenous knowledge and practice as the basis for strengthening best practice, addressing institutional racism and realising equitable outcomes for Māori. Described as a revolutionary first for mental health and addiction services in Aotearoa (Tipene-Leach, Able, Hiha, & Matthews, 2019), Mahi a Atua was operationalised by Te Kūwatawata ki Tairāwhiti in 2017; a pilot project seeking to fully transform mental health and addiction service delivery through an Indigenous-led Single Point of Entry (SPoE).

Te Kurahuna, Mahi a Atua, and Te Kūwatawata have not only laid a pathway to achieve enhanced access to mental health and addiction services, a priority identified by the 2018 Government Inquiry into Mental Health & Addiction (Tipene-Leach et al., 2019), they also explicitly respond to directives across multiple reports, inquiries and reviews that institutional racism must be addressed in order to realise equitable outcomes for Māori. With this overt focus on challenging institutional racism, alongside operationalising a necessary paradigm shift to whānau ora and whānau-centred practice, Te Kurahuna, Mahi a Atua, and Te Kūwatawata are centrally positioned as an Indigenous framework able to realise the systemic innovation and transformation across sectors which has long been called for.

The magnitude of the task attempted by Te Kurahuna cannot be underestimated: the implementation of a 'by Māori for everyone' approach, unequivocal in its aim of tackling institutional racism via privileging mātauranga Māori and confronting the dominant biomedical deficit-focused model of mental health, was always going to be enormously challenging (Tipene-Leach et al., 2019). An indicator of institutional racism itself, resistance to Indigenous initiatives, particularly those explicitly challenging the status quo, is not unexpected. With Te Kurahuna having considerable potential to actively inform transformative change well beyond the health sector, as more and more spaces seek to become Indigenised, so too will more boundaries be directly contested.

The 2019 Health & Disability Systems Review (HDSR) concluded there was significant evidence that not only had universal health systems failed to improve health outcomes for Māori, existing health service design, purchasing and contracting approaches had in fact served to *increase* inequities for Māori. The Māori Health Authority (MHA), a significant component of

newly announced health system reforms resulting from the HDSR, is anticipated to both commission services specifically targeted for Māori, as well as work with Health NZ to ensure all services delivered are of high quality and deliver equitably for everyone (Department of Prime Minister and Cabinet, 2021).

The establishment of the MHA signifies a new era of possibility and opportunity. It is important Te Kurahuna takes full advantage of these opportunities and possibilities, as well as others which emerge, for example Iwi seeking to fully realise their rangatiratanga and mana motuhake across a range of sectors. Utilising the written evidence base effectively and strategically is a key element of this, and it is timely that Te Kurahuna begin consolidating its existing evidence base and communicating it more widely. The knowledge and practice-based evidence of Te Kurahuna, Mahi a Atua and Te Kūwatawata continues to advance. Recognising this, this report provides the foundation for the development of a strategically focused, comprehensive publication and information dissemination approach which ensures Te Kurahuna, Mahi a Atua, and Te Kūwatawata are fully understood as far-reaching, uniquely Indigenous-informed pathways able to effect the transformation which is necessary to realise equity for Māori. The report can also serve as a platform for the development of a strategically focused research agenda able to support Te Kurahuna into the future.

This report is structured in three sections. Section One, in exploring the long call for transformation in Aotearoa, investigates the wider context in relation to equity, institutional racism, and the existing transformative paradigms of whānau ora, Kaupapa Māori, and cultural safety: evidence bases of direct relevance to Te Kurahuna, Mahi a Atua, and Te Kūwatawata. Section Two describes the philosophy and practice of Te Kurahuna, Mahi a Atua, and Te Kūwatawata. The outcomes and key success factors of Te Kūwatawata, alongside challenges are also described, along with how institutional racism manifests in the privileging of the currently favoured integrated primary mental health and addictions model. Section Three offers concluding commentary on two themes: the courage of Te Kurahuna to advance a fully transformative agenda; and the critical importance of a collective commitment to fully engaging in the complete transformation process.

2.0 The Long Call for Courageous Transformation

In 1988, *Puao-Te-Ata-Tu*: *The Report of the Ministerial Advisory Committee* (Department of Social Welfare, 1988) was intended to herald the light of a new dawn, a bravely transformed world in which inequities for Māori were addressed and the potential residing within Māori communities realised. Since that time, for over 30 years, reviews and inquiries across multiple sectors[1], have persistently emphasised the failure for Māori communities of past and current approaches premised upon Western knowledge systems and models of practice (Boulton,

---

[1] Health and Disability System Review (2020), *Health and Disability System Review—Final report—Pūrongo whakamutunga;* Waitangi Tribunal (2019), *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575 Waitangi Tribunal Report)*; Te Uepū Hāpai i te Ora (2019), *Turuki! Turiku! Move Together;* Whānau Ora Review Panel (2019), *Whānau Ora Review;* Welfare Expert Advisory Group (2019), *Whakamana Tāngata— Restoring Dignity to Social Security in New Zealand;* Chief Victims Advisor to the Government (2019), *Strengthening the criminal justice system for victims: Te Tangi o te Manawanui—Recommendations for Reform;* Noonan et al., (2019), *Te Korowai Ture ā-Whānau: The Final Report of the Independent Panel Examining the 2014 Family Justice Reforms;* Te Uepū Hāpai i te Ora *(2018), He Waka Roimata: Transforming Our Criminal Justice System;* Government Inquiry into Mental Health & Addiction (2018), *He Ara Oranga: Report of the Government Inquiry into Mental Health & Addiction;* Office of the Health and Disability Commissioner (2018), *New Zealand's Mental Health and Addiction Services: The monitoring and advocacy report of the Mental Health Commissioner.*

Levy, & Cvitanovic, 2020). Those reviews and inquiries have also unwaveringly called for the same transformative change sought by Puao-Te-Ata-Tu: innovative, localised solutions designed, delivered and implemented by whānau, hapū, iwi and hapori (Government Inquiry into Mental Health & Addiction, 2018; Kawai et al., 2020; Māori Affairs Committee, 2013; Te Uepū Hāpai i te Ora, 2019). With the situation in 1988 described as being one of "crisis proportions" for Māori (Department of Social Welfare, 1988, p8), in 2021, the urgent need for bold transformational action remains (Boulton et al., 2020).

2.1 Equity

Health equity can be described as "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically" (World Health Organisation, 2020). In this definition attention is focused on how resources, including services, are distributed to the community (Reid & Robson, 2007). Health systems in Aotearoa have long been evidenced as supporting non-Māori to live longer healthier lives than Māori, with inequities seen throughout the lifecourse, from before birth, through childhood and youth, to adulthood and into old age (Health Quality & Safety Commission, 2019).

Equity of outcomes for Māori across the health system are influenced by three factors: inequity in access whereby services are less accessible for Māori; inequity in quality whereby services are not providing the same benefits for Māori; and inequity in improvement whereby efforts to improve service quality do not always result in improved equity for Māori (Health Quality & Safety Commission, 2019). An extensive literature base clearly documents the impacts of differential access and quality for Māori at all levels of health care services, including primary care (Health & Disability System Review, 2019; Health Quality & Safety Commission, 2019; Reid, Robson, & Jones, 2002; Russell, Smiler, & Stace, 2013). Specifically in relation to mental health, access to services is a priority issue, with key recommendations from the 2018 Government Inquiry into Mental Health & Addiction focused on significantly enhancing service accessibility (Government Inquiry into Mental Health & Addiction, 2018). However, the evidence base also shows that even when barriers to service access are absent, inequity for Māori in relation to the quality of services and treatments received remain. That is, even if Māori are able to access health services, optimal quality of care is not always received, and this negatively affects outcomes: increased access does not automatically equate with equitable outcomes (Health Quality & Safety Commission, 2019).

Furthermore, alongside the wider social and economic determinants of health which create a level of disadvantage for Māori even before engagement with the health system, not only do services fail to provide the same benefits to Māori, in some cases engagement with those services actually serves to increase inequity (Health Quality & Safety Commission, 2019; Reid et al., 2002). Included within this is that even when gains have been made through overall changes in policy or service quality, structural inequities mean Māori are not benefiting proportionately from those gains (Health & Disability System Review, 2019; Te Uepū Hāpai i te Ora, 2019): overall improvements in service quality do not equate with enhanced equity for Māori. Combined, these factors not only result in disadvantage and inequity accumulating for Māori, they also result in an accumulation of advantage for non- Māori (Health Quality & Safety Commission, 2019; Reid et al., 2002; Russell et al., 2013), Evidence of such cumulative inequity is widely reported across numerous areas, for example suboptimal and over-

prescribing to Māori; delays in treatment and surgical interventions; and longer hospital bed stays after acute admissions (Health Quality & Safety Commission, 2019).

Indicators of inequity manifesting beyond service access is also apparent in mental health. Māori have differential experiences of, and are not well served by, current mental health services and approaches, with this seen in poorer outcomes across a variety of measures (Cunningham et al., 2018; Kopua, Kopua, & Bracken, 2020; Taitimu, Read, & McIntosh, 2018). The 2018 Government Inquiry into Mental Health & Addiction reported that while the prevalence of mental distress among Māori is almost 50% higher than among non-Māori, Māori are 30% more likely than other ethnic groups to have their mental illness undiagnosed. With regard to secondary care, Māori are more likely to be admitted to mental health facilities; readmitted after discharge; secluded during admission; and compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992 (Government Inquiry into Mental Health & Addiction, 2018; Initial Mental Health & Wellbeing Commission, 2021). Seclusion is experienced by Māori as being punitive in nature, with many losing faith in the mental health system and its processes (Russell, Levy, & Cherrington, 2018; Wharewera-Mika et al., 2016).

Māori voices to the 2018 Government Inquiry into Mental Health & Addiction characterised optimal access as whānau receiving the right support at the right time, clearly expressing a desire for substantially improved access to culturally-aligned services and tools (Russell et al., 2018). As was highlighted in 2018 to Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575), if health services are delivered inadequately or inappropriately, then the delivery method of those services itself can become a negative determinant of health outcomes (Waitangi Tribunal, 2019). Supporting this, a recurring theme consistently identified over the past 30 years is that reliance on Western knowledge has led to a lack of recognition and understanding of te ao Māori, Māori concepts and Māori models of practice (Boulton et al., 2020; Chief Victims Advisor to the Government, 2019; Government Inquiry into Mental Health & Addiction, 2018). Research focused on primary care identifies that although Primary Health Organisations (PHOs) have attempted to tailor their responses to the specific access barriers faced by Māori, this has not necessarily resulted in improved health outcomes for Māori. Whilst economic and geographic barriers to access are considered relatively easily identified and solved by PHOs, a disconnect between Māori models of health and wellbeing and the dominant disease-oriented models of health utilised by PHOs has not been addressed (Russell et al., 2013). The HDSR concluded there was significant evidence that universal health systems had not only failed to improve health outcomes for Māori, existing health service design, purchasing and contracting approaches had in fact served to increase inequities. The evidence is unequivocal: more of the same will not address the disadvantage and inequity which accumulate for Māori.

2.2 Institutional Racism

Despite high levels of health inequity for Māori being well documented and widely discussed for several decades, this inequity has persisted. The literature base has also long demonstrated that these persistent inequities are structural, and are underpinned by institutional racism (Boulton et al., 2020; Clark, Le Grice, Moselen, Fleming, & Crengle, 2018; Jackson, 1987; Māori Affairs Committee, 2013; Modernising Child Youth and Family Expert Panel, 2015; Reid, Cormack, & Paine, 2019; Te Uepū Hāpai i te Ora, 2019; Whānau Ora Review

Panel, 2019). Described as critical to address if long term change was to be achieved in Aotearoa, recommendation one of Puao-Te-Ata-Tu in 1988 explicitly called for an attack on "all forms of cultural racism in New Zealand that result in the values and lifestyles of the dominant group being regarded as superior to those of other groups, especially Māori" (Department of Social Welfare, 1988, p9). Over thirty years later, institutional racism continues to be positioned as central in addressing health inequity for Māori. In Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575), consistent with the established evidence base, all parties, including the Crown, accepted institutional racism was a known determinant of health and wellbeing. Senior Māori health researchers have consistently called for entrenched institutional racism to be addressed; and for racism to be declared a public health crisis (Parahi, 2020; Reid & Robson, 2007). The HDSR (2020) stressed the impacts of racism must be addressed; and the need to eliminate systemic racism within mental health and addiction services was highlighted in the 2018 Government Inquiry into Mental Health & Addiction (Government Inquiry into Mental Health & Addiction, 2018; Russell et al., 2018).

Addressing health inequity requires those with the highest levels of need receive attention and resources proportionate to that need (World Health Organisation, 2020). Expert evidence presented to WAI2575 defined institutional racism as 'inaction in the face of need' (Waitangi Tribunal, 2019, p21). Again, all parties to the WAI 2575 Claim, including the Crown, agreed that the severity and persistence of health inequity Māori continued to experience was an indicator that the health system was institutionally racist. The Waitangi Tribunal also concluded that the framework for the primary health system in New Zealand was institutionally racist in that Māori, as those with the highest levels of need, were not receiving resources proportionate to that need (Waitangi Tribunal, 2019).

Repeated failure by the health system to respond to the significant inequities in Māori health outcomes; higher exposure by Māori to determinants of ill health and disease; and the ongoing under-representation of Māori across the health workforce (Health & Disability System Review, 2019) is all evidence of the extent to which persistent inequity for Māori has become 'normalised'. Far from generating a sense of urgency, inequity for Māori has come to be almost routine; an expected and accepted feature of our national landscape (Reid & Robson, 2007). Sustaining much of this normalisation is the dominance of individualised deficit theory, language and indicators which sustain the stereotype that inequity results from the individual failings of Māori, as opposed to systemic structural bias (Waitangi Tribunal, 2019). The normalisation of this stereotype then serves as justification for the continued existence of ongoing inequitable service delivery, in the process endorsing ongoing structural racism (Keddell, 2018; Rua et al., 2019; Waitangi Tribunal, 2019). For example, the deficit-oriented term 'hard to reach', often used by policy makers and health professionals when attempting a focus on Māori communities, is acknowledged as masking the failure of health care service delivery, and the wider complexities for whānau which arise from the social determinants of health (Russell et al., 2018; Waitangi Tribunal, 2019).

Institutional racism manifests across majoritarian decision-making systems (Waitangi Tribunal, 2019). Health systems are comprised of decision-making individuals, including those who determine health priorities, funding, and health workforce development. It has been argued that public policy decisions and processes are not ideologically neutral, instead heavily

influenced by the normative cultural expectations of those designing them (O'Sullivan, 2019). The ideology of 'equality' which positions Indigenous models and services as undesirable for central government, results in prescriptive contracts, short contracting periods and onerous accountability requirements, all of which have been identified as symptomatic of a deeper desire on the part of the state to maintain control over Indigenous development (Lavoie et al., 2016; New Zealand Productivity Commission, 2015; Smith, Moore., et al 2019). That fundamental Māori concepts and processes are not understood by decision makers, despite the availability of a robust evidence base to inform them, is yet another indicator of how institutional racism is embedded and sustained within systems (Boulton et al., 2020). The Waitangi Tribunal conclusion in 2019 that the Crown, despite being fully aware of the presence and ongoing impact of institutional racism across the health sector, had nevertheless failed to address that institutional racism, is further evidence of this normalisation (Waitangi Tribunal, 2019). Normalisation results in inaction(Reid & Robson, 2007), and inaction in the face of high need is the definition of institutional racism.

2.2.1 Diagnosis and Distress

Reflecting that inequity stems not only from differential access to services, but that services do not provide the same benefits to Māori, and in some cases actually serve to maintain disadvantage and increase inequity for Māori, the concept of 'inappropriate' action can be added to the definition of institutional racism (Health & Disability System Review, 2020; Health Quality & Safety Commission, 2019). 'Inappropriate' action includes those that occur when systems and services continue to be founded upon and embedded within monocultural perspectives and worldviews, despite evidence which indicates the ineffectiveness of doing so (Health Quality & Safety Commission, 2019). Consistent with a substantial literature base, both the 2018 Government Inquiry into Mental Health & Addiction, and the Initial Mental Health & Wellbeing Commission identify a central element of the institutional racism perpetuating inequity for Māori across the mental health system is domination by a monocultural, bio-medical, deficit-oriented, risk-averse model, with existing systems only serving to strengthen that domination (Government Inquiry into Mental Health & Addiction, 2018; Initial Mental Health & Wellbeing Commission, 2021; Russell et al., 2018).

Primarily led by psychiatrists and psychologists, the privileging of this bio-medical model as the foundation for 'usual care' in mental health has persisted, with widely known significant inequity for Māori failing to evoke any demonstrable change to this dominant paradigm (Kopua & Kopua, 2021; Russell et al., 2018). However, the overwhelming message provided to the 2018 Government Inquiry into Mental Health & Addiction was the need for a new approach. Māori voices to the Inquiry were clear that a radical transformation away from the existing dominant biomedical model to a wellbeing paradigm founded within Te Ao Māori was critical (Russell et al., 2018).

Paradigms upon which understandings of mental health, distress and wellbeing are based guide and inform priorities for training, research, interventions, and understandings of what is considered effective and what is not (Bracken & Thomas, 2017). Psychiatry and psychology, as behavioural sciences premised upon causal, universal, diagnostic-based models of mental disorder, are grounded within what some refer to as the 'technological paradigm' (Bracken & Thomas, 2017). Based on a pathologised deficit model, mental health problems are viewed as resulting from universally described and individually located, biological, cognitive or

emotional processing defects, which exist independent of any broader context (Beresford, 2002). Lying at the heart of the technological paradigm are diagnostic classification systems of disorder, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD). It is these diagnostic systems which regulate access to the medically dominated and controlled mental health system, with the majority of resources consumed by individualised psychiatric treatments, clinics and units (Government Inquiry into Mental Health & Addiction, 2018; Rangihuna, Kopua, & Tipene-Leach, 2018a). The technological mind-set also explicitly prioritises the status of the 'expert' professional, with innovation perceived as deriving only from 'technical' experts, as opposed to local communities themselves (Bracken & Thomas, 2017; Kopua et al., 2020).

The past decade has seen the emergence of the Movement for Global Mental Health which seeks to train more workers around the world in assessment, diagnostic, and intervention technologies premised upon the biomedical paradigm of mental health (Kopua et al., 2020). There is however a growing counter-discourse concerned at the global exportation of this Western technological paradigm. Because these 'technological' ways of understanding mental illness are perceived of as being the only 'scientific' way of understanding distress, universal, diagnostic-based models of mental illness are considered superior to any other forms of understanding, including Indigenous psychologies (Bracken & Thomas, 2017). Challenging the dominant way of framing and understanding states of distress, critical psychiatry has centred its arguments on the way in which the technological approach disconnects discussion about distress from the 'non-technical' aspects of mental health, such as values and relationships. Echoing this view, the 2018 Government Inquiry into Mental Health & Addiction also emphasised the way in which the dominant mental health paradigm served to reflect a "colonising world view largely hostile to Māori understandings of wellbeing" (p40), essentially eliminating the opportunity to consider relationships, meaning, values, beliefs and cultural practices important to Māori (Rangihuna et al., 2018a). Related to colonial authority and the replacement of realities which result from the colonial project, the concept of 'mental health' is itself directly linked with economies of extraction, and Indigenous dispossession, relocation and containment (Tina Ngata, 2021, personal communication, 1 October). Critical questions are raised regarding the limitations of attempting to address issues created by colonial authority with solutions which are themselves created within that same system (Tina Ngata, 2021, personal communication, 1 October).

Challenges are also made regarding the lack of empirical evidence regarding the clinical utility of diagnostic frameworks (Timimi, 2013), with it stressed that the intellectual and practical deficiencies of both mental health diagnostic typology and the therapeutic responses which occur as a result, have long been evidenced (Beresford, 2002). Identifying the colonial underpinnings of the dominant paradigm, and emphasising the fundamental importance of addressing this, it has been concluded that "diagnostic-based services are inherently institutionally racist, and no service that takes seriously trying to provide a culturally-appropriate service can claim to have made such forward strides in doing so without first abandoning the use of diagnostic-based thinking" (Timimi, 2013, p26). The 2018 Government Inquiry into Mental Health & Addiction highlighted past mental illness prevalence survey

methodology based on DSM diagnostic criteria was unable to capture the full range of challenges and distress encountered by communities.

In resisting the relevance and importance of contextual information, dominant paradigms of mental health contribute to the rigid medicalisation of problems that are more accurately categorised as "problems of living" (Timimi, 2013, p22). The British Psychological Society have been explicit in proposing a conceptual change to psychiatric classifications relating to emotional distress, and troubled or troubling behaviour, seeking to frame them not as illness but as reasonable responses to adverse social and cultural states of being (Johnstone & Boyle, 2018). These views are consistent with whānau experiences in Aotearoa who criticise mental health services, both for their reliance on pharmaceutical approaches, as well as their failure to acknowledge the extent to which mental wellbeing is related to meaningful work, healthy relationships with family, whānau and community, good physical health, and strong connection to land, culture and history (Government Inquiry into Mental Health & Addiction, 2018; Kopua et al., 2020). Findings such as these reflect the importance of developing ways in which states of distress, madness, and dislocation in Indigenous societies can be discussed without automatically invoking the idiom, language, and assumptions of Western psychiatry (Kopua et al., 2020). The 2018 Government Inquiry into Mental Health & Addiction has highlighted the broad utility of 'distress' as a concept, able to encompass those experiencing mental illness, those who are severely distressed, as well as those reacting normally in response to stressful situations.

Complex challenges, in particular addictions, homelessness, and poverty, are seen as significant drivers of compounding stressors for individuals, whānau and communities (Government Inquiry into Mental Health & Addiction, 2018; Russell et al., 2018). Furthermore, the evidence clearly shows wider social and economic determinants of health create a level of disadvantage for Māori even before there is engagement with the health system (Health Quality & Safety Commission, 2019; Reid et al., 2002; Russell et al., 2013). Given this, it is impossible to separate out the emergence and experience of mental distress from wider society and culture, including people's experiences of power and powerlessness. Supporting the importance of an enhanced emphasis on the integration of an equity lens within therapeutic contexts, utilising non-diagnostic understandings of emotional and psychological distress and troubling behaviour has been shown to reveal complexities a diagnostic model serves to obscure (Johnstone & Boyle, 2018).

The commonly used terms 'mild', 'moderate' and 'severe' have likewise been rejected as not capturing the full range of experiences and needs of those in distress. The 2018 Government Inquiry into Mental Health & Addiction emphasised that whilst mental distress can be disabling, it can also be understood and addressed with a non-medicalised response, and as such should not be classified as illness (Government Inquiry into Mental Health & Addiction, 2018). Stressing that people wished to be active participants, encouraged and supported to heal and restore their sense of self, as opposed to passive recipients of services, mental and emotional distress can be perceived of as a recoverable social, psychological, spiritual or health disruption (Government Inquiry into Mental Health & Addiction, 2018). Medically focused approaches which define distress as illness and as such require people to present as 'sick' in order to qualify for assistance, are not only restrictive, they are counter-productive (Initial Mental Health & Wellbeing Commission, 2021). Furthermore, there is evidence

suggesting that not only are mental health services as they are currently configured of limited effectiveness in treating mental health conditions, they may be more likely to prolong the difficulties faced (Johnstone & Boyle, 2018). Because not everyone will want or need 'formal' therapy, for many, the essential elements of effective assistance to deal with distress are the development of supportive and trusting therapeutic relationships based on narrative dialogue, relationship, and evolving meaning (Johnstone & Boyle, 2018; Russell et al., 2018). Therapies are co-created in real-time, and solutions embedded within everyday life, such as meaningful activity, social relationships, employment opportunities, housing, income and other forms of practical support. That the most effective support may be found in community led, culture-specific initiatives encompassing these elements is also highlighted (Johnstone & Boyle, 2018).

2.2.3 The 'Evidence'

Supported by a substantial evidence base, universalist approaches to mental health are argued as ineffective for Māori, with it being recognised that unless the deeply engrained bias towards Western knowledge is addressed, inequity for Māori will persist (Government Inquiry into Mental Health & Addiction, 2018; Health & Disability System Review, 2020; Initial Mental Health & Wellbeing Commission, 2021). The bio-medical model dominating mental health seeks the scaling-up of 'evidence-based' interventions (Lancet Global Mental Health Group, 2007). However, the concept of 'evidence-based' is also grounded within the dominant paradigm, with it being argued, including from within the disciplines of psychiatry and psychology, that because emotional and behavioural distress will always reflect prevailing social and cultural discourse and norms, a global psychiatry or psychology simply cannot exist (Johnstone & Boyle, 2018). Given this, what is truly required is a scaling down of Western psychiatry and psychology (Kopua et al., 2020). Confronting the evidence regarding the history of harm manifest by psychiatry and psychology on Indigenous peoples is essential if the mental health system itself is to be fit for purpose (Tina Ngata, 2021, personal communication, 1 October).

A lack of investment into growing the research and evaluation base for mātauranga Māori approaches to wellbeing, and the impacts of this, particularly in terms of ongoing perpetuation of the view that mātauranga approaches lack a robust evidence base, significantly contributes to persistent systemic institutional racism in health systems (Russell et al., 2018). Māori voice to 2018 Government Inquiry into Mental Health & Addiction expressed astonishment that ineffective, individualised, deficit-focused foreign models were still being imported and invested in. This astonishment resulted not only from the demonstrated lack of benefit for Māori from such models, but also the growing evidence base displaying the presence of successful Indigenous models (Russell et al., 2018).

The 'politics of ethnicity' is a term used to describe the situation whereby not only do uniquely Indigenous Māori solutions lack state commitment and support, they also become the focus of persistent scrutiny (New Zealand Productivity Commission, 2015, p345). For example, despite the substantial evidence base demonstrating the success of Whānau Ora in effecting transformative outcomes for Māori, indicative of the pervasive reach of institutional racism, Whānau Ora remains vulnerable to challenge in a political climate not receptive to policies shaped around Indigenous practices and values (New Zealand Productivity Commission, 2015; Smith et al., 2019). It appears highly contradictory that although the evidence base clearly

demonstrates the effectiveness of Whānau Ora as a sustainable transformative solution, it continues to be side-lined by state agencies (Boulton et al., 2020).

The constant scrutiny of Indigenous solutions starkly contrasts with a visible lack of consequences for mainstream health and social service providers in relation to the poor outcomes they produce for Māori (Boulton et al., 2020). For example, over the past decade, systemic institutional racism has been constantly directed toward Whānau Ora providers as they have sought to implement whānau-centred practice (Whānau Ora Review Panel, 2019). Contrast the experience of Whānau Ora providers with that of Plunket, an organisation in existence for over a century, and the largest provider of Well Child Tamariki Ora health services nationally, collecting 60 million dollars in annual funding. In 2021, after a report in which Plunket was found to be 'outdated and inequitable' (Trafford, 2021), the organisation acknowledged it had been failing Māori and Pacific whānau and that it needed to do better (Robson, 2021). Illustrating an integral element of institutional racism, that of a failure of consequence for poor performance (Came, Doole, McKenna, & McCreanor, 2018; Waitangi Tribunal, 2019), there was no state or public outcry over what was essentially the misuse of public money.

Also relevant to the issue of the evidence base is mātauranga Māori approaches being measured and assessed according to dominant paradigm frameworks, which have in themselves contributed to the very existence of health inequity for Māori (Russell et al., 2018). For example, highlighting issues regarding how and what is measured, Māori health researchers have noted how common methods for reporting and describing Māori health are focused on experiences of ill health, as opposed to more holistic views of health and wellbeing (Russell et al., 2013). With an identified need for culturally relevant evaluations and assessment mechanisms, quality for Māori must be defined by Māori (Health & Disability System Review, 2020), with Māori data and analytical approaches serving to strengthen and broaden evidence bases for health care (Health Quality & Safety Commission, 2019). Reflecting an understanding of how inequities are created and maintained, commonly used measures of access, such as increased service utilisation, cannot automatically be considered a proxy for decreased inequity (Russell et al., 2013).

Contradictions are clearly evident when the importance of not relying solely on international research to meet the specific needs of Aotearoa is emphasised, whilst at the same time stressing new initiatives should not be implemented in the absence of robust research and evaluation (Government Inquiry into Mental Health & Addiction, 2018). Building an evidence base around what works continues to be emphasised as important, however the same attention and consequence is not evident when the ineffectiveness of imported, mainstream models for Māori is apparent. That significant resources have been invested in the development of strategies and research that have failed to address inequity, alongside a constantly identified lack of investment in the development of mātauranga Māori approaches (Initial Mental Health & Wellbeing Commission, 2021; Government Inquiry into Mental Health & Addiction, 2018), evidences all the characteristics of institutional racism: a lack of action; inappropriate actions; and lack of consequence for poor outcomes.

Despite the extensive evidence base and multitude of review and inquiry recommendations compiled over several decades, the overall structural and systemic transformation necessary

to genuinely address intergenerational inequity for Māori remains absent (Boulton et al., 2020). Most recently, the Initial Mental Health & Wellbeing Commission (2021) has reported a distinct lack of action in regard to the transformative systemic changes and innovation required to realise improved outcomes for Māori. The evidence is clear: we cannot continue to privilege ways of working which are shown to be ineffective, and still expect transformative change will occur.

2.3 Platform for Transformation: Whānau Ora

The importance of the health and disability system creating opportunities for Māori to exercise rangatiratanga and mana motuhake, particularly in terms of exerting control over systems and models of care grounded in te ao Māori, has been emphasised for some time (Initial Mental Health & Wellbeing Commission, 2021; Health & Disability System Review, 2020; Waitangi Tribunal, 2019; Government Inquiry into Mental Health & Addiction, 2018). Te Tiriti o Waitangi is recognised as the foundation for addressing inequity in Aotearoa, providing a framework to support the sustained, systemic and multileveled approaches needed to advance Māori health and equity, as well as drive the realisation of self-determined priorities and aspirations (Health Quality & Safety Commission, 2019). Reflecting the need for movement to action, the Initial Mental Health & Wellbeing Commission (2021) highlights the importance of going beyond the simple recognition of basic Te Tiriti principles to greater partnership and power sharing with Iwi Māori. Of note is that Iwi strongly asserted to the 2018 Government Inquiry into Mental Health & Addiction their desire to exercise rangatiratanga and mana motuhake (Russell et al., 2018).

Māori voices to the 2018 Government Inquiry into Mental Health & Addiction were clear a radical transformation away from existing bio-medically focused illness models to a wellbeing paradigm founded within Te Ao Māori was required (Russell et al., 2018). The 2018 Government Inquiry into Mental Health & Addiction, HDSR (2020), and Initial Mental Health & Wellbeing Commission (2021) have all emphasised mātauranga Māori as integral to addressing health inequity and mental health service transformation, recommending funding and support be directed to supporting the elevation and implementation of mātauranga Māori approaches.

Those same voices calling for radical transformation also emphasise the foundations for such transformation already exists: whānau ora (Russell et al., 2018). Maori voices have for decades asserted that if inequities for Māori are to be addressed, whānau must be placed at the centre of solutions (Boulton et al., 2020). Whānau ora, the uniquely Indigenous strengths-based paradigm, recognises the wellbeing of individuals is inextricably linked to the wellbeing of the collective (Taskforce on Whanau-Centred Initiatives, 2009). Supported by an evidence base demonstrating compartmentalised, siloed, individualised approaches do not work, Māori organisations, providers, communities and collectives have been operationalising whānau ora for decades, repeatedly calling for whānau ora to become entrenched across all sectors, including mental health and addiction (Boulton, Cvitanovic, & Cropp, 2018; Russell et al., 2018; Te Uepū Hāpai i te Ora, 2019; Welfare Expert Advisory Group, 2019; Whānau Ora Review Panel, 2019). Recommendations to support the transformative potential of whānau ora via the development of whānau-centred policy frameworks across state agencies; embedding whānau-centred approaches across the wider non-government sector; and the exploration of more localised commissioning options have been made for some time

(Whānau Ora Review Panel; 2019; New Zealand Productivity Commission, 2015). Recognising the significant potential yet to be realised, strengthening whānau ora and whānau-centred practice remains the foremost call across health, welfare, social service and justice sectors, supporting the proposition that never before have we as Māori had such consistent, widely agreed upon, and clearly articulated aspirations for wellbeing (Boulton et al., 2020).

Whānau ora recognises whānau as the foundation of strength, support, identity and wellbeing (Ministry of Health, 2002). Prioritising an Indigenous worldview that positions the wellbeing of individuals as inseparably linked to the wellbeing of the collective (Taskforce on Whanau-Centred Initiatives, 2009), whānau ora explicitly encompasses the collective impact of mental distress (Russell et al., 2018). Of central importance is that whānau ora is premised upon fully realising whānau potential for transformative change. Emphasising rangatiratanga resides within collectives, not only are whānau seen as holding untapped potential for change, they themselves are positioned as the central agents of that change (Te Puni Kōkiri & The Treasury, 2019). Culturally and relationally grounded, whānau ora and whānau-centred practice: places whānau aspirations, needs, and self-determination at the centre; is premised upon transformation not transaction; and is focused on solutions not issues (Gifford, Tuaine, Muir, & Harford, 2013).

A whānau ora paradigm exists within a much wider theoretical context which nurtures uniquely Maori approaches: Kaupapa Māori. Deliberately positioned as an overtly proactive and emancipatory form of resistance to the status quo which creates and maintains inequity for Māori, Kaupapa Māori has emerged from, and is legitimated by, Māori communities (Bishop & Glynn, 1999; Mikaere-Hall, 2017). Kaupapa Māori is embedded within a wider context focused on what Professor Linda Tuhiwai Smith refers to as "a particular struggle over the legitimacy of our identity" (Smith, 2011, p11). Operating as a transformative theory across a range of contexts, including education, health, and research, Kaupapa Māori seeks to reclaim Indigenous spaces and knowledge, whilst at the same time de-centering Pākehā domination (Rua, 2015). Theories which are truly transformative for Indigenous communities, must be 'owned' and 'make sense' to those communities (Smith, 2003). Consistent with this, much of the strength of Kaupapa Māori theory has resulted from Māori communities seeing the relevance of, and recognising much of what Kaupapa Māori speaks to, reflected in their own priorities and practices (Pihama, 2001; Smith, 2012).

Kaupapa Māori is underpinned by several key principles. The principle of tino rangatiratanga emphasises control over one's life and cultural wellbeing, and Indigenous reclamation over spaces (Pihama, Cram, & Walker, 2002; Smith, 2003). This includes challenging mechanisms which serve to maintain dominant ideologies, and providing ways in which deficit colonial worldviews can be critiqued (Cram, Pipi, & Paipa, 2018; Mikaere-Hall, 2017). Taonga Tuku Iho, the principle of cultural aspiration, asserts, normalises, validates and legitimises the centrality of te reo Māori, tikanga, and mātauranga Māori (Smith, 2012). Questions embedded within Māori worldviews become relevant from the perspective of this principle, for example, why are wānanga valued as a shared learning process; and what does koha and manaakitanga mean (Smith, 2015). Although, Kaupapa Māori does not automatically reject knowledge solely because it has Western origins, Kaupapa Māori focuses on challenging and deconstructing dominant paradigms, alongside one's own colonially influenced beliefs (Walker, Eketone, & Gibbs, 2006).

Kia piki ake i ngā raruraru o te kāinga - the principle of socio-economic mediation, recognises the importance of critically analysing Western knowledge bases, unequal power relations and structural issues which serve to conceal, sustain and maintain inequities for Māori (Smith, 2003). Also relevant to a critique of power structures which perpetuate inequity is Kaupapa - the principle of collective philosophy. This principle speaks to the importance of an overall commitment to the collective vision of Māori communities, with these embedded in broader aspirations for political, social, economic and cultural wellbeing (Cram et al., 2018).

Whānau - the principle of extended family structure, emphasises the centrality of the relationships connecting Māori to each other and the wider world. Directly linked is Āta - the principle of growing respectful relationships. Stressing the importance of building and nurturing relationships, and initially developed as a transformative approach in social service delivery, āta encompasses issues such as negotiating boundaries and holding safe spaces when engaging in relationships with people, kaupapa and environments (Pohatu, 2005).

The 2018 Government Inquiry into Mental Health & Addiction, the HDSR (2020), and the Initial Mental Health & Wellbeing Commission (2021) have all concluded universalist approaches are ineffective for Māori. It is well recognised that going beyond the provision of 'cultural add-on' options, requires the health system be configured in such a way that prioritises local innovation over international and imported models. Furthermore, an approach which gives priority to Māori theories of health, wellbeing and aspirations, will benefit not only Māori, but all New Zealanders (Health & Disability System Review, 2020). Clearly reflecting central principles of Kaupapa Māori theory, Indigenous approaches to mental health and wellbeing offer not just an adjunct to, but a valid alternative to the interventions of Western psychiatry. They provide a framework through which not only can individuals and whānau negotiate their journeys through mental health crises and difficulties, but Indigenous communities can also reinstate and celebrate narratives, and healing practices previously marginalised and suppressed (Kopua et al., 2019).

2.3.1 Decentering the expert: a whānau-centred workforce

Many of the conclusions reached by recent reviews and inquiries highlight the centrality of the workforce as a key enabler in addressing inequities for Māori (Health & Disability System Review, 2020; Government Inquiry into Mental Health & Addiction, 2018). Also clearly emphasised across recent literature is that new models, and different ways of utilising workforces are needed. For example, the HDSR (2020) concluded current models characterised by highly medicalised professional silos will not effectively meet future health system needs. Systemic transformation requires working collaboratively to look beyond outdated professional boundaries and scopes of practice, with the HDSR unequivocal in stressing that if inequity for Māori was to be addressed, the status quo could not continue: all parts of the system needed to work differently in order to deploy alternative workforces and ways of working (Health & Disability System Review, 2020).

Over 30 years ago, Puao-Te-Ata-Tu similarly recognised the workforce as central to transformation, specifically emphasising a community workforce was best placed to meet whānau needs. This was as opposed to a "professional" workforce predominantly utilising internationally derived models considered inappropriate for the Aotearoa context

(Department of Social Welfare, 1988). Decades later, communities positioned as 'champions of change' continue to be regarded as the biggest untapped wellbeing workforce resource (Russell et al., 2018), with increasing recognition that solutions do not result from the technical skills of mental health clinicians, but from whānau themselves (Initial Mental Health & Wellbeing Commission, 2021).

Critical psychiatry emphasises the dominant technological paradigm of mental health effectively undermines conditions for real dialogue (Bracken & Thomas, 2017; Timimi, 2013). Deriving from the dominance of the biomedical model in mental health, and the associated positioning of 'technical' knowledge as the primary authority, the experiences and expertise of those seeking assistance are demoted to that of a passive recipient, secondary always to the technical proficiency of the professional (Bracken & Thomas, 2017). Conversely, critical psychiatry focuses on actually hearing those in distress, generating opportunities for individuals and their whānau to drive their own journey forwards (Bracken & Thomas, 2017; Timimi, 2013). Decentering the importance of professionals enables what has been referred to as 'extra therapeutic factors', such as real life histories, support, relationships, and culture, all of which play a significant role in achieving positive outcomes, to be explicitly prioritised (Timimi, 2013). Moving away from the idea that services will 'fix you', and entirely consistent with a whānau ora paradigm, Māori voices to the 2018 Government Inquiry into Mental Health & Addiction asserted effective services were creative, fluid, and adaptable. Such services sat with whānau to not only feel their pain and challenges, but also: provided opportunities for whānau growth, development and leadership; privileged Indigenous healing, knowledge and processes; drew on whānau strengths and aspirations; listened to whānau journeys; and empowered whānau to tell their own stories (Russell et al., 2018). Similarly, the HDSR emphasised a workforce able to effect whānau-centred practice was integral to building the trusting relationships necessary if whānau were to be supported to determine their own health needs (Health & Disability System Review, 2019).

2.3.2 Cultural Safety

Cultural safety is recognised as a key approach to eliminating institutional racism in the health system (Health & Disability System Review, 2020). Regulatory bodies and health training institutions in Aotearoa have tended to position cultural competency as something able to be fully achieved through a static process of knowledge and skill acquisition, in the same way other technically oriented competencies are acquired. However, it is argued that these narrow individualised cultural competency frameworks not only perpetuate deficit discourses in terms of attributing responsibility for problems to individuals, in the process promoting over-simplified understandings based on cultural stereotypes, they also entirely ignore the systemic drivers of inequity, including the role played by health professionals in creating and maintaining these inequities (Curtis et al., 2019). It is recognised that the health system must move beyond simply acknowledging inequity, to actively ensuring services, organisations and staff are equipped with the knowledge, tools and endorsement to identify and address institutional racism (Health Quality & Safety Commission, 2019). Achieving this requires a shift from cultural competency to the more transformative concept of cultural safety (Curtis et al., 2019).

Dr. Irihapeti Ramsden, a pioneer in the field of cultural safety, understood the centrality of critical theory to addressing health inequity for Māori. Described as a 'movement to critical

consciousness', critical theory focuses on examining structural variables such as power, social justice and equity, with reflective self-assessment of power, privilege and bias by health practitioners essential in the journey towards cultural safety (Curtis et al., 2019). Cultural safety also positions the recipients of care as those best able to judge whether the service they have received is culturally safe (Ramsden, 2015). Of central importance is that cultural safety extends past just that of the individual, with researchers arguing there is evidence clearly highlighting the critical role played by health care services in creating culturally safe environments (Curtis et al., 2019). Cultural safety recognises that services must move beyond being 'culturally appropriate', understanding that if services are delivered inadequately, the service delivery method can in itself become a negative determinant of health outcomes. In this way, pathways to cultural safety which will impact inequity most effectively are those collectively directed toward the individual health workforce, healthcare organisations, and the wider systems in which those individuals and organisations exist (Curtis et al., 2019).

The inward focus of cultural safety on confronting one's own personal culture, bias and power often requires a significant paradigm shift for many. Unsurprisingly, the concept and process of cultural safety is therefore often seen and experienced as being more confronting and challenging for health organisations, professionals, and students than that of a technical competency acquisition approach (Baker & Levy, 2013). Questions can be raised regarding why, despite individuals and organisations having genuine insight and motivations to change, long lasting transformative outcomes do not result. Of importance is the need for a dual approach in which re-Indigenising occurs alongside processes of anti-colonialism which are focused on explicitly exposing barriers, illuminating injustice and clearing pathways forward (Tina Ngata, 2021, personal communication, 1 October). Such barriers include understanding the role played by self-preservation and 'colonial compulsion' when people are asked to dismantle those systems which in reality accord them the most privilege and benefit (Tina Ngata, 2021, personal communication, 1 October).

Further evolving since being first introduced, effective cultural safety training is considered to be:
- focused on achieving health equity, with progress towards this endpoint able to be measured;
- centred on clearly explained concepts of cultural safety and critical consciousness as opposed to narrow conceptualisations of cultural competency;
- focused on application within systemic and organisational contexts in addition to the individual provider-whānau interface;
- framed as requiring a focus on power relationships and inequities within health care interactions that reflect historical and social dynamics; and
- aligned across all training and practice environments, systems, structures, and policies, as opposed to limited to formal training curricula. (Curtis et al., 2019)

Alongside the focus on cultural safety, it has also long been argued that significantly more attention and resources need to be prioritised for growing the Indigenous health workforce (Health & Disability System Review, 2020; Government Inquiry into Mental Health & Addiction, 2018; Baker & Levy, 2013). Mental health training systems grounded in the dominant biomedical paradigm not only fail to prioritise increasing the mātauranga Māori health workforce, they can produce the exact opposite outcome. Many studies identify the

extent to which Māori come under pressure to compromise cultural values and identity in order to succeed within mainstream mental health-related training programs, a serious consequence of which is a loss of confidence in the validity of Kaupapa Māori processes and models (Elder, 2008; Levy, 2007; Love, 2008; Milne, 2005; Wilson, McKinney, & Rapata-Hanning, 2011). Of importance is that whilst all medical disciplines are challenged by a need to decolonise their training and curriculums, psychiatry and psychology face issues that challenge the very core of its identity, specifically in terms of their reliance on the biomedical technological paradigm of mental illness and disorder (Kopua, 2020).

Māori voice to the 2018 Government Inquiry into Mental Health & Addiction emphasised the need for investment in education and employment pathways that amplify Indigenous intelligence across all health systems (Russell et al., 2018). Such pathways would explicitly include a focus on Indigenising spaces and practice, and creating environments in which there is freedom to be proactively Māori (Russell et al., 2018). Culturally safe learning environments, such as wānanga, and noho, which strengthen and support one's identity as Māori by providing access to Māori world views, language and ways of knowing are recognised as essential to health workforce development, learning and ongoing professional development (Hopkirk, 2010; Levy, 2007; Robertson, Haitana, Pitama, & Huriwai, 2006; Sheehan & Jansen, 2006; Wilson et al., 2011).

3.0 Te Whare Wānanga o Te Kurahuna: Transformation in Action

The pūrākau of Mataora, tells the story of an ariki (high chief) who had believed he was not accountable to anybody. However, guided by the love he had for his wife, Niwareka, Mataora became a kaitiaki for changing attitudes, beliefs and behaviour; firstly his own and then actively influencing changes in those around him (Kopua & Kopua, 2021; Te Whare Wānanga o Te Kurahuna, 2021). As demonstrated in Part One, the evidence is clear: addressing institutional racism lies at the heart of the transformation required to address engrained systemic inequity for Māori. Te Whare Wānanga o Te Kurahuna is a precious source of knowledge steeped in traditional practises consistent with a Maori worldview. Te Kurahuna is the kaitiaki of Mahi a Atua: a 'way of being' which privileges Indigenous knowledge and practice as the basis for strengthening best practice, addressing institutional racism and realising equitable outcomes for Māori (Rangihuna, Kopua, & Tipene-Leach, 2018b; Te Whare Wānanga o Te Kurahuna, 2021). Guided by the knowledge embedded in the pūrākau of Mataora, Te Kurahuna understands genuinely addressing equity for Māori requires an uniquely transformative Indigenous workforce development approach.

Te Kurahuna and Mahi a Atua encompass significantly more than that of a cultural competency approach or culturally appropriate service model focused solely on individual change. As a deliberate multi-level response, Te Kurahuna training is grounded on the premise that systemic institutional racism can be addressed by a collective consciousness on the part of both Māori and non-Māori. Fully aligned with the underpinning principles of cultural safety, Te Kurahuna understands movement to critical consciousness as an ongoing process of examining structural variables such as power, social justice and equity, alongside active critical self-reflection and assessment of the privilege and bias of health practitioners. This includes one's own contribution to institutional racism, particularly for those trained within dominant biomedical paradigms which serve to support and sustain ingrained systemic racism (Te Whare Wānanga o Te Kurahuna, 2021). In this way, Te Kurahuna contributes to

what Tina Ngata describes as 'healing of the system, healing of practitioners, and healing of those who wield power' (Tina Ngata, 2021, personal communication, 1 October).

Of importance is that cultural safety critical theory goes beyond that of the individual, with evidence highlighting the central role played by health care services in creating culturally safe environments (Curtis et al., 2020). Te Kurahuna understands that pathways to cultural safety which are able to impact inequity most effectively are those directed toward the health workforce, healthcare organisations, and the wider systems in which those workforces and organisations exist. Te Kurahuna seeks change at both the individual and systems level, aspiring to create a collective consciousness which results in a critical mass of Mataora; a workforce of 'change agents', able to influence and embed sustainable transformative change (Te Whare Wānanga o Te Kurahuna, 2021). It is this aspiration for collective consciousness, and the recognition of the collective power of individuals to effect systemic change across systems, that differentiates Te Kurahuna and Mahi a Atua from other culturally derived therapies or competency programmes.

At an individual level, Te Kurahuna and Mahi a Atua emphasise being accountable for one's own actions, with institutional racism firstly addressed by Mataora actively reinstating, embedding, and practicing Indigenous knowledge across every element of their personal and professional spaces(Te Kurahuna Ltd, 2019). At a systems level, Te Kurahuna optimises collective workforce capacity and effectiveness by validating and maintaining mātauranga Māori knowledge and practices, alongside developing a collective confidence to change service environments by supporting the application of Indigenous knowledge and practice in service delivery to whānau (Te Kurahuna Ltd, 2019). Comprising more than a static model, framework, or intervention, Mataora trained in Mahi a Atua wānanga not only become competent in the therapeutic application of Indigenous narratives, they are also equipped with innovative ways of operationalising this knowledge within their workplaces, with this in turn providing a tangible pathway by which to effectively address institutional racism (Tipene-Leach et al., 2019).

As the kaitiaki of Mahi a Atua, Te Kurahuna specialises in both the initial training, and the ongoing professional and personal development of the Mataora workforce. Consistent with the concept that collective consciousness produces systemic change, the development of a Mataora workforce is not discipline, profession, sector or role specific. Nor is Mahi a Atua training and practice limited to Māori only. Mahi a Atua wānanga reach across the community, recognising that anyone has the potential to be an agent of change (Te Kurahuna Ltd, 2019). This includes: the regulated clinical workforce such as general practitioners, psychiatrists, psychologists, counsellors, nurses, social workers, occupational therapists, and midwives; the non-regulated health workforce such as cultural advisors, community and peer support workers; as well as managers, administrators, educators, artists, and whānau members - anyone wishing to become part of a transformative collective consciousness to address institutional racism is welcomed by Te Kurahuna (Rangihuna et al., 2018a). The potential of Te Kurahuna to actively inform transformative change well beyond the health sector, across for example education, justice and social services has been recognised (Hamilton, 2020; OECD, 2018).

3.1 Te Kurahuna: Shifting the Paradigm

Fundamental to Te Kurahuna achieving its aspiration of growing a collective consciousness able to shift institutional racism and effect transformative systemic change is a paradigm shift. Māori health providers and communities have a long history of innovation: the past 40 years have seen the incorporation of mātauranga Māori into health service delivery; an increase in Kaupapa Māori services and the use of Indigenous models and healing practices; alongside Māori workforce development and leadership strategies (Health & Disability System Review, 2019). However, none of these innovations have focused on transforming the wider systems underpinning healthcare service delivery in Aotearoa (Rangihuna et al., 2018a). As was identified by the HDSR (2020), improving equity and wellbeing for Māori requires urgent improvements in the way the system in its entirety delivers for Māori. However, genuine transformation which is centred on enhanced rangatiratanga and mana motuhake requires more than just the addition of more Kaupapa Māori services. The overwhelming message provided to the 2018 Government Inquiry into Mental Health & Addiction was a new approach to mental health and addiction in Aotearoa was needed (Government Inquiry into Mental Health & Addiction, 2018; Russell et al., 2018).

Aligned with Kaupapa Māori, whānau ora and cultural safety theory, Te Kurahuna draws on the work of the British Psychological Society (BPS) who through their 'Power Threat Meaning Framework' provide 'an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, as an alternative to psychiatric classification and diagnoses system' (Johnstone & Boyle, 2018, p5); and the position statement from the BPS Division of Clinical Psychology which calls for a paradigm shift in relation to the classification of behaviour and experience in relation to functional psychiatric diagnoses (British Psychological Society, 2013). Three core issues are of central concern for Te Kurahuna: the psychiatric classification system; impact on whānau; and impact on society. Central to the training provided by Te Kurahuna is that dominant disease-focused psychiatric classification systems continue to minimise psychosocial causal factors, in the process concealing links between people's experiences, distress and behaviour, and their social, cultural, familial and personal historical context (Te Whare Wānanga o Te Kurahuna, 2021).

Whilst not denying biological understandings of distress and experiences, Te Kurahuna emphasises the evidence which shows current classification systems which have originated from and are embedded within Western worldviews, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM, and International Statistical Classification of Diseases (ICD), are not reliable, valid or generalisable, nor do they expand understandings of how human beings relate to their wider environment (Te Whare Wānanga o Te Kurahuna, 2021). Conversely, the evidence indicates how such systems are in reality discriminatory to a diverse range of groups, overlooking key elements such as ethnicity, sexuality, gender, class, spirituality and culture (Timimi, 2013). Not only are there limitations in the utility of a diagnostically driven model for purposes such as determining interventions, developing treatment guidelines, and commissioning services and research, the evidence also demonstrates the diagnostic model is over-reliant on psychiatric medications, whilst at the same time minimising the serious physical and psychological effects of those medications (Te Whare Wānanga o Te Kurahuna, 2021).

In addressing the paradigm change necessary, Te Kurahuna specifically focuses on ensuring Mataora are deliberate in the language used. Central to this is that where possible, the use of diagnostic language in relation to functional psychiatric presentations is avoided; terms that assume a diagnostic or narrow biomedical perspective are replaced with ordinary language equivalents; and in situations where the use of diagnostic-related terminology is difficult to avoid, awareness of the problematic and contested nature of the diagnostic model is made explicit. For example, the term 'mental illness' is replaced with distress-focused terms, such as emotional, mental or psychological distress, and language which attempts to describe behaviour and experience in non-medical terms, and within personal, interpersonal, social and cultural contexts is used (Te Whare Wānanga o Te Kurahuna, 2021). As emphasised by the 2018 Government Inquiry into Mental Health & Addiction, the concept of 'distress' is able to encompass those who are severely distressed, through to those reacting 'normally' in response to stressful situations.

Central to the paradigm shift required if inequities for Māori are to be eliminated is a critique of the power relations responsible for the deliberate and systemic marginalisation of mātauranga Māori and the resulting inequitable outcomes for Māori communities (Te Whare Wānanga o Te Kurahuna, 2021). Consistent with transformative Kaupapa Māori theory, the priority given to Indigenising spaces recognises that these spaces, both physical and mental, have been dominated by a colonised world view which has, and continues to, deliberately exclude and delegitimise Indigenous world views and knowledge (Kopua et al., 2020). The prioritising of mātauranga Māori does not abandon western approaches. By facilitating movement away from solely using Western ideology to categorise distress, and moving instead towards the elevation of other principles such as relationships, a quicker, more connected response is enabled, as opposed to one which essentially serves to disempower whānau and communities (Kopua, 2019). Te Kurahuna training emphasises the 'myth of meritocracy' which argues against the assertion that achievement results only from individual capability and merit. The individual focus of meritocracy results in individuality being promoted above collective responsibility and care, with Te Kurahuna recognising that systemic change entails the workforce understand ways in which historical factors have contributed to structuring opportunity that in turn unfairly disadvantage Māori (Te Whare Wānanga o Te Kurahuna, 2021). An understanding of those factors then needs to be woven into therapeutic relationships with whānau, with a critical component of the paradigm shift sought by Te Kurahuna being whānau awareness of the wider context in which their distress is positioned is deliberately enhanced.

Alongside the strong call for a transformative paradigm shift in mental health and wellbeing, Māori voices to the 2018 Government Inquiry into Mental Health & Addiction emphasised the foundations for such transformation already existed: whānau ora (Russell et al., 2018). Maori voices have been asserting for decades that if inequity for Māori is to be addressed, whānau must be placed at the centre (Boulton et al., 2020). Of importance is that not only are whānau seen as holding untapped potential for change, but as they are supported to move beyond situations where they have been rendered overwhelmed, diminished and powerless, whānau themselves become the central agents of that change (Russell et al., 2018). Fundamental to the widely evidenced success of whānau ora and culturally anchored whānau-centred practice is that whānau capacity is enhanced via building on whānau strengths; issues of most importance to whānau are concentrated on; and intergenerational

and enduring outcomes are supported (Boulton, Cvitanovic, Potaka-Osborne et al., 2018; Kaiwai et al., 2020; Smith et al., 2019).

Consistent with whānau ora and whānau-centred practice, Te Kurahuna positions whānau voices at the centre. Acting as a barrier to whānau actively making choices about their own pathways forward, dominant diagnostic classification systems position whānau as dependent on expert advice and 'treatment', with decisions about how to classify a person's behaviour and experience routinely imposed as an objective fact, as opposed to being shared in transparent and open ways (Timimi, 2013). Whānau often emphasise the crucial significance of the practical, material, interpersonal and social aspects of their experiences; elements which are primarily perceived of as minor in current psychiatric classification systems (Beresford, 2002). Any whānau disagreement with a diagnostic classification can lead to labels, such as 'lacking insight', without any acknowledgement of the limitations of the classification system itself (Te Whare Wānanga o Te Kurahuna, 2021).

Te Kurahuna is acutely aware that comprehensive, ongoing training and professional development opportunities which provide opportunities to critically reflect on the professional and systemic factors perpetuating inequities for Māori are severely lacking. Alongside this is the reality that those who wish to work from an Indigenous worldview have struggled to detach themselves from the restrictions inherent in the dominant Western biomedical service delivery paradigm (Kopua & Kopua, 2021). Such is the dominance of the biomedical paradigm, Te Kurahuna training often requires a fundamental shift for participants in orientation and practice, particularly for those trained within mainstream institutions (Kopua & Kopua, 2021). Related to this, Te Kurahuna understands the wide diversity, particularly among clinicians, of comfort and confidence levels in terms of utilising mātauranga Māori based interventions and methodologies (Kopua & Kopua, 2021). As stated earlier, consistent with the underpinning principles of cultural safety, movement to critical consciousness is an ongoing and often challenging process of active critical self-reflection about one's own contribution to institutional racism (Curtis et al., 2019). Reflecting the centrality of this to how Mataora practice, Te Kurahuna has a core focus on growing a curiosity about racism, understanding responses to discussions about racism, and exploring the impacts of racism on Indigenous wellbeing. Relevant pūrākau are specifically utilised as an Indigenous resource which supports reflection in relation to one's own position regarding racism, as well as creating possibilities to actively address racism (Te Whare Wānanga o Te Kurahuna, 2021).

The on-going exploration of pūrākau across Te Kurahuna wānanga is deliberately focused on supporting the workforce to become culturally connected, confident and empowered to lead and utilise Māori models of practice, alongside growing an awareness of their individual and collective responsibility as Mataora, change agents (Kopua, 2019). As with reflective discussions regarding racism, an intentional process of wānanga and ongoing professional development opportunities, which give time and space for meaningful reflection and growth is essential. The initial exposure to learning about Mahi a Atua often triggers a desire by wānanga participants to learn more and more (Kopua, 2019).

Implicit within the focus on wānanga as the primary training mechanism for Te Kurahuna is acknowledgement that such opportunities are rare or non-existent across existing health

workforce training programmes (Kopua, 2019). This underscores the importance of Te Kurahuna being independent from mainstream training institutions, many of whom have been extremely resistant to critiquing the racism inherent within their own curricula (Tipene-Leach et al., 2019). Such resistance is well-evidenced as a barrier significantly impacting on workforce demographics, with this in turn contributing to the ongoing and worsening systemic inequity across the health workforce (HDSR, 2020).

3.2 Mahi a Atua: Walking in the Footsteps of our Ancestors

First created in the 1990's, Mahi a Atua originated as a way of meaningfully engaging with Māori whānau. In 2014, evolving beyond solely that of a therapeutic practice, Mahi a Atua, in explicitly referencing the direct connection between institutional racism and inequity for Māori, began to focus more specifically on the creation of intentional pathways of systemic transformation across DHBs, health providers, iwi, education, social, and art sectors; and the wider community (Kopua & Kopua, 2021; Te Kurahuna Ltd, 2019).

A 'way of being', as opposed to a therapy or technique (Kopua et al., 2020), Mahi a Atua focuses on reinstating and embedding Indigenous knowledge systems which then lays the foundations for deliberate and intentional systemic transformation (Te Kurahuna Ltd, 2019). Grounded in Indigenous ontology and epistemology, Mahi a Atua is founded on 'He Oranga Whakapapa' which acknowledges everything has an origin that can be traced back to these pūrākau (Te Whare Wānanga o Te Kurahuna, 2021). Operationalised with whānau in a wānanga process, the pūrākau provide snapshots of 'mental states of being' and 'responses to distress and dis-ease' as illustrated by the archetypal characters of the Atua Māori (Rangihuna et al., 2018a). Whilst pūrākau versions vary depending on which Iwi, community or individuals are sharing the story, generic elements across the stories are able to demonstrate not only the spectrum of family and social issues faced by our earliest ancestors, but also the strength and resilience of the Atua as they made sense of their realities, re-balanced, overcame struggles, and enacted pathways to resolution and well-being (Rangihuna et al., 2018a, 2018b). The messages held within these Indigenous knowledge forms inspire those working with them to reclaim their voices in order to act in ways that will result in positive outcomes for whaiora (service users), their whānau, clinicians, institutions and communities (Kopua & Kopua, 2021).

Te Kurahuna Mahi a Atua training is founded upon three matapono (principles): Tenei te pō, nau mai te ao (Indigenise your Spaces); Ka mā te ariki ka mā te tauira (Remain an Active Learner); Hongihongi te wheiwheiā (Embrace Negative Feedback) (Te Whare Wānanga o Te Kurahuna, 2021). It is through the daily application of these Mahi a Atua principles that Iwi, communities, providers, and workforces are able to collectively rethink and find ways out of dominant prescribed narratives, thus providing pathways to transformative solutions genuinely able to improve equity for Māori (Kopua & Kopua, 2021).

3.2.1 Tēnei te Pō, Nau mai te Ao: Coming in from the dark, welcoming the light

At the heart of Mahi A Atua is Ko wai au? Who am I? Connected with pre-European knowledge and traditions such as pūrākau orokohanga (creation stories) of the Atua Māori; karakia tawhito (ancient rituals); tikanga Māori (customary Māori protocols); and whakapapa (genealogy/history), an authentic connection to Indigenous knowledge is at the heart of the Mahi a Atua process. With its conceptual translation of 'Indigenise your space', this principle

originates from a karakia used in Te Kurahuna, *Tēnei te Pō, Nau mai te Ao,* and drives the objective of introducing mātauranga Māori into one's daily personal and professional life, rethinking one's usual way of being (Kopua & Kopua, 2021; Te Whare Wānanga o Te Kurahuna, 2021).

Mataora are trained to embed Mahi a Atua principles in their lives as they prioritise oranga whakapapa (bringing our stories to life), and share pūrākau via the many different mediums available (Te Whare Wānanga o Te Kurahuna, 2021). Carefully selected pūrākau are introduced in wānanga, with whaiora and their whānau contributing to the pūrākau as they are able (Rangihuna et al., 2018b). Using a range of tools such as words, images, and narratives, whānau in distress are creatively supported to reconnect and build a relationship with the pūrākau and their own stories. In this way pūrākau are utilised as a way to frame, analyse, and discuss modern situations, with whānau gaining an understanding of the characteristics, roles and responsibilities of the various Atua. This in turn facilitates a shift in perspective, thinking, understanding, and ultimately healing for whānau (Kopua, 2019; Rangihuna et al., 2018b).

Reflecting the broad applicability and accessibility of Mahi a Atua, the ability to access this culturally located frame of reference is not reliant on familiarity with mātauranga Māori. Te Kurahuna recognises there are many versions of pūrākau which can be discussed, ranging from a simplified account to more detailed descriptions of roles, responsibilities and relationships of the many Atua. In this way, those with greater access to traditional knowledge are supported to grow their knowledge, whilst those who are less connected to their Indigenous identity are supported to develop stronger cultural connections (Kopua, 2019). Mahi a Atua wānanga also incorporate access to traditional healing strategies not previously accessible to whānau within the health system. Directly connected to specific pūrākau and Atua, these strategies include rituals such as kumara burial ceremonies, water cleansing ceremonies, and moko.

3.2.2 Ka mā te ariki, ka mā te tauira: As the teacher is enlightened, so is the student

Taken from another Te Kurahuna karakia, the principle of *ka mā te ariki, ka mā te tauira* privileges Indigenous ways of learning, ensuring there is a focus on developing active learners who are open to other perspectives. In this way, consistent with the fundamental principles of cultural safety, change and accountability is firstly located within oneself (Te Whare Wānanga o Te Kurahuna, 2021).

The process of wānanga, a ''taonga tuku iho'' (gift from the past) is central to Mahi a Atua (Kopua et al., 2020). Because Mahi a Atua is connected to whakapapa, relationally Mahi a Atua belongs to both the Māori clinician and whānau (Kopua, 2019). Forming the basis of therapeutic contact and purposefully used at every stage of the whānau journey towards wellbeing, Mahi a Atua wānanga are a deliberate process of coming together which recognises that gaining clarity about future directions requires a strong connection to the past, whilst staying present in the moment (Kopua et al., 2020). Mahi a Atua wānanga are facilitated by an 'Ue'; a multi-disciplinary team who, depending on the specific needs of the whānau, may include those with mental health backgrounds such as clinical specialists, social workers, advocacy-support workers, cultural advisors and tohunga, as well as those outside of the mental health system, such as artists (Rangihuna et al., 2018a).

Reflecting the paradigm shift away from the biomedical diagnostic model, the deliberate multi-disciplinary lens of the Ue operates from a narrative orientation which prioritises working collectively to explore the socio-cultural contexts in which issues reside, as opposed to focusing on identifying internal deficit or dysfunction (Rangihuna et al., 2018a). Pūrākau act as a frame of reference, providing whaiora and whānau the opportunity to externalise an issue or situation, and by looking through a different lens, contextualise, organise, and communicate a problem within the context of their own reality and what matters most to them (Kopua & Kopua, 2021). This principle of 'active learning' encourages practitioners to be responsive to whānau and the community (Rangihuna et al., 2018b). With whānau assisted to develop meaningful responses to distress and dis-ease in this way, the 'diagnosis' and the psychiatric format becomes somewhat secondary to the process of privileging and reinstating the Te Ao Māori voice and finding culturally relevant meaning (Rangihuna et al., 2018a).

Mahi a Atua wānanga emphasise āta whakarongo (active listening), kōrero (discussion), co-creativity, and reflective communication in order to weave together the many points of view about their distress and create new shared understandings in which everyone contributes important threads (Tipene-Leach et al., 2019). From this orientation, the many voices within the whānau, including those who are silent, less vocal, hesitant, bewildered, or difficult to understand, are brought forward and offered a space of recognition and validation. In taking this approach, the Mahi a Atua wānanga process explicitly recognises the collective nature of distress (Kopua et al., 2020; Tipene-Leach et al., 2019). With whānau positioned as the experts of their own experiences, Mataora learn to be active participants in a process of sharing aspirations, with both parties giving and accepting koha within the relationship (Te Whare Wānanga o Te Kurahuna, 2021).

Walking in the footsteps of our ancestors is not a rigid prescription (Kopua & Kopua, 2021). Because the nature of distress for each whānau is different, no conclusions are drawn prior to wānanga (Kopua et al., 2020). Mataora listen for information and clues around the whānau connection to pūrākau. Again guided by the underpinning principles of whānau ora and whānau-centred practice, it is assumed that strengths will always be present within whānau, even in times of distress, and that whānau are more likely to find, draw upon and mobilise their own resources and strengths when pre-planned therapeutic interventions are absent. Without reference to an internalised deficit model, the emphasis within the Mahi a Atua wānanga process is on finding meanings which can create a shift in awareness and perspective, both individually and collectively (Kopua et al., 2020; Rangihuna et al., 2018a). Integral to the wānanga process is that reflective talk can assist in tolerating uncertainty, and when uncertainty is shared it can lead to being together differently. This in turn provides a space for whaiora and whānau to explore culturally and spiritually acceptable pathways of resolution, many of which can be found in everyday life practices and events (Kopua & Kopua, 2021; Kopua et al., 2020; Rangihuna et al., 2018a).

Huaki Pouri is an alternative Indigenous approach to Multi-Disciplinary Team (MDT) meetings. MDTs, positioned as the central organisational and service delivery model for community mental health services, are premised upon an inherent assumption that they improve quality of care by incorporating diverse professional perspectives into care planning. However, MDTs are also perceived of as being poorly managed and lacking in clarity and purpose. Premised

upon the principle of always remaining an active learner, Huaki Pouri is an Indigenous derived conceptual term indicating flexible thinking which derives from our pūrākau orokohanga. Meeting weekly in Huaki Pouri facilitates teamwork and collective thinking, allowing Mataora to both share information as well as seek diverse input, in the form of 'koha wonderings' from colleagues. Mataora are liberated via the use of this Indigenous system as they work towards addressing issues at systemic, practitioner and whānau levels (Te Whare Wānanga o Te Kurahuna, 2021).

3.2.3 Hongihongi te wheiwheiā: Inhale the unusual

Integral to Te Kurahuna Mahi a Atua training is embracing a culture of feedback, with *hongihongi te wheiwheiā* emphasising the importance of a workforce who always strive to understand how to do better. With outcomes for whaiora and whānau positioned as the most important factor in Mahi a Atua wānanga, Te Kurahuna emphasises the importance of developing a culture of feedback individually, collectively, and organisationally. Directly informed by Hinekauorohia, the Atua of healing and reflection, Mataora are trained in the practice of constantly seeking feedback from whānau and colleagues regarding their performance (Te Whare Wānanga o Te Kurahuna, 2021).

The principle of hongihongi te wheiwheiā operationalises transparency, openness and inclusivity which ensures whānau are fully involved in both interpretations of their experience and recommendations for pathways going forward (Tipene-Leach et al., 2019). Positioning whānau are the valued experts of their own experience, alongside growing a culture of feedback, empowers Mataora to remain curious, imaginative and deliberate in their practice. Of importance is that the process of changing behaviour in response to feedback requires that Mataora remain open and responsive, especially to feedback which may be negative (Te Whare Wānanga o Te Kurahuna, 2021). Reflecting the interconnectedness of the Mahi a Atua matapono, intertwined with embracing negative feedback is the concept of 'failing successfully', that is, the need to continuously remain an active learner (Te Whare Wānanga o Te Kurahuna, 2021).

Most decisions about outcomes in mental health have been based on practitioner-centred tools, for example the Health of the Nation Outcome Scales (HoNOS). A core element of operationalising hongihongi te wheiwheiā is training in the routine use of Feedback Informed Treatment (FIT). Emphasising the critical importance of practice-based evidence to support ongoing evaluation, the FIT model, an essential element of Te Kurahuna training, places service effectiveness as judged by the individual and their whānau at the centre. Originally developed by Scott Miller and Barry Duncan, and supported by a virtual centre of excellence, FIT provides a valid and reliable measure of alliance and outcome, as well as an effective framework by which to enhance collective potential, as Mataora gather information and constructively critique in real time whether their practice is having a positive impact on the people they are working with (Te Whare Wānanga o Te Kurahuna, 2021; Tipene-Leach et al., 2019).

Actively engaging in the FIT process requires Mataora remain active learners, also learning how to value feedback, and if required, respond and make necessary changes to improve practice and performance. FIT supervision, in which Mataora and supervisors reflect, review, and explore new ideas and methods, including the provision of resources (e.g. assigning

articles or manuals to read, providing training and practice of FIT concepts), ensures that data is centrally positioned when discussing any case , thus ensuring the whānau voice drives service delivery (Te Whare Wānanga o Te Kurahuna, 2021. The FIT process is supported by platforms able to store real-time data (e.g. MyOutcomes) which assists practitioners predict the plan of action for each whānau, as well as make critical adjustments to these plans when needed (Te Whare Wānanga o Te Kurahuna, 2021; Tipene-Leach et al., 2019).

At a higher level, Mataora are continually monitoring for factors that facilitate or act as barriers toward achieving health equity for Māori, thus promoting a culture of organisational feedback. The importance of promoting systemic change by responding positively to feedback received from all stakeholders within the community is emphasised (Te Whare Wānanga o Te Kurahuna, 2021). Viewed more broadly in terms of its contribution to wider systemic transformation, FIT also serves to develop, grow and embed an organisational culture of routine evidence-based evaluation of practice quality, effectiveness and ongoing learning (Tipene-Leach et al., 2019).

Assumptions about the level of knowledge required to engage in Mahi a Atua training have for some operated as a barrier to engagement (Hamilton, 2020; Kopua & Kopua, 2021). Incorporating principles of active learning and real-time feedback in Te Kurahuna training has assisted to address this. For example, confidence is developed by injecting pūrākau into as many sessions as possible. When individuals are confidently utilising Mahi a Atua regardless of their level of knowledge, it is usually because they have realised that remaining active in learning is a positive way of engaging whānau (Kopua & Kopua, 2021). Both Mahi a Atua principles of remaining an active learner and embracing a culture of feedback embrace foundational elements of cultural safety. Genuinely positioning whaiora and whānau outcomes as the most important factor in Mahi a Atua wānanga is understood to be challenging, both individually and organisationally (Tipene-Leach et al., 2019). Reflective of this, Te Kurahuna estimates it can take at least three years for an organisation to develop a culture of feedback (Te Kurahuna Ltd, 2021).

3.3 Operationalising Mahi a Atua

Mahi a Atua has been operationalised across a range of settings. Most prominent has been the development and implementation of Te Kūwatawata. Te Kūwatawata is named after the Atua who stood in a transitional space between the physical and spiritual worlds, providing guidance for those seeking entrance to the Māori spirit world (Rarohenga) (Rangihuna et al., 2018b; Te Whare Wānanga o Te Kurahuna, 2021). Described as a revolutionary first for mental health services in Aotearoa, Te Kūwatawata was first developed in 2017 as a primary and secondary mental health service partnership that would enable a Māori-resonant and responsive Single Point of Entry (SPoE) to mental health services in Tairāwhiti (Tipene-Leach et al., 2019). Successively introduced to the Hauraki region in 2020, Te Kūwatawata recognises that addressing systemic institutional racism requires organisations focus on factors which contribute to inequity. The 'waharoa', space where those seeking wellness are first welcomed, is historically understood as a barrier where strict access criteria and unfriendly approaches have contributed to service inaccessibility (Te Whare Wānanga o Te Kurahuna, 2021). Given change at the entry point is essential to realising overall systemic change and improving equity outcomes, Te Kūwatawata is intentionally positioned as a SPoE, promoting guardianship of both physical and spiritual wellbeing to provide a gateway for

whānau in distress to walk through and receive help and support, irrespective of the level of that distress (Te Whare Wānanga o Te Kurahuna, 2021).

Moving beyond the traditional goals of a SPoE, such as reducing fragmentation, and increasing service integration (Cumming, 2011), to explicitly focus on addressing inequity, Te Kūwatawata committed to the reinstatement of an Indigenous paradigm via Mahi a Atua, and the development and growth of a Mataora workforce. Within this context, Te Kūwatawata courageously positions itself as a 'by Māori for all' SPoE, removing all access criteria to provide an immediate response, and offering a range of Indigenous-led services, including a 'service as usual' pathway, to meet the self-determined needs of whānau (Rangihuna et al., 2018b; Tipene-Leach et al., 2019).

Directly originating from the principles and values of Te Kurahuna and Mahi a Atua, seven principles characterise the way in which Te Kūwatawata operates: immediate response; a whānau network perspective; flexibility and adaptability; responsibility; continuity; tolerance of uncertainty; and wānanga (Te Whare Wānanga o Te Kurahuna, 2021). Mahi a Atua matapono are explicitly activated, with Te Kūwatawata supported by 'live' service overview and operations manuals which incorporate comprehensive guidance regarding both the conceptual orientation and practical implementation of Mahi a Atua principles, processes, and procedures (Te Whare Wānanga o Te Kurahuna, 2021). Descriptions of key processes, roles and responsibilities are also detailed in these manuals. This includes: the Matataki process which ensures whānau receive the best start possible; the Eke process which ensures uncertainty, risk and safety are immediately and collectively explored and solved; and the use of Ue, therapeutic teams of Mataora who operationalise the principles of Te Kurahuna, Mahi a Atua, and Te Kūwatawata as they work collectively with whānau. Providing guidance to practitioners, managers, funders, evaluators and whānau regarding service delivery, the policies and systems within these manuals are, like the Atua, in a process of constant change and improvement (Te Whare Wānanga o Te Kurahuna, 2021).

Although Te Kurahuna has thus far primarily focused its training within mental health settings, the growing number of Maori and non-Maori clinicians, practitioners, and kaimahi across wider health, education, justice and other social service sectors, who have undertaken Mahi a Atua training attests to a growing demand for a workforce able to address institutional racism via a mātauranga Māori, whānau ora and whānau-centred practice base (Kopua & Kopua, 2021).

3.3.1 Te Kūwatawata ki Tairāwhiti

Established in September 2017, Te Kūwatawata ki Tairāwhiti was a SPoE for both primary and secondary mental health care in Gisborne. Specifically designed to meet the needs of the Gisborne community, where Māori make up half the total population and two thirds of those using mental health services, Te Kūwatawata ki Tairāwhiti was Hauora Tairāwhiti's bold attempt to address institutional racism within mental health services in the region (Tipene-Leach et al., 2019). Te Kūwatawata ki Tairāwhiti was intended as a partnership of the Hauora Tairāwhiti (DHB) secondary service, Pinnacle Midlands Health Network PHO, and the community-based NGO, Te Kupenga Net Peer Support and Advocacy Trust. Funded via the Ministry of Health's 'Fit for Future - A Systems Approach' programme, Te Kūwatawata commenced on 1 September, 2017, with funding subsequently extended until June 2019.

Te Kūwatawata ki Tairāwhiti Mataora included psychiatrists, psychiatric nurses, counsellors/therapists, support workers, social workers, general practitioners, tohunga, managers, administrators, and researchers. These staff were supported by art graduates from Toihoukura, the local School of Māori Arts; a specialist Mataora workforce who brought diverse experiences of mātauranga Māori, local community connections and a visually creative means by which to generate kōrero and reflection with whānau. The deployment of this multi-disciplinary Ue provided a range of expertise with a broad skill base which could be called upon when working with whānau (Tipene-Leach et al., 2019).

3.3.2 Te Kūwatawata ki Hauraki: Hauraki Nation is a Healthy Nation.
Operating under the Hauraki Māori Trust Board, Te Korowai Hauora o Hauraki (TKHoH) was established in 1994. Like many other Iwi or Kaupapa Māori organisations, TKHoH manages multiple contracts and service specifications from the Ministry of Health, DHBs and other agencies. Varied reporting requirements focused on volumes and service utilisation, as opposed to outcomes or equity measures, and mental health and addiction silos were evident as clinicians worked in isolation across separate services for children, young people and whānau. The majority of referrals to TKHoH mental health and addiction services came via general practitioners, however there were minimal self-referrals and low referrals for Māori. In addition, there were multiple service entry criteria, referral and waitlist management processes; lengthy wait times; clients were seen individually; issues, assessments and care plans were framed within a Western biomedical paradigm; and multi-disciplinary reviews occurred in the absence of whānau voices (Ngamane-Harding, 2021).

Although termed 'Kaupapa Māori', in reality TKHoH mental health and addictions team struggled to provide a Kaupapa Māori mental health and addictions service, instead delivering what was essentially a mainstream service governed by a Māori organisation. Acknowledging that these services were in fact perpetuating institutional racism, even when operating under the name of 'Kaupapa Māori', and encouraged by the equity outcomes demonstrated by Te Kūwatawata ki Tairāwhiti, the introduction of Te Kurahuna Mahi a Atua training was a deliberate effort by Riana Manuel, Manukura (CEO) of TKHoH, to socialise a 'new way of being': 'Hauraki as a healthy nation'. Reflecting Te Kurahuna and Mahi a Atua principles, this new way of being privileged mātauranga Māori, whānau outcome measurement, and a culture of feedback able to support the development of practice-based evidence (Te Kurahuna Ltd, 2021). Alongside the introduction of Mahi a Atua, TKHoH were supported to continuously reflect on how they maintained institutional racism, thus ensuring Indigenous knowledge systems were actively prioritised, and enhanced outcomes for whānau facilitated (Te Kurahuna Ltd, 2021).

In February 2020, TKHoH in collaboration with Te Kurahuna, commenced a system and service re-design, with the aim of gradually transitioning the existing mental health and addictions service from a western dominated paradigm to a system built upon an Indigenous framework. Socialising concepts prior to the introduction of substantial change was the focus of a series of initial wānanga facilitated by Te Kurahuna, with TKHoH leadership first attending wānanga in Tūranganui-a-Kiwa, followed by a two-day wānanga in Manaia. A further two day wānanga, open to 50 attendees from different organisations, was subsequently held, during which five Mataora were trained.

With the arrival of COVID-19 in March 2020, what was originally intended as a six-month project, rapidly changed. Providing the catalyst for immediate action, the swiftly changing landscape necessitated a re-imagining, particularly in relation to how Mahi a Atua could be implemented in an environment where face to face contact was severely restricted. Within two weeks Te Kurahuna had supported TKHoH to install the systems necessary to operationalise Mahi a Atua. Renamed Te Kūwatawata ki Hauraki, an immediate response hotline was established and widely promoted for whānau in distress, irrespective of the level or nature of that distress, or the presence or absence of any psychiatric diagnosis. Changes were made to call flow systems; Ue formation and roster systems were created to facilitate timely virtual responses; a Matataki process was implemented at the waharoa; ZoomVision was introduced to ensure wānanga were able to be delivered virtually; and a MyOutcomes system was installed (Te Kurahuna Ltd, 2021). Over the 18 months which followed, Te Kurahuna continued to provide leadership to TKHoH as they worked to implement and embed system changes. This included ongoing Mataora training focused on operationalising Mahi a Atua principles and pūrākau; practitioner development via supervision, leadership, coaching and governance training; and the co-creation of a detailed operations manual available via an online training platform (Te Kurahuna Ltd, 2021).

Te Kurahuna systematically introduced the principle of immediate response to whānau in distress, providing continuous oversight of the Matataki team to ensure processes were followed, with space created to wānanga real-time feedback, ensuring outcomes for whānau were enhanced (Te Kurahuna Ltd, 2021). Underpinned by data systems such as MyOutcomes, Te Kurahuna also supported TKHoH to actively engage in a data informed way which prioritised whānau voice, and increased understanding of the critical importance of data collection, and systematic analysis and audit by ethnicity in order to monitor access, effectiveness, and equity for Māori (Te Kurahuna Ltd, 2021). The design of multi-disciplinary team meetings changed to a Huaki Pouri orientation whereby practitioners were trained to focus on their own practice and the systemic factors contributing to poor outcomes for whānau. More broadly, the TKHoH Whānau Ora team were supported via the development of a 'Mahi a Atua Wednesday Wānanga' as an alternative pathway for healing (Te Kurahuna Ltd, 2021). Lastly, Te Kurahuna also provided oversight of and leadership to TKHoH's 'Integrated Primary Mental Health' contract, with a focus on ensuring the sustainability of Te Kūwatawata ki Hauraki systems and processes. This was particularly in relation to ensuring Mahi a Atua principles and practice were not overshadowed by newly introduced Health Improvement Practitioner and Health Coach roles which had been prioritised for nationwide implementation (Te Kurahuna Ltd, 2021).

3.3.3 Te Hiringa Matua

In 2016, the Ministry of Health funded three DHBs to deliver Pregnancy and Parenting Services (PPS); intensive, assertive outreach case-coordination services for pregnant women, and parents of children under three years, who were experiencing problems with alcohol and other drugs, and were poorly connected to health and social services (Malatest International, 2019). The Hauora Tairāwhiti PPS, Te Hiringa Matua, is led by Ngāti Porou Hauora and delivered by three community providers. Recognising that a mainstream clinically-led and delivered service model would not effectively reach whānau, and would essentially continue to perpetuate inequity for Māori, Te Hiringa Matua prioritised the reinstatement of

mātauranga Māori, whānau-centred practice, and the elimination of institutional racism. Te Kurahuna was involved in both the design and operationalising of Te Hiringa Matua, including training Mataora to implement and deliver Mahi a Atua wānanga for whānau engaging with Te Hiringa Matua. Centrally located in the city, with the capacity for whānau to self-refer, although Te Hiringa Matua were focused on whānau Māori, all ethnicities were welcome.

Reflecting the influence of Te Kurahuna, Te Hiringa Matua goes beyond a narrow bio-medically focused clinical model which views whānau complexity solely from the perspective of whānau dysfunction, as opposed to such complexities being a consequence of ongoing systemic institutional racism. Whānau who present to Te Hiringa Matua often experience multiple, interrelated, complex issues, for example addiction, poor mental and physical health, poverty, family violence, abuse, custody disputes, and involvement with child welfare and justice agencies. The training provided by Te Kurahuna enhances understanding that these issues and the associated development of long term sustainable pathways forward for whānau must be understood within the broader historical and sociocultural context of institutional racism. Integral to this is an emphasis on the importance of systemic change across sectors such as justice.

3.3.4 Camberley School
Camberley School in Hastings caters for students from Years 1 to 6. The relationship between Te Kurahuna and Camberley started when several staff from the school attended Mahi a Atua wānanga as individuals. Staff reported gaining a sense of validation from the wānanga, specifically in relation to the inner turmoil felt by Māori educators which occurred as a result of the direct and indirect institutional racism and bias operating across mainstream education settings. These experiences laid the foundation for seeing opportunities to introduce Mahi a Atua more widely across the Camberley school environment (Amohia Rolls, 2021, personal communication, 16 September).

Of importance was the need to heal the impacts of institutional racism already being experienced in education both as individual practitioners, and as a school embedded in a high needs, largely Māori community, as well as identifying how institutional racism was still present within the kura. All staff attended Mahi a Atua wānanga, in the process activating a conscious decision and commitment to begin a journey of Indigenising the kura space and actively removing systemic blockages in order to unapologetically be and thrive as Māori (Amohia Rolls, 2021, personal communication, 16 September). This commitment is seen in the Camberley School Strategic Aims 2020-2023 where the vision of Kia Ū (to embody and develop students conceptual understanding); Kia Ora (to grow understanding and applied practice); and Kia Rere (to take knowledge and practice and innovate), is explicitly premised upon the three Mahi a Atua principles of Tēnei te Pō, Nau mai te Ao; Ka mā te ariki, ka mā te tauira; and Hongihongi te wheiwheiā (Camberley School, 2021). Strategic aims and actions for Camberley School include: learners will be immersed in cultural narratives embracing a world view and unlocking creative and cultural potential; implement school wide approach to Tikanga, including curriculum design and behaviour management plans aligning with Atua; teacher and student inquiry based on Atua; learning environments are set up and based on Atua; pūrākau are visible and taught in all spaces; and staff partake in school-wide professional development, including Mahi a Atua (Camberley School, 2021).

Camberley School focused on intentionally integrating pūrākau into the curriculum they had created in response to their community. What was learnt in Mahi a Atua wānanga was innovated upon as pūrākau were shared with tamariki early in their life and educational journey. At the same time, Mahi a Atua was woven into the approach used by kaimahi in Rongo Mauri, a whānau-serving-whanau model based at Camberley School. All Rongo Mauri kaimahi have attended Mahi a Atua wānanga and the Rangi Parauri training to become Mataora, and the same pūrākau tamariki learn are used in the healing and support work with whānau. This intentional sharing of pūrākau across both spaces enables the pūrākau to become living tools and narratives within homes and the wider community. "Parents, tamariki, grandparents, caregivers and siblings can be both leaders and learners, givers and receivers within their own whare: they can heal and be healed with and for each other" (Amohia Rolls, 2021, personal communication, 16 September).

3.3.5 Ngātahi Takitahi
Te Paepae Arahi (TPA) is an organisation based in Te Awakairangi/Hutt Valley, who deliver strength-based supports to rangatahi via a school-based programme *Ngātahi Takitahi (Mā te mahi ngātahi a te takitini, ka pakari te tangata takitahi)*. Set within a marae context, this programme utilises a whānau ora approach, mātauranga Māori, and tikanga Māori to assist rangatahi find a place they can stand strong (Te Pae Pae Arahi Charitable Trust, 2018). TPA also explicitly understands youth wellbeing, rangatahi ora and resilience as priority equity issues for Māori. Ngātahi Takitahi programme staff undertook Mahi a Atua training which emphasised the deliberate engagement of mātauranga Māori and culturally informed practices as a basis for understanding and resolving issues with whānau (Hamilton, 2020).

3.4 Outcomes
Drawing primarily on the experiences of Te Kūwatawata, this section describes the key outcomes which have resulted from operationalising Mahi a Atua.

3.4.1 Overall
Formal evaluation findings concluded Te Kūwatawata ki Tairāwhiti met all expectations of Hauora Tairāwhiti specifically in relation to improving service responses to whānau experiencing mental health distress; increasing whanaungatanga within and across both services and whānau; building the cultural competencies of the workforce working with whānau; and enabling whānau to achieve holistic health and wellbeing from within a Te Ao Māori paradigm (Tipene-Leach et al., 2019). An Organisation for Economic Cooperation and Development (OECD) authored report into mental health and work in Aotearoa has described Te Kūwatawata as an innovative partnership across DHB, PHO, and Iwi (OECD, 2018).

However, comprising significantly more than a Kaupapa Māori service added to an unchanged mainstream system, Te Kūwatawata not only laid a pathway to achieve enhanced service access as identified in the 2018 Government Inquiry into Mental Health & Addiction (Tipene-Leach et al., 2019), it also responded to calls from multiple reports, inquiries and reviews that institutional racism be addressed in order to realise equitable outcomes. With this explicit focus on challenging institutional racism, alongside operationalising the necessary paradigm shift to whānau ora and whānau-centred practice, Te Kūwatawata was identified by the 2018 Government Inquiry into Mental Health & Addiction, the HDSR (2020), and the Initial Mental Health & Wellbeing Commission (2021) as an exemplar of an Indigenous paradigm able to

realise the systemic innovation and transformation long called for. In demonstrating how to truly revolutionise mental health spaces for Māori, Mahi a Atua and Te Kūwatawata is seen as having far reaching implications for the future delivery of health services (Rangihuna et al., 2018b). Maori voices to the 2018 Government Inquiry into Mental Health & Addiction expressed a strong desire to see Mahi A Atua and Te Kūwatawata expanded and grown to its full potential across Aotearoa (Russell et al., 2018).

Outcomes from the implementation of Mahi a Atua in settings other than Te Kūwatawata have also been demonstrated. For example, Te Hiringa Matua demonstrated positive outcomes of PPS for whānau, as well as the effectiveness of Kaupapa Māori services to reinstate mātauranga Māori and reduce the impacts of colonisation on whānau Māori (Malatest International, 2019). The evaluation concluded disparities for Māori could be reduced via the expansion of the Te Hiringa Matua Mahi a Atua based service model (Malatest International, 2019).

At Camberley School, the benefits of Mahi a Atua were reported as being immediately evident across the kura, with tamariki being excited and focused, as they contributed, created, and explored ideas and storylines within the pūrākau. Discussions regarding similarities and the relevance of the pūrākau to their own families and situations became commonplace, as did the ability of tamariki to observe themselves objectively and to consider the perspectives of others (Amohia Rolls, 2021, personal communication, 16 September). Mahi a Atua resulted in the creation of many new tools for their kete, including narratives which assisted tamariki to navigate their own lives (Amohia Rolls, 2021, personal communication, 16 September).

3.4.2 Enhanced Service Access and Early Intervention

The data collected by Te Kūwatawata ki Tairāwhiti and Te Kūwatawata ki Hauraki clearly demonstrated the impact of Te Kūwatawata in addressing the inequities which occurred for Māori at the point of entry to mental health services. Across both Te Kūwatawata ki Tairāwhiti and Te Kūwatawata ki Hauraki access to primary mental health care was enhanced via facilitating easy service access and providing a quick response (Te Kurahuna Ltd, 2021; Tipene-Leach et al., 2019). Appointment blockages were reduced, particularly as a result of strict service criteria being eliminated, and whānau having the ability to access Te Kūwatawata directly off the street (Te Kurahuna Ltd, 2021; Tipene-Leach et al., 2019). The removal of referral barriers to mental health services by Te Kūwatawata ki Tairāwhiti reduced unmet mental health need, with an overall increase in Māori referrals to mental health services evidence of a significant step towards more equitable outcomes (Tipene-Leach et al., 2019).

Data collected over the 13 month Te Kūwatawata ki Tairāwhiti pilot showed significant numbers of referrals being processed by Te Kūwatawata, with two thirds (66%) of the 1666 new referrals over that time being Māori (Tipene-Leach et al., 2019). The number of both Māori and non-Māori self-referrals also increased over time. Of importance from an equity perspective, the data shows a greater increase in referrals over time for Māori than for non-Māori (Tipene-Leach et al., 2019). The Te Kūwatawata ki Tairāwhiti evaluation concluded that as the Te Kūwatawata model became more embedded within the community, referrals by external providers such as schools and Police would also increase (Tipene-Leach et al., 2019). Te Kūwatawata ki Hauraki data from March 2020-April 2021 also showed significantly increased service access, with total referrals increasing by 50%. Total referrals for Māori

increased by 53%, and 50% for non-Māori. Significantly, self-referrals for Māori were shown as increasing by 235% (increasing from 40 to 134) , with non-Māori self-referrals increasing by 26% (increasing from 92 to 116). Referral source data showed the majority of referrals were self-referrals, followed by GP/Nurses, and then Probation Services (Te Kurahuna Ltd, 2021).

Other outcomes achieved by Te Kūwatawata in relation to enhanced access and early intervention, particularly for youth were also identified. For example, a significant proportion (one third) of total referrals to Te Kūwatawata ki Tairāwhiti comprised youth (aged <18 years). Youth referrals to the PHO Primary Health Mental Health Service and Hauora Tairāwhiti Infant, Child, and Adolescent Mental Health Service, and admissions to the in-patient ward, decreased during the pilot period, and the use of compulsory treatment orders (CTOs) for Māori clients fell by 30% over the year (Tipene-Leach et al., 2019). Youth data (12-24yrs) from Te Kūwatawata ki Hauraki showed an overall increase in Māori youth referral rates of 150% (increasing from 59-147). Non-Māori youth referral rates increased from 50 referrals pre-Te Kūwatawata ki Hauraki to 91 post Te Kūwatawata ki Hauraki (Te Kurahuna Ltd, 2021). A recent study concluded TKHoH were making a significant contribution to rangatahi wellbeing through the implementation of Mahi a Atua, specifically the innovative way in which Mahi a Atua addressed service access for rangatahi (Ngamane-Harding, 2021).

Data showing a relatively fast response time to referrals indicated Te Kūwatawata saw people early in their distress. For example, Te Kūwatawata ki Tairāwhiti saw a third of referrals within one day, and over half within a week. Similarly Te Kūwatawata ki Hauraki made immediate contact with those in distress (Ngamane-Harding, 2021). Te Kūwatawata ki Tairāwhiti also occupied an important bridging role, ensuring those in the process of waiting for access to specialist secondary mental health services were not left unsupported (Tipene-Leach et al., 2019).

Service adaptations, particularly in the form of new technologies implemented as a result of the 2020 COVID-19 lockdown resulted in a more efficient and flexible system able to overcome obstacles and challenges. For Te Kūwatawata ki Hauraki, zoom wānanga with whānau and Te Kūwatawata portals became of high priority as whānau were engaged with and supported using a different means of communication (Te Kurahuna Ltd, 2021). Beyond the immediate needs presented by COVID-19, such developments further enhanced accessibility, creating additional options for whānau for whom virtual connection was the preferred, and/or most accessible, option (Ngamane-Harding, 2021).

Te Hiringa Matua were located on a main street in Gisborne, with the majority of their referrals being self or whānau referrals. Of importance was although service entry was tightly controlled in the original PPS service design, Te Hiringa Matua were able to, through Mahi a Atua wānanga, support all whānau, including those who did not fit the strict PPS access criteria. This included finding other services and supports which were more appropriate for whānau (Malatest International, 2019). Reflecting the centrality of relationships to equitable outcomes, the evaluation of Te Hiringa Matua recognised initial engagement with whānau was often difficult, with the development of a trusting relationship the critical first step (Malatest International, 2019). Addressing the institutional racism which impacts on the development of such relationships and subsequently the achievement of equitable outcomes

for Māori is a key focus for Te Kurahuna and Mahi a Atua. The Te Hiringa Matua evaluation also reported whānau felt respected by the Te Hiringa Matua team, with this being the first time whānau felt heard and their needs understood. This included understanding that issues such as housing and income support often needed to be addressed before addiction related issues could be specifically focused on. Whānau were also supported in their interactions with the Ministry for Children and/or the justice system. For example, described as making a significant difference for whānau, Te Hiringa Matua provided a warm, tamariki friendly environment for supervised access visits (Malatest International, 2019).

3.4.3 By Māori for All

Addressing equity requires more than simply increasing access. It is about having access to the right service. Unique to Te Kūwatawata, and indeed its major point of difference, is the aspiration to address inequity for Māori via the application of a Te Ao Māori approach for everyone. Operationalising a single point of entry (SPoE) to mental health services which prioritises Kaupapa Māori methodology and whānau ora as the norm is the first time such a comprehensive attempt has been made to move beyond the 'by Māori, for Māori' model, a common focus since the health reforms of the 1990s, to the 'by Māori, for all' approach. Having said that, the idea that holistic Indigenous paradigms can lead the way for all in Aotearoa is not new, and is indeed emphasised in the conclusions reached by the 2018 Government Inquiry into Mental Health & Addiction.

Te Kurahuna, Mahi a Atua and Te Kūwatawata seek movement away from the dominant bio-medical, illness-focused model of mental health, by explicitly prioritising a shift towards Indigenous paradigms. Evaluation data demonstrated that an Indigenous paradigm in mental health and addiction service delivery was considered appropriate and acceptable for non-Māori clients: holistic, whānau-centred, inclusive wānanga infused with care, choice and the invitation to provide honest feedback was valuable for all (Rangihuna et al., 2018a, 2018b; Tipene-Leach et al., 2019). The data also indicated Te Kūwatawata Mataora were culturally respectful and careful to provide options for whānau. With a service-as-usual pathway also accessible, Te Kūwatawata was not restricted by, nor imposed on those not comfortable within its parameters (Rangihuna et al., 2018a; Tipene-Leach et al., 2019). These findings were seen as supporting the proposition that 'getting it right for Māori, does in fact get it right for everyone' (Tipene-Leach et al., 2019, p96).

A major theme conveyed to the 2018 Government Inquiry into Mental Health & Addiction was persistent institutional racism had resulted in the continual underfunding, undervaluing and marginalising of Kaupapa Māori mental health services (Government Inquiry into Mental Health & Addiction, 2018; Russell et al., 2018). For some, the Kaupapa Māori 'by Māori for Māori' service approach is considered entirely unsustainable in the long term (Tipene-Leach et al., 2019). Some providers who have operated under the name of 'Kaupapa Māori' have themselves recognised that the current system essentially results in the provision of a mainstream service, even if the service is governed by a Māori or Iwi organisation. In these cases, Kaupapa Māori services themselves are inadvertently perpetuating institutional racism. The reality of this situation was a primary driver behind the desire of TKHoH to establish Te Kūwatawata within their region. Significantly, a number of regions have emphasised the most effective and sustainable long term strategy for addressing inequity for

Māori was, as Te Kūwatawata had implemented, the 'by Māori for all' approach (Tipene-Leach et al., 2019).

3.4.4 Scaling Up

The initial tender for the Te Kūwatawata ki Tairāwhiti pilot required it have the potential to be scaled up, and that it provide evidence to inform the Ministry of Health's future plans to reshape the mental health and addiction system. The evaluation concluded Te Kūwatawata ki Tairāwhiti was scalable, identifying that although implementation challenges remained, Te Kūwatawata had evolved into a community-driven initiative with far reaching implications for the future delivery of both health and non-health services in Aotearoa (Tipene-Leach et al., 2019). Demonstrating the transformative potential of Te Kūwatawata, the evaluation specifically referenced high interest from other regions wishing to implement their own mana whenua version of Te Kūwatawata. Key elements identified as resonating with these regions included that Te Kūwatawata was grounded in Māori aspirations; took a 'distress' as opposed to illness approach; and prioritised the development of the Mataora workforce (Tipene-Leach et al., 2019).

The validity of the conclusion that Te Kūwatawata ki Tairāwhiti was scalable is seen in the establishment of Te Kūwatawata ki Hauraki. The detailed exploration and reporting of philosophy, components and wānanga pathways in the formal evaluation of Te Kūwatawata ki Tairāwhiti was instrumental in scaling the intervention to TKHoH. Policy and process improvements made by Te Kūwatawata ki Hauraki, including in relation to formalising clinical performance, risk and best practice, occurred as a direct result of issues identified in the Te Kūwatawata ki Tairāwhiti pilot. Such information, including that now being gathered by Te Kūwatawata ki Hauraki, will be crucial to informing the ongoing development of similar programmes premised upon Mahi a Atua.

Reflecting the long-held desire for movement towards approaches which prioritise mātauranga Māori, whānau ora and whānau-centred practice, the wide applicability of Mahi a Atua, Te Kūwatawata and a Mataora workforce well beyond the mental health system has been emphasised (Hamilton, 2020; OECD, 2018; Tipene-Leach et al., 2019). For example, an OECD (2018) report exploring mental health and work in Aotearoa recommends increasing the role of Mataora across social services. Because mātauranga Māori contains foundational principles and values that pertain to life in general, Mahi a Atua can be applied to any context which requires a collective cultural shift in order to effect the systemic transformation needed to realise equity for Māori. Reflecting a growing view that the transformative potential of Mahi a Atua is far from being fully realised, it has been identified that progress in addressing institutional racism could rise exponentially across organisational and community levels if a critical mass were able to be trained in Mahi a Atua (Hamilton, 2020). Mataora as leaders of change serve to normalise mātauranga Māori across all areas they are present, thus increasing both the impact of Mahi a Atua and the potential for its ongoing sustainability (Hamilton, 2020).

As is discussed in more detail in future sections, resistance to Te Kūwatawata ki Tairāwhiti as a SPoE mainly transpired from the primary care sector. The pathway Hauora Tairāwhiti proceeded down post the Te Kūwatawata pilot was seen as critical. It was acknowledged that a Te Kūwatawata-like service added-on to a mainstream SPoE would likely simplify primary

and secondary care collaboration and overcome primary care resistance to a Māori-led SPoE (Tipene-Leach et al., 2019). However, the evaluation advised against this, recognising the PHO is likely to advance the stepped care model of brief interventions delivered from within GP practices, with a probable consequence being less GP referrals to Te Kūwatawata ki Tairāwhiti. As a result the unique SPoE 'by Māori for all' approach would disappear, as would opportunities for genuine systemic transformation. The evaluation recommended continued investment in the Kaupapa Māori led SPoE which was demonstrating a positive contribution to both addressing inequity and benefiting all (Tipene-Leach et al., 2019).

3.5 Key Success Factor: Te Whare Wānanga o Te Kurahuna

The removal of access barriers to mental health services by both Te Kūwatawata ki Tairāwhiti and Te Kūwatawata ki Hauraki reduced unmet mental health need, with the overall increase in Māori referrals to services, evidence of a significant step towards more equitable outcomes (Ngamane-Harding, 2021; Tipene-Leach et al., 2019). However, as has been emphasised in the literature, equity requires more than increased access alone; what is delivered, and how it is delivered also significantly impacts on the extent to which equitable outcomes for Māori are achieved.

Many of the conclusions reached by recent health-focused reviews and inquiries highlight the workforce as a key enabler in addressing inequity for Māori (Government Inquiry into Mental Health & Addiction, 2018; Health & Disability System Review, 2020). Although the 2018 Government Inquiry into Mental Health & Addiction recommended enhancing the utility of the specialist mental health professional workforces and using a broader range of therapeutic approaches, the Inquiry also explicitly acknowledged such recommendations were within the parameters of existing systems, and as such would not provide the innovative and transformative workforce solutions required (Government Inquiry into Mental Health & Addiction, 2018). Genuine system transformation requires a workforce willing and able to work collaboratively and move beyond what are now considered to be outdated professional boundaries and scopes of practice (Health & Disability System Review, 2020). The HDSR (2020) was unequivocal that if inequities were to be addressed, there was no room for working as we always have. Over 30 years ago, Puao-Te-Ata-Tu (Department of Social Welfare, 1988) also recognised the workforce as central to systemic transformation, specifically emphasising the community workforce as best placed to meet whānau needs.

Recognising that simply providing more of the same will not result in the transformative outcomes long sought, Te Kurahuna responds to the call to grow innovative community driven pathways to healing in ways which are not discipline, profession, or sector specific, but are determined by who is best positioned to engage with whānau in order to realise equitable outcomes. Seeking systemic transformation through a uniquely Indigenous workforce development approach which activates a collective consciousness, Te Kurahuna has evolved Mahi a Atua far beyond that of a culturally appropriate service model or workforce, with its key point of difference being the development of the Mataora workforce: change agents operating from Indigenous paradigms and worldviews who reach across all parts of the community. Built on well-established theoretical and practice-based foundations of Kaupapa Māori, whānau ora, and cultural safety, Te Kurahuna, as the kaitiaki of Mahi a Atua, challenges the dominance of a monocultural, bio-medical, deficit-oriented paradigm of mental health

and wellbeing; decenters the professional workforce; and facilitates a focus on the wider systemic factors needing to be addressed in order to address equity for Māori.

Māori voices to the 2018 Government Inquiry into Mental Health & Addiction asserted effective services were creative, fluid, and adaptable, sitting with whānau to not only feel their pain and challenges, but also providing opportunities for whānau growth, development and leadership (Russell et al., 2018). Data from Te Kūwatawata ki Tairāwhiti and Te Kūwatawata ki Hauraki demonstrates how the shift to culturally resonant, holistic, whānau-centred service provision delivered from within a Te Ao Maori paradigm impacts positively for whānau. Prioritising working with whānau to determine their needs, the Mahi a Atua wānanga process is recognised as an innovative and powerful means by which whānau have the opportunity to not only understand and articulate their experiences and distress, but also develop agreed upon pathways to wellness via a culturally narrated lens (Kopua & Kopua, 2021; Rangihuna et al., 2018a; Tipene-Leach et al., 2019). In doing so Mahi a Atua wānanga explicitly reflect the central elements of whānau ora and whānau-centred practice in that they are: underpinned by mātauranga Māori; position whānau aspirations, needs, self-determination, and transformation at the centre; prioritise effective relationships; and focus on solutions not issues. Innovative ways in which a multi-disciplinary Ue facilitate access to a whānau-centered wānanga process underpinned by the healing power of pūrākau is highlighted (Rangihuna et al., 2018a). The rapid development of therapeutic relationships; a likely increase in 'talk therapy' and decrease in medication; increased whānau involvement alongside an appreciation of the complex interconnection of relationships that comprise reality for whaiora and their whānau have all been identified as resulting from Mahi a Atua wānanga (Rangihuna et al., 2018a).

3.5.1 Cultivating a 'way of being'
Te Kurahuna maintains shared oversight for the operationalising of Mahi a Atua via initial training and ongoing professional development and clinical supervision for Mataora, both Māori and non-Māori. Through shared trainings and continuing professional development wānanga, Te Kurahuna focuses its activities around the learning of pūrākau and how to apply these narratives therapeutically, as Mataora share how Mahi a Atua is incorporated as a way of being across both their personal and professional lives. Wānanga Pākehā which explore technical and professional development aspects of case management from within the context of Mahi a Atua are also provided by Te Kurahuna (Rangihuna et al., 2018a). The oversight provided by Te Kurahuna is essential to maintaining the high level of integrity and enthusiasm necessary to both develop and sustain a strongly connected multi-disciplinary Mataora workforce (Tipene-Leach et al., 2019).

Reflecting underpinning principles of Kaupapa Māori and cultural safety theory, the training environment and context provided by Te Kurahuna ensures Te Kūwatawata and other ways of implementing Mahi a Atua do not simply replicate the existing system of competency acquisition. From a Kaupapa Māori theory perspective, which asserts recognition, affirmation, and validation of Māori worldviews, it is clear Māori practitioner workforce development is not simply about the acquisition of technical skills, but forms part of a wider liberation movement built on our own methods and mechanisms of critique, measurement, and judgment (Baker & Levy, 2013). Reflecting this, Mataora, both Māori and non-Māori refer to their own practice and identity transformations which have occurred as a result of

undertaking Te Kurahuna training (Kopua et al., 2020). For Mataora who were Māori, there was a sense of liberation in being able to build on a wealth of existing skills; work in ways which felt 'normal'; and gain more confidence in the application of mātauranga Māori models (Hamilton, 2020; Kopua et al., 2020; Tipene-Leach et al., 2019). Non-Māori Mataora gained confidence through being provided with an entry point, alongside processes by which they were able to effectively engage with Māori whānau. For those with no previous training in a Western psychological paradigm, Mahi a Atua served to expand their therapeutic scope (Tipene-Leach et al., 2019). Truly transformative Indigenous theories are those which are 'owned' and 'make sense' to those communities (Smith, 2003). That Te Kurahuna training is seen as inclusive and valued by the community itself (Tipene-Leach et al., 2019), lends weight to central role being played by Te Kurahuna in operationalising systemic transformation.

With its focus on addressing institutional racism and systemic inequity, Te Kurahuna training differs from other cultural competency workforce training models, in that it often requires a fundamental shift in orientation and practice, particularly for those trained within mainstream institutions (Kopua & Kopua, 2021): movement to critical consciousness is an ongoing and often challenging process of active critical self-reflection about one's own contribution to institutional racism (Curtis et al., 2019). The challenging nature of making fundamental and sustainable paradigmatic shifts emphasises the centrality of deliberate wānanga processes and ongoing professional development opportunities which create environments conducive to meaningful reflection and growth, alongside deep, courageous and transparent collective learning (Kopua, 2019).

In building a critical consciousness able to address institutional racism, Te Kurahuna understands the wide diversity of comfort and confidence levels relating to mātauranga Māori. Mahi a Atua recognises the wealth of skills already possessed, and consistent with the aspiration of Mahi a Atua as a 'way of being', it has been found that initial exposure to learning about Mahi a Atua often triggers a desire by wānanga participants to learn more (Kopua, 2019). However, it has also been found that a fear of 'getting it wrong' can impact on engagement in Mahi a Atua training. In some ways, this can be considered a positive reflection of Mahi a Atua principles in relation to the ongoing learning and growth which occurs for both individuals and organisations as one engages in the process of being trained as a Mataora (Hamilton, 2020).

Supporting that attention must be paid to the process of training and professional development, Māori voice to the 2018 Government Inquiry into Mental Health & Addiction emphasised the need for investment in education pathways that amplify Indigenous intelligence across all health systems (Russell, et al., 2018). Training systems grounded in the dominant biomedical paradigm not only fail to prioritise increasing the mātauranga Māori health workforce, but have also been extremely resistant to critiquing the racism inherent within their own curricula (Kopua, 2020). Many studies identify the extent to which Māori come under pressure to compromise cultural values and identity in order to succeed within mainstream health-related training programs, a serious consequence of which is a loss of confidence in the validity of Indigenous processes and models (Levy, 2007; Milne, 2005). As is implemented by Te Kurahuna, pathways premised upon Indigenous intelligence explicitly focus on Indigenising spaces and practice, and creating environments where there is freedom to be proactively Māori (Russell et al., 2018). Culturally safe learning environments, such as

wānanga, and noho, which strengthen and support one's identity as Māori by providing access to Māori world views, language and ways of knowing have long been recognised as essential for Māori health workforce development (Hopkirk, 2010; Robertson et al., 2006; Sheehan & Jansen, 2006; Wilson et al., 2011).

With the potential of Mahi a Atua yet to be fully realised, Te Whare Wānanga o Te Kurahuna occupies a central role in meeting the growing demand across sectors for a workforce able to effectively practice from a mātauranga Māori, whānau ora and whānau-centred practice base. Growing this broad critical mass is essential to realising the critical consciousness required to address institutional racism and generate systemic transformation. The pivotal role played by Te Kurahuna is reflected in Te Kūwatawata ki Tairāwhiti evaluation recommendations which emphasise: the importance of preserving the content and experience of Te Kurahuna as the kaitiaki of Mahi a Atua; further developing Te Kūwatawata in conjunction with Te Kurahuna; and further developing Te Kurahuna workforce training and development opportunities across sectors (Tipene-Leach et al., 2019).

A collective organisational commitment to working with Te Kurahuna is integral to the workforce transformation necessary. Described as sitting at the heart of Te Kūwatawata, Te Kurahuna holds critical responsibility for maintaining the prioritised position of Te Ao Māori across Te Kūwatawata ki Tairāwhiti and Te Kūwatawata ki Hauraki. That Te Kurahuna is independent from mainstream health institutions and their dominant biomedical paradigm is significant, particularly when challenging organisations at a strategic level in order to ensure the focus firmly remains on addressing institutional racism in order to realise equity for Māori. With the embedding of a culture of feedback within organisations and systems seen as being particularly challenging, Te Kurahuna provides vital training in how to implement the uniquely Indigenous Hinekauorohia process which emphasises whānau-centred reflective transparent discussion, as well as relevant quality improvement tools such as Feedback-Informed Treatment (FIT) (Tipene-Leach et al., 2019).

Systemic change requires time to fully embed. Ongoing attention by Te Kurahuna to the development of Mahi a Atua leadership able to champion ongoing skill development, clarity, and fidelity with Mahi a Atua principles whilst transitioning to an Indigenous system is essential (Te Kurahuna Ltd, 2021). Ripples of positive change across the wider service environment influence change at an institutional level, with this in turn supporting leaders and the wider community be more open to change (Kopua & Kopua, 2021). Without such leadership, the risk of returning to the dominant biomedical clinically focused approach is high (Te Kurahuna Ltd, 2021). This is particularly relevant in the midst of the current nationwide rollout of the general practice-led, bio-medically focused, Integrated Primary Mental Health and Addictions model. Critical ongoing roles for Te Kurahuna in Te Kūwatawata include the training of Mahi a Atua champions; ongoing practitioner supervision, and facilitating essential elements of Mahi a Atua such as, Huaki Pouri and Hinekauorohia, whilst future Mahi a Atua champions are being trained (Te Kurahuna Ltd, 2021).

3.6 Challenges: Entrenched Institutional Racism

As was concluded in the formal evaluation, the Te Kūwatawata ki Tairāwhiti pilot established an appropriate pathway to meet Ministry of Health aspirations for a mental health system which was 'fit for future' (Tipene-Leach et al., 2019). Te Kūwatawata ki Tairāwhiti achieved

this by: demonstrating outcomes for those in distress who did not meet the access criteria for specialist services, and who were not easily managed in primary care; constructing an evidence base about an effective integrated model with the potential to be scaled up; and providing evidence able to inform the Ministry's longer term strategic plan to reshape the mental health and addiction system (Tipene-Leach et al., 2019).

As was to be expected from a pilot, the detailed evaluation of Te Kūwatawata ki Tairāwhiti identified a range of recommendations for improvement, including addressing issues relating to clinical performance, risk, and best practice; and ongoing improvements to governance policy and procedures, quality improvement processes, best practice documentation, human resources support, and clinical supervision (Tipene-Leach et al., 2019). Overall it was found Te Kūwatawata ki Tairāwhiti demonstrated significant outcomes in a short time frame, making a positive contribution to addressing inequity, as well as benefiting all. Given this, continued investment in the Te Ao Māori SPoE was recommended (Tipene-Leach et al., 2019).

However, despite its successful implementation and the demonstration of positive outcomes, together with multiple reports positioning Te Kūwatawata ki Tairāwhiti as an exemplar of the transformative paradigm shift required in mental health and addiction (e.g. Government Inquiry into Mental Health & Addiction, 2018; Health & Disability System Review, 2020; Initial Mental Health & Wellbeing Commission, 2021), the Te Kūwatawata ki Tairāwhiti pilot was not subsequently widely supported. The magnitude of task attempted by Te Kūwatawata ki Tairāwhiti cannot be underestimated: the implementation of the wholly new 'by Māori for everyone' approach which explicitly sought to address institutional racism by privileging mātauranga Māori and confronting the dominant biomedical deficit-focused model of mental health was always going to extremely challenging (Tipene-Leach et al., 2019).

3.6.1 Systemic Transformation: By Māori for All

In considering the challenges encountered by Te Kūwatawata ki Tairāwhiti, the evaluation identified that mainstream initiatives using a Te Ao Māori methodology often risk being attributed with blame for issues which are in reality systemic problems (Tipene-Leach et al., 2019). Perhaps unsurprisingly, institutional racism, the very issue Te Kurahuna, Mahi a Atua, and Te Kūwatawata seeks to address in order to address inequity for Maori, itself undermined the potential of Te Kūwatawata ki Tairāwhiti (Tipene-Leach et al., 2019). Whilst acknowledging the importance of specialist change management input in any future Te Kūwatawata implementation, the evaluation also identified a fundamental element of resistance to change was driven by "opposition to a Māori-focused approach in the lead position, a Māori voice exposing inequities, and an 'unproven' Indigenous therapeutic modality entering into a fraternity of (sometimes unproven) Western practices"(Tipene-Leach et al., 2019, p14).

That resistance to Kaupapa Māori initiatives challenging the status quo is underpinned by institutional racism is widely evidenced. For example, resistance to the whānau ora paradigm is an ongoing reality (Whānau Ora Review Panel, 2019), as is an unwillingness within primary health to recognise the expertise of Māori clinicians and the validity of mātauranga Māori (Russell et al., 2013; Waitangi Tribunal, 2019). As was concluded in the evaluation of Te Kūwatawata ki Tairāwhiti, resistance from organisations identified as being institutionally racist, such as PHOs, is seen as often playing out on a day to day basis as complaints about

issues such as risk and safety (Tipene-Leach et al., 2019). For example, concern was expressed by some, particularly the PHO, regarding Te Kūwatawata ki Tairāwhiti operating as a SPoE for all, irrespective of distress levels. The lack of differentiation between distress levels formed the basis of views clinical risk and safety was not being appropriately acknowledged or addressed (Tipene-Leach et al., 2019). In discussing this, the evaluation referred to the paradigm shift advocated by Te Kūwatawata ki Tairāwhiti, and its alignment with the 'post-psychiatry' movement, which would claim mental health is over-medicalised, a result of which is the interests of professionals are incorrectly prioritised. However, the importance of attending to issues relating to clinical risk and safety was also acknowledged, with recommendations to address such concerns made (Tipene-Leach et al., 2019).

Whilst issues such as an unwillingness to relinquish control are faced by SPoE initiatives generally (Raine, Carter, Senky, & Black, 2005), Te Kūwatawata ki Tairāwhiti faced additional difficulties in that institutional racism, power and privilege were explicitly positioned as issues needing to be discussed. Almost identical to what Puao-Te-Ata-Tu (Department of Social Welfare, 1988) reported over 30 years ago, discussing racism can lead to some feeling personally attacked and unsafe, rendering it difficult to enter into honest discussions. As is identified within the cultural safety literature, the inward focus of confronting one's own personal culture, bias and power is often seen and experienced as being confronting for health organisations, professionals, and students (Baker & Levy, 2013; Initial Mental Health & Wellbeing Commission, 2021). The points made earlier regarding the centrality of Te Kurahuna in maintaining shared oversight for the operationalising of Mahi a Atua are highly relevant here.

Given the magnitude of the change being sought by Te Kūwatawata ki Tairāwhiti and the challenges it faced, the evaluation concluded it would be unrealistic to expect substantial institutional change to occur in the short time frame offered by the pilot project. This is not dissimilar to the conclusion emphasised in the evaluation of the pilot integrated primary mental health and addiction (IPMHA) service model, that systemic change requires adequate time to be fully embedded (Appleton-Dyer, Andrews, Reynolds et al., 2018).

3.6.2 Challenging the Establishment
Also related to the magnitude of change being sought, the importance of understanding the markedly different foundations on which Te Kūwatawata ki Tairāwhiti key stakeholders were based was highlighted (Tipene-Leach et al., 2019). The primary source of resistance to Te Kūwatawata ki Tairāwhiti occurred from within the primary healthcare sector: the PHO did not sign a Memorandum of Agreement with Te Kurahuna; PHO staff did not attend Mahi a Atua training; and the PHO did not encourage their GP members to refer all clients to the SPoE (Tipene-Leach et al., 2019).

GPs were reported as the biggest single source of referrals to Te Kūwatawata ki Tairāwhiti, with many supportive of its Kaupapa Māori service provision, walk-in service access and short waiting times. In addition, some GPs had trained as Mataora and identified significant personal and professional benefit from working in accordance with Mahi a Atua principles (Tipene-Leach et al., 2019). However, although GP referrals of Māori to Te Kūwatawata ki Tairāwhiti increased over time, referrals of non-Māori did not, with the data showing non-Māori increasingly being referred to the PHO Primary Mental Health Service. With clinical

assessments shown as underpinning referral practices for the majority of GPs, the evaluation concluded some GPs perceived of Te Kūwatawata as a 'Māori service', as opposed to the intended SPoE for all (Tipene-Leach et al., 2019). Factors identified by some GPs as limiting Te Kūwatawata ki Tairāwhiti were its Te Ao Māori approach; the encouragement of wider whānau involvement; and the use of a collective therapeutic team. Interestingly, these same factors were identified by GPs as strengths of Te Kūwatawata (Tipene-Leach et al., 2019). Considered a form of gatekeeping, the misperception by some GPs of Te Kūwatawata ki Tairāwhiti as a 'Māori service', alongside perceived limitations of the therapeutic options offered by Te Kūwatawata ki Tairāwhiti, served to influence the service options chosen by GPs for their clients. GPs practicing in this way were thus essentially undermining the effectiveness of Te Kūwatawata ki Tairāwhiti as a SPoE service (Tipene-Leach et al., 2019).

Contrary to the beliefs of some GPs, evaluation findings confirmed whānau in Te Kūwatawata ki Tairāwhiti were offered choices around practitioner, approach and venue, with the pathway forward determined by whānau themselves (Tipene-Leach et al., 2019). The evaluation also identified what was described as an 'inherent disconnect', with GPs, who although wanted to take advantage of pathways able to benefit their clients, likewise did not wish to relinquish any of their control as part of that process (Tipene-Leach et al., 2019, p101). The explicit introduction of a client voice into the clinical process was also likely seen as challenging by the primary healthcare sector overall. Of note is that other SPoE projects have similarly demonstrated a desire for an easier referral processes without the presence of any associated loss of clinical control (Raine et al., 2005; Tipene-Leach et al., 2019).

Exploring this issue further, it was noted that although the primary healthcare sector were fully supportive of resources being moved in its direction, the PHO, as a private enterprise primarily responsible to its patient-centred independent business owning membership, was, as to be expected, interested in protecting its own referral pathways and primary mental health team (Tipene-Leach et al., 2019). That different approaches are seen as a threat to established primary healthcare models, particularly by those who have heavily invested in the establishment of businesses has been previously identified (Russell et al., 2013). Te Kūwatawata ki Tairāwhiti was focused on addressing inequities by operating from a whānau-centred perspective in which whānau were supported to lead and fully participate in decisions around their own health. As noted by the evaluation, these two agendas did not sit easily alongside each other (Tipene-Leach et al., 2019).

Given the challenges for Te Kūwatawata ki Tairāwhiti which emerged from primary care, a range of future potential options for Te Kūwatawata ki Tairāwhiti were identified. This included continuing with a secondary services SPoE with no access criteria, the potential for walk-ins, and GPs able to refer those who request Te Kūwatawata ki Tairāwhiti. This option was seen as both acknowledging GP requests for other options, whilst allowing time to further engage primary care in better understanding Te Kūwatawata ki Tairāwhiti and Mahi a Atua methodologies (Tipene-Leach et al., 2019). An alternative option suggested was to separate out the SpoE, positioning Te Kūwatawata ki Tairāwhiti as a stand-alone Kaupapa Māori service. However, the evaluation concluded both options inherently contradicted the overall aspirations of Te Kurahuna, Mahi a Atua and Te Kūwatawata ki Tairāwhiti to address the institutional racism inherent within mainstream primary and secondary mental health services (Tipene-Leach et al., 2019).

A major difference in the implementation of Te Kūwatawata ki Hauraki was that unlike the Te Kūwatawata ki Tairāwhiti pilot, TKHoH had prioritised the embedding of Mahi a Atua throughout their organisation, and did not need to enter into any new partnerships prior to implementation. Existing partnership relationships with the Hauraki PHO, Waikato DHB and the wider Hauraki Cluster were already well established. These relationships provided a solid foundation on which to grow and develop Te Kūwatawata ki Hauraki, with less attention and energy needing to be spent both on relationship building and development, as well as problem resolution. Irrespective of the existence of these positive relationships, learnings from the Te Kūwatawata ki Tairāwhiti pilot regarding the importance of high trust relationships to success were emphasised to TKHoH during the development and implementation process.

Despite being initiated and fully supported by TKHoH, Te Kūwatawata ki Hauraki nevertheless encountered issues which arise when undertaking processes requiring significant cultural change. These included the ongoing prioritisation of Western dominated approaches; difficulty adjusting to the transparency and feedback informed practice required by Mahi a Atua; and being unwilling to consider issues regarding racism, implicit bias, and inequities. It was also observed more work was required to ensure individuals and teams were flexible and adaptable to the changing needs of their community (Te Kurahuna Ltd, 2021). This situation supports conclusions reached in the evaluation of Te Kūwatawata ki Tairāwhiti regarding the reality that change management will be just as challenging anywhere a Te Ao Māori approach is prioritised (Tipene-Leach et al., 2019). Ongoing changes to processes in response to real-time critical feedback remained an essential element of Te Kūwatawata ki Hauraki (Te Kurahuna Ltd, 2021).

Despite the evaluation recommending the continuation of Te Kūwatawata ki Tairāwhiti as the SPoE, this has not occurred. Conversely, what did occur was that specific elements of Te Kūwatawata ki Tairāwhiti were retained, arguably those more consistent with the existing primary mental health paradigm and system, whilst other elements were not. Of particular concern is that Te Whare Wānanga o Te Kurahuna was excluded when the pilot programme was extended. This continued post-pilot when Te Kūwatawata ki Tairāwhiti was transformed into 'Te Waharoa'. In referring to the work being undertaken to create co-designed, diverse and culturally aligned services that provide a next step between primary and specialist care, the Initial Mental Health & Wellbeing Commission (2020) refer to the 'Te Waharoa' model as an exemplar of the system transformation sought by the 2018 Government Inquiry into Mental Health & Addiction. Exemplars are described as providing a template for leaders to follow, with the long term vision and courage of communities to stand by their models and work differently acknowledged. When referring to 'Te Waharoa', data is cited regarding shortened waiting times, increased referrals, wider whānau involvement, and whānau-inclusive practices (Initial Mental Health & Wellbeing Commission, 2021). However, the outcomes and successes described were not achieved by the altered Te Waharoa model: they were achieved by Te Kūwatawata ki Tairāwhiti, with Te Kurahuna and Mahi a Atua positioned at the centre.

In moving forward, understanding the holistic picture is essential. The success of Te Kūwatawata in delivering whānau-centred service delivery, realising whānau ora outcomes

and equity for Māori lies in the entirety of its components. As experience across other sectors has shown, the selective appropriation of culturally-based practices does not work (Te Uepū Hāpai i te Ora, 2018). As is clearly demonstrated, Te Whare Wānanga o Te Kurahuna, as the kaitiaki of Mahi a Atua, is fundamental to Te Kūwatawata and the operationalising of Mahi a Atua principles. The unique training environment and context provided by Te Kurahuna ensures Te Kūwatawata does not simply replicate existing systems.

The implementation and embedding of Mahi a Atua in other settings also faced challenges stemming from entrenched institutional racism. For example, in implementing PPS in Te Hiringa Matua, the prioritisation of the clinically focused medical paradigm over Indigenous knowledge continued to be an area of tension. Likewise Camberley School also identify that despite their approach being widely recognised as groundbreaking, innovative and successful, government agencies continued to oppose funding uniquely Indigenous determined and controlled solutions (Amohia Rolls, 2021, personal communication, 16 September).

3.7 Privileging the Integrated Primary Mental Health and Addiction Service Model: Institutional Racism in Action

Expanding access and choice to mental health and addiction services is the target of substantial government investment in Aotearoa. The integrated primary mental health and addiction (IPMHA) service model favoured for nationwide implementation is centred on a general practice team supplemented with a new workforce of Health Improvement Practitioners (HIPs), and Health Coaches. Originating in a context significantly different to Aotearoa, the IPMHA model is based on the North American Behavioural Health Consultant (BHC) model. With improving efficiency and effectiveness as a central aim, the BHC model is premised upon the applicability of behavioural science in addressing commonly presenting primary care issues, for example chronic disease management, lifestyle problems, fatigue and stress, alongside what are described as 'sub-threshold' problems such as relationships, parenting, finance, and employment (Hunter et al., 2016; Robinson, n.d.).

HIPs are qualified mental health professionals who have completed specialist training in the integrated primary mental health model, whilst Health Coaches may be a registered or unregistered health practitioner (Te Tumu Waiora, 2021). In some areas, a NGO community worker is included, providing a 'culturally responsive connection point' (Appleton-Dyer et al., 2018, p3). This new primary care health workforce is intended to maximise access to 'effective, focused, evidence-based psychological strategies' (Bagnall, 2016, p5) such as talk therapies and brief behavioural interventions; support behavioural or lifestyle changes; promote self-management and goal achievement; and assist in navigating and connecting people to other services (Robinson, n.d.).

There are major concerns about the deployment of the IPMHA model in Aotearoa. Whilst described as 'unique' and able to 'effectively address mental health and wellbeing needs of populations in Aotearoa' (ProCare, n.d., p7), the IPMHA model, which privileges a bio-medical, GP focused approach, essentially leaves the system itself untouched. The IPMHA model explicitly fails to recognise that the widely accepted social and economic determinants of health, determinants which tend to appear under the category of 'commonly presenting issues' or 'sub-threshold' problems in the BHC model, create a level of disadvantage for Māori, even before Māori engage with the health system (Health Quality & Safety

Commission, 2019; Reid et al., 2002; Russell et al., 2013). The IPMHA also fails to acknowledge and address the well evidenced conclusion that inequities for Māori are structural, and are underpinned by institutional racism. Key concerns regarding the privileging of the IPMHA model are discussed below.

3.7.1 Absent Evidence

The IPMHA model is promoted as being a "suite of services, based on best available evidence of 'what works', that will enhance the ability of primary and community care to re-orientate towards achieving positive outcomes across health and social need" (Te Tumu Waiora, 2021), with HIPs and Health Coaches constantly promoted as having high efficacy (Hallwright & O'Connell, 2017). Yet such statements are made despite their being little evidence to support the effectiveness of behavioural health consultancy models for Indigenous peoples. For example, in one paper reviewing integrative health coaching and behavioural health consultancy models, the only mention of Indigenous people is a footnote indicating a lack of research targeting Indigenous populations in Australia, the US, or Canada (Bidwell, 2016). Likewise a review of evidence focused on the development of a primary mental health care model in Aotearoa, whilst acknowledging a need for adaptations when working with Māori, makes no reference to any evidence regarding the effectiveness of IPMHA models for Indigenous peoples (Bagnall, 2016). Another paper concludes more research is needed to understand the outcomes effected by the behavioural health primary care model for racial and ethnic minority populations (Hunter et al., 2016). Similarly, an unpublished proposal to introduce a UK based model centred on a new workforce of Psychology Wellbeing Practitioners who would undertake tasks similar to that of HIPs, highlighted positive outcomes of this workforce for many people. However, despite projected effectiveness for Māori being a key element of the proposal, it was only in the footnotes that poor uptake by minority cultures was acknowledged, suggesting benefits for Māori were most likely heavily overstated.

3.7.2 Ignored Evidence

The IPMHA also ignores the extensive literature base which clearly documents the impacts of differential access and quality for Māori at all levels of health care services, including primary care services (Health & Disability System Review, 2019; Health Quality & Safety Commission, 2019; Reid et al., 2002; Russell et al., 2013). This includes the reality that not only do primary care services fail to provide the same benefits to Māori, in some cases engagement with those services actually serves to increase inequity (Reid et al., 2002). For example, evidence presented to the Waitangi Tribunal shows, despite Māori accessing primary care at the same or higher rates as non-Māori, more Māori are diagnosed with cancer in Emergency Departments than within General Practice settings (Waitangi Tribunal, 2019). Past research also shows that although more Māori visits to GPs are graded as urgent, GPs report spending less time with Māori in consultations; order fewer follow-up investigations; recommend lower levels of follow-up visits as compared with non-Māori; and make less referrals for Māori (Crengle, Davis, & Lay-Yee, 2004). Specifically in relation to mental health care, there is evidence that Māori present more often to general practices with mental health related problems, however their problems are underdiagnosed (Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Bushnell, 2005). Such findings support the conclusion that whilst increasing enrolments and utilisation of primary care services may be a positive indicator of

engagement, they alone do not sufficiently address issues underpinning inequity for Māori (Russell et al., 2013).

Cost has been widely reported as a barrier to accessing a general practitioner (Health Quality & Safety Commission, 2019). Related to this, whilst the GP may be an important first contact for many people presenting with mental health symptoms, for others it will not be (OECD, 2018). The Initial Mental Health & Wellbeing Commission (2021) identifies the importance of ensuring non-medical approaches to supporting whānau in distress are available, emphasising for Māori, primary care often exists not in clinics but in communities. Supporting this, research has emphasised that whilst economic and geographic barriers to access are relatively easily identified and solved by PHOs, barriers originating from a disconnect between Māori models of health and wellbeing, and the disease-oriented medical model are not (Russell et al., 2013). The Waitangi Tribunal heard substantial evidence that those who work in more preventative primary care services are likely to promote a knowledge system that perpetuates racism and contributes to worsening outcomes for Māori (Waitangi Tribunal, 2019). Primary care providers, like other health professionals, may inadvertently provide less care to those with the greatest health needs due to a lack of cultural alignment, with this lack of background or understanding inhibiting the therapeutic relationship, thus impacting the quality of care received (Jansen & Smith, 2006; Russell et al., 2013).

Access is being equated with equity in IPMHA model. Yet as the evidence clearly shows equity cannot be measured solely by access alone. The evidence is in no doubt that institutional racism is critical to address if health inequities for Māori are to be eliminated. Yet there is no evidence that the IPMHA model has any focus on institutional racism or on the collection of data which enables equity to be fully assessed and monitored. Likewise, there is no evidence that the normalisation of inequity for Māori is being addressed, with dominant individualised deficit theory, language and indicators which sustain the stereotype that inequity results from the individual failings of Māori, as opposed to systemic structural bias, remaining prevalent in the IPMHA model.

The experiences of Te Kūwatawata ki Tairāwhiti and Te Kūwatawata ki Hauraki provide valuable information regarding how the GP and bio-medically dominated IPMHA model impacts on addressing inequity for Māori. For example, in Te Kūwatawata ki Tairāwhiti it was found the newly favoured IPMHA models would likely result in less referrals to Te Kūwatawata ki Tairāwhiti from GPs, meaning the SPoE and 'by Māori for all' approach of Te Kūwatawata ki Tairāwhiti would be lost (Tipene-Leach et al., 2019). Of major concern is the IPMHA model is becoming increasingly pervasive, to such an extent that Indigenous designed and led initiatives such as Te Kūwatawata are now being expected to fit within the parameters of the imported IPMHA model.

3.7.3 Whānau Ora

Not only does the IPMHA model lack evidence regarding its effectiveness with Indigenous peoples, as well as overlook the evidence which documents how inequities are perpetuated by the current GP dominated primary care system, the IPMHA model also overtly ignores what is known to be effective for Māori. Underpinned by an established evidence base documenting its success, whānau ora and whānau-centred practice, the uniquely Indigenous strengths-based paradigm that recognises that the wellbeing of individuals is inextricably

linked to the wellbeing of the collective (Taskforce on Whanau-Centred Initiatives, 2009), remains the foremost call across health, welfare, social service and justice sectors (Boulton et al., 2020). In 2018 the Government Inquiry into Mental Health & Addiction was clear whānau ora was transformative paradigm shift required in order to effect positive outcomes for Māori (Government Inquiry into Mental Health & Addiction, 2018; Russell et al., 2018).

Despite this clearly established evidence base, the IPMHA model remains explicitly 'person-centric' (Appleton-Dyer et al., 2018). Irrespective of being overtly 'person-centric', the IPMHA model is promoted as adaptable for Māori in that it is holistic and well integrated, with HIPs and Health Coaches expected to link with local community resources that support wellbeing, including whanau ora services (ThinkPlace New Zealand Ltd, 2017). In addition, the 'culturally responsive connection point' referred to earlier is emphasised; an Awhi Ora NGO worker who works alongside HIPs and Health Coaches (Appleton-Dyer et al., 2018). Of note is that although this role is described as a 'key part' of the model, it is not detailed alongside HIPs and Health Coaches as a core element of the IPMHA model, with it stated such a role occurs only where DHB contracts allow (Te Tumu Waiora, 2021). Other references have been made regarding it being unclear how the Awhi Ora worker contributes, with potential overlaps across roles needing to be navigated, particularly in relation to access across general practice teams (Appleton-Dyer et al., 2018). That the Awhi Ora role is specifically recommended as an important 'consideration' in future IPMHA roll-outs (Appleton-Dyer et al., 2018) further indicates a 'culturally responsive connection point' is not actually an assumed non-negotiable component of the IPMHA model.

Although statements are made in relation to the capacity of the IPMHA model to be adapted for whānau, it is not grounded within the whānau ora paradigm. As has been well documented, whānau ora and whānau-centred practice encompasses significantly more than that of simply delivering to a group. It is the holistic totality of the whānau ora paradigm which makes it successful: an Indigenous worldview in which culturally anchored whānau-centred practice is prioritised; the wellbeing of individuals is inextricably linked with the wellbeing of the collective; rangatiratanga is considered as residing within whānau collectives; and whānau are viewed not only as the foundation of strength and wellbeing with potential for transformative change, they themselves are the agents of that change (Gifford et al., 2013; Ministry of Health, 2002; Taskforce on Whanau-Centred Initiatives, 2009; Te Puni Kōkiri, 2015). As has been emphasised by the Initial Mental Health & Wellbeing Commission (2021), cultural components of a service must not be confused with an entirely culturally grounded model.

Despite it having been emphasised for some time that the health system must create opportunities for Māori to exercise rangatiratanga and mana motuhake, particularly in terms of exercising control over systems and models of care grounded within te ao Māori (Health & Disability System Review, 2020; Initial Mental Health & Wellbeing Commission, 2021; Waitangi Tribunal, 2019), the implementation of the IPMHA model has ignored the reality that whānau ora and whānau-centred providers are already well positioned to take the lead in the design, development and implementation of services for whānau in distress. A thorough understanding of the whānau ora paradigm and its strengths should have been a logical first step in determining how any integrated primary mental health and addictions model could effectively impact equity for Māori.

3.7.4 Institutional Racism in Action

Despite clear calls for systemic structural transformation and culturally-led initiatives which address inequity, and despite Mahi a Atua, Te Kurahuna and Te Kūwatawata being widely acknowledged as exemplars of the pathway needed into the future, an imported model, complete with an imported training paradigm, has emerged as the favoured solution for enhancing access and choice in mental health and addiction services in Aotearoa. Transformative responses such as Te Kurahuna, Mahi a Atua and Te Kūwatawata, in explicitly recognising the wider determinants of health and wellbeing, seek to effect significantly wider solutions than that of the IPMHA. Recognising whānau ora as being at the centre of necessary transformative change, Te Kūwatawata is underpinned by Te Kurahuna, a kaupapa Māori wānanga space responsible for delivering a workforce able to explicitly practice at the whānau ora-mental health interface (Kopua, Levy, & Cherrington, 2019). The Ministry of Health has itself acknowledged the need for whānau-centred services designed, developed and delivered for and by hapū, iwi and Māori communities (Ministry of Health, 2016). Yet, paradoxically, in proceeding to mandate what primary mental health care must look like, the Ministry of Health has maintained a somewhat standard practice of importing international programmes with limited or unknown effectiveness for Indigenous and minority peoples (Boulton et al. 2020).

Significant funding has been allocated to a model with no evidence it is able to successfully impact inequity for Māori. That models such as IPMHA have been prioritised over Indigenous led and designed paradigms such as Te Kurahuna, Mahi a Atua and Te Kūwatawata which directly target institutional racism, recognised as the underpinning cause of inequity for Māori, is of course ironically illustrative of institutional racism. The primary health care framework in Aotearoa has already been identified as institutionally racist by the Waitangi Tribunal (Waitangi Tribunal, 2019). That significant resources have been invested in the development of strategies and research that have subsequently failed to address inequity, alongside a constantly identified lack of investment and support for mātauranga Māori approaches, encompasses all the characteristics of institutional racism: lack of action; inappropriate action; and lack of consequence for poor outcomes.

4.0 Concluding Commentary

This report provides the foundation for the development of a strategically focused, comprehensive publication and information dissemination approach which ensures Te Kurahuna, Mahi a Atua, and Te Kūwatawata are fully understood as far-reaching, uniquely Indigenous informed pathways able to effect the transformation necessary to realise equity for Māori. The report can also serve as a platform for the development of a strategically focused research agenda able to support Te Kurahuna into the future. Doing so will ensure Te Kurahuna takes full advantage of future opportunities and possibilities, particularly those likely to emerge under the MHA. This section offers some concluding commentary on two relevant themes: the courage of Te Kurahuna to advance a fully transformative agenda; and the critical importance of a collective commitment to fully engaging in the entire transformation process.

4.1 Te Kurahuna: Courage to Transform

Acknowledged as the first time such a bold transformation has been attempted, Te Kurahuna has demonstrated how to truly revolutionise mental health spaces not only for Māori, but for all (Tipene-Leach et al., 2019). As is shown throughout this report, Te Kurahuna, Mahi a Atua and Te Kūwatawata are seen as having far reaching implications for the future delivery of health services (Rangihuna et al., 2018b). Te Kurahuna, as the kaitiaki of Mahi a Atua, goes far beyond that of cultural adaptation, responsiveness, or even competency, by understanding, as is consistent with the evidence, that structural systemic transformation is required if equity for Māori is to be achieved. Recognised as an exemplar of an Indigenous framework able to realise the systemic innovation and transformation long called for (Initial Mental Health & Wellbeing Commission, 2021), Te Kurahuna, Mahi a Atua, and Te Kūwatawata have laid a pathway to achieve enhanced service access, a priority identified in the 2018 Government Inquiry into Mental Health & Addiction (Tipene-Leach et al., 2019). Significantly, Te Kurahuna, Mahi a Atua, and Te Kūwatawata address the heart of equity for Māori, responding to the conclusion reached across multiple reports, inquiries and reviews that equity encompasses more than simply access to services: institutional racism must be eliminated to realise equity for Māori.

Purposefully focused on transformative change, as opposed to the reformation of existing systems, Te Kurahuna boldly advocated a 'by Māori, for all' approach. Entirely consistent with the view that when we get it right for Māori, we will get it right for everyone, the move to this approach recognises the reality that Kaupapa Māori 'by Māori for Māori' service provision has been severely decimated over past decade. In operationalising the paradigm shift to whānau ora and whānau-centred practice as the norm, Te Kurahuna, Mahi a Atua, and Te Kūwatawata actively claim culturally defined theoretical and applied spaces, embedded within a wider context which nurtures uniquely Maori approaches. Institutional racism cannot not exist where an Indigenous paradigm is the norm.

Embedded within transformative Kaupapa Māori theory, the whānau ora evidence base, and pioneering cultural safety theory and practice, Te Kurahuna and its uniquely Indigenous workforce development approach encompasses all elements necessary for creating a collective consciousness to lead, influence and embed sustainable transformative change. Te Kurahuna recognises genuine transformation requiring significant cultural change will always be challenging. Paradigm shifts and movement to critical consciousness are a long term, and often difficult, process of active critical self-reflection about one's own contribution to institutional racism (Curtis et al., 2019). Issues such as the ongoing prioritisation of Western dominated approaches, difficulty adjusting to the transparency and feedback informed practice required by Mahi a Atua, and being unwilling to consider issues regarding racism, implicit bias, and inequity (Te Kurahuna Ltd, 2021) all emphasise the centrality of Te Kurahuna wānanga processes, and the importance of long term professional development opportunities which create environments conducive to courageous and transparent collective learning (Kopua, 2019). As the transition to a fully Indigenised system progresses, continued focus on the development of leadership able to champion ongoing skill development and fidelity with Mahi a Atua principles and operational practices and processes is critical. Te Kurahuna, with its independence from mainstream institutions, and its determination to ensure attention remains focused on addressing institutional racism is at the centre of this process.

Research able to support Te Kurahuna into the future has been identified as necessary (Kopua et al., 2020). Any future research agenda for Te Kurahuna must rest upon the principles of Kaupapa Māori theory and Mahi a Atua matapono: autonomy and control over research, including the setting of research aspirations and priorities; Māori knowledge bases and worldviews are the norm; critical analyses expose underlying values and assumptions of Western knowledge bases and power structures, and the impact of these on Māori; and researchers remain active learners who embrace a culture of feedback. Ongoing attention to the growth of practice-based evidence able to support continuous whānau-centred service evaluation is critical.

Fundamental to the transformation being sought by Te Kurahuna is a paradigm shift away from the dominant biomedical model of mental health, to a wellbeing paradigm founded within te ao Māori. Although it is recognised that shifting to a whānau ora oriented paradigm is difficult in the face of such deeply engrained bias towards western knowledge (Russell et al, 2018), it is likewise understood that unless this deeply engrained bias is addressed, inequity for Māori will persist (Initial Mental Health & Wellbeing Commission, 2021). More specifically, as is evidenced by the literature "diagnostic-based services are inherently institutionally racist, and no service that takes seriously trying to provide a culturally-appropriate service can claim to have made such forward strides in doing so without first abandoning the use of diagnostic-based thinking" (Timimi, 2013, p26).

It is widely understood and accepted that a central element of the institutional racism perpetuating inequity for Māori across the mental health system is domination by a bio-medical, mono-cultural, illness-focused model. However, whilst calls have been made to decolonise and transform professional mental health training curricula (Kopua, 2020; Waitangi Tribunal, 2018), we are yet to see, as has occurred in the British Psychological Society, mental health diagnostic classification systems in Aotearoa substantially challenged either institutionally (i.e. within training programmes) or structurally (i.e. from professional organisations). Paradigm shift away from diagnostic classification systems is central to the transformation being sought by Te Kurahuna, Mahi a Atua, and Te Kūwatawata. The call to abandon diagnostic classification systems is not limited to Te Kurahuna, nor does it exist only on the fringes of the literature base. For many, the essential elements of effective assistance to deal with distress are the development of supportive and trusting therapeutic relationships based on narrative dialogue, relationship, and evolving meaning, as opposed to formal therapies provided by a psychologist or psychiatrist (Johnstone & Boyle, 2018). Going forward, the essential elements of the paradigm shift required, including movement away from diagnostic systems to conceptualisations more appropriately focused on distress, need to be clearly articulated and implanted into mainstream consciousness. An element of this may include further articulating the concept of Te Kūwatawata as a social model of support for those in distress, which is then backed-up with clinical support.

Growing understandings of Mahi a Atua as 'a way of being', specifically in relation to articulating how Mahi a Atua acts to create a collective consciousness which addresses institutional racism across multiple levels in order to reinstate equity may also be useful going forward. Such research would utilise a range of methodologies, both quantitative and

qualitative, which incorporate a focus on communicating practice-based evidence, measures of success and outcomes which matter to whānau (Kopua et al., 2020; Johnstone et al., 2018).

4.2 Commitment to Act

The Waitangi Tribunal has emphasised how hard-fought gains in the health sector, achieved over many years, were often at risk of being easily eroded (Waitangi Tribunal, 2019). Alongside this, the Initial Mental Health & Wellbeing Commission (2021) has raised concern that services for those most in need are taking the longest to eventuate, with this only leading to inequities rising even further. Importantly, but often obscured in discussions regarding inequity, is that continuing with the status quo risks not only the ongoing over-representation of Māori across negative indicators, but also substantial lost opportunities for whānau to realise their potential (State Services Commission, 2019).

Despite the existence of a robust knowledge base to guide transformation, and the abundance of reports and reviews, many of which are described as a 'once in a generation opportunity to do things differently', none have resulted in sustainable and enduring change for Māori communities (Boulton et al., 2020). Specifically in relation to mental health, investment in the IPMHA model fails to act on the established evidence base which advocates for movement away from dominant biomedical illness-focused paradigms of mental health towards Indigenous paradigms of wellbeing. Nor does the IPMHA model in any way reflect the fundamental importance of eliminating systemic racism if inequity is to be genuinely addressed. With the need to address institutional racism in order to effect transformational change long established, a commitment to action must extend far beyond broad non-specific statements such as those made by the HDSR in 2020 that "an absence of racism must be a given" (p.5). Proposed HDSR reforms have promised enhanced opportunity for Māori to exercise rangatiratanga and mana motuhake, particularly in terms of exercising control over systems and models of care grounded within te ao Māori. If such opportunities are to be realised, it is critical that these reforms do not simply result in more of the same. The evidence is clear: cumulative inequities impacting Māori will not be addressed by increased access to services which continue to be premised upon Western knowledge systems and models of practice (Boulton et al., 2020). A lack of evidence cannot continue to be used as a rationale for inaction in relation to supporting Indigenous approaches, whilst the failure of imported mainstreamed models to evidence outcomes for Indigenous peoples is consistently overlooked. Addressing institutional racism cannot be acknowledged and emphasised as fundamental to realising equity for Māori, then simply ignored in the actions supported going forward.

As is discussed in the previous section, operating from the premise that 'when it is right for Māori, it will be right for all', Te Kurahuna, Mahi a Atua, Te Kūwatawata encompass the core elements necessary to effect systemic transformation. The evidence supports the reality that genuine transformation is not a short-term process; there are no short cuts in the challenging process of shifting one's paradigm and in the critical self-reflection necessary for movement to critical consciousness and the embedding of Mahi a Atua as a 'way of being'. Consistent with Māori voice to the 2018 Government Inquiry into Mental Health & Addiction, a long term approach to transformation which allows adequate time for meaningful change to evolve, develop and be embedded is required (Russell et al., 2018). Whilst such change is acknowledged as likely being both challenging and confrontational (Initial Mental Health &

Wellbeing Commission, 2021), it is likewise entirely possible for Aotearoa to courageously disrupt and transform existing systems (Boulton et al., 2020).

There can be no doubt that realising equity for Māori across all sectors requires significantly more than what is currently supported by the State, its agencies, training institutions, and professional organisations. Enacting a genuine commitment to move away from the status quo requires those in positions of power and influence actively work to eliminate the institutional racism permeating our state institutions (Boulton et al., 2020). Being fully committed to the complete implementation of a transformative agenda able to effect equity for Māori requires rejecting the commonly used policy and decision-making tactic of selectively choosing only those elements which appear more politically palatable (Boulton et al., 2020). As is intrinsic to Te Kurahuna, Mahi a Atua and Te Kūwatawata, courage to take bold steps is required: resistance will always occur when the status quo is challenged. The need for commitment to genuine transformation via addressing institutional racism and structural bias is only amplified in the new COVID-19 world, where inequity for Māori is intensified as the economic, social and cultural repercussions of the pandemic reverberate for years to come (Boulton et al., 2020).

The experience of Te Kūwatawata ki Hauraki demonstrated what could be achieved when resistance to challenging the status quo is absent, replaced instead with a collective commitment to the entire transformative pathway being facilitated by Te Kurahuna, Mahi a Atua, and Te Kūwatawata. Importantly, such collective commitment allowed for resolution to occur even in the face of contention or disagreement. This call for collective commitment to long term transformation is not only relevant to the State and its agencies. It is a call to remain steadfast in our own commitment to effecting the principles of Mahi a Atua: to Indigenise spaces, remain active learners, and embrace a culture of feedback, even in the face of resistance. To continue to strategise and hold strong in the face of the evidence which shows Te Kurahuna exemplifies transformation in action. As Iwi leaders have recently asserted, the "opportunity to effect real social change in a manner that has never been achieved before, has arrived"(National Iwi Leaders Technical Working Party, 2016, p10).

5.0 References

Appleton-Dyer, S., Andrews, S., Reynolds, J., Henderson, G., & Anasari, Z. (2018). Fit for Future: Evaluating Integrated Practice Teams. Retrieved from https://static1.squarespace.com/static/57a93203d482e9bbf1760336/t/5c09b5f58a9 22de1eafd8235/1544140300132/Synergia+ADHB+FftF+Enhanced+integrated+practi ce+teams+evaluation+FINAL+1....pdf

Bagnall, C. (2016). Developing a service model for primary mental health support for moderate need. An evidence review developed by Network 4 in partnership with Platform Trust. Retrieved from https://static1.squarespace.com/static/57a93203d482e9bbf1760336/t/59127673d2 b857d64b9f9435/1494382207821/Primary+Mental+Health+Evidence+Review+- +Network+4+and+Platform+Trust.pdf

Baker, M., & Levy, M. (2013). E Toru Ngā Mea. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 11*(13), 471-483.

Baxter, J., Kingi, T., Tapsell, R., Durie, M., & McGee, M. (2006). Prevalence of mental disorders among Māori in Te Rau Hinengaro: The New Zealand Mental Health Survey. *Australian and New Zealand Journal of Psychiatry, 40*(10), 914-923.

Beresford, P. (2002). Thinking about 'mental health': Towards a social model. *Journal of Mental Health,, 11*(6), 581-584. doi:10.1080/09638230020023921

Bidwell, S. (2016). *New models for health improvement and behaviour change (Occasional Paper 4)*. Retrieved from https://www.pegasus.health.nz/wp-content/uploads/2018/05/New-models-for-health-improvement-and-behaviour-change-Susan-Bidwell.pdf

Bishop, R., & Glynn, T. (1999). *Culture Counts: Changing Power Relations in Education*. Palmerston North: Dunmore Press Limited.

Boulton, A., Cvitanovic, L., & Cropp, T. (2018). A Maori-informed approach to health social work. In M. Petrakis (Ed.), *Social Work Practice in Health*: A&U Academic.

Boulton, A., Cvitanovic, L., Potaka-Osborne, G., & Williams Blyth, T. (2018). E Tipu E Rea: The care and protection of Indigenous (Māori) children. *New Zealand Law Journal, 3*(26), 3-6.

Boulton, A., Levy, M., & Cvitanovic, L. (2020). Beyond Puao-Te-Ata-Tu: Realising the promise of a new day. *Te Arotahi Paper Series, December*(Number 06).

Bracken, P., & Thomas, P. (2017). Reflections on critical psychiatry. In B.Cohen (Ed.), *Routledge International Handbook of Critical Mental Health* (pp. 98-106). London: Routledge.

British Psychological Society. (2013). Classification of behaviour and experience in relation to functional diagnoses: Time for a paradigm shift. Retrieved from https://www.bps.org.uk/sites/www.bps.org.uk/files/Member Networks/Divisions/DCP/Classification of behaviour and experience in relation to functional psychiatric diagnoses.pdf

Bushnell, J. (2005). Mental Disorders Among Māori Attending Their General Practitioner. *Australian & New Zealand Journal of Psychiatry, 39*(5), 401-406.

Camberley School. (2021). *Our School Charter 2020.* Retrieved from https://www.camberley.school.nz/our-school-charter

Came, H., Doole, C., McKenna, B., & McCreanor, T. (2018). Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand. *SocSciMed, 199*, 132-139.

Chief Victims Advisor to the Government. (2019). *Strengthening the Criminal Justice System for Victims: Te Tangi o te Manawanui - Recommendations for Reform*. Retrieved from https://chiefvictimsadvisor.justice.govt.nz/assets/Documents/Publications/Te-Tangi-Final-PDF.pdf:

Clark, T., Le Grice, J., Moselen, E., Fleming, T., & Crengle, S. (2018). Health and wellbeing of Māori secondary students in New Zealand: Trends between 2001, 2007, and 2012. *Australian and New Zealand Journal of Public Health, 42*(6), 553-561.

Cram, F., Pipi, K., & Paipa, K. (2018). Kaupapa Māori evaluation in Aotearoa New Zealand. In F.Cram, K. A. Tibbetts, & J.LaFrance (Eds.), *Indigenous Evaluation: New Directions for Evaluation.* (pp. 63-77): Wiley Online Library.

Crengle, S., Davis, P., & Lay-Yee, R. (2004). *Māori Providers: Primary health care delivered by doctors and nurses: The National Primary Medical Care Survey 2001/02. Report 3.* Retrieved from https://www.otago.ac.nz/wellington/otago067738.pdf

Cumming, J. (2011). Integrated care in New Zealand. *International Journal Integrated CARE, 11*(138).

Cunningham, R., Kvalsvig, A., Peterson, D., Kuehi, S., Gibbs, S., McKenzie, S., . . . Every-Palmer, S. (2018). *Stocktake Report for the Mental Health and Addiction Inquiry.* Retrieved from https://mentalhealth.inquiry.govt.nz/assets/Summary-reports/Otago-stocktake.pdf

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S., & Reid , P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *Int J Equity Health, 18*(174).

Department of Prime Minister and Cabinet. (2021). *Our health and disability system*. Retrieved from Wellington: https://dpmc.govt.nz/sites/default/files/2021-04/heallth-reform-white-paper-summary-apr21.pdf

Department of Social Welfare. (1988). *Puao-te-ata-tu*. Department of Social Welfare, Wellington, New Zealand.

Elder, H. (2008). Ko wai ahau? (Who am I?) How cultural identity issues are experienced by Maori psychiatrists and registrars working with children and adolescents. *Australas Psychiatry, 16*(3), 200-203.

Gifford, H., Tuaine, N., Muir, E., & Harford, R. (2013). *Whānau Ora: making a difference to New Zealand's Waistline?* Paper presented at the National Centre for Diabetes and Obesity Research, June 7, University of Otago.

Government Inquiry into Mental Health & Addiction. (2018). *Te Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Retrieved from https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/

Hallwright, S., & O'Connell, J. (2017). *New Roles, New Workforce: Health Improvement Practitioners and Health Coaches in General Practice*. Retrieved from https://www.healthnavigator.org.nz/media/3840/johnny-oconnell-sue-hallwright-workforce-development-moh-conference.pdf

Hamilton, K. (2020). *Ngātahi Takitahi Evaluation Report*. Karearea Institute for Change.

Health & Disability System Review. (2019). *Health and Disability System Review - Interim Report. Hauora Manaaki ki Aotearoa Whānui –Pūrongo mō Tēnei Wā*. Retrieved from https://systemreview.health.govt.nz/

Health & Disability System Review. (2020). *Health and Disability System Review – Final Report – Pūrongo Whakamutunga.* Retrieved from https://systemreview.health.govt.nz/

Health Quality & Safety Commission. (2019). *A Window on the Quality of Aotearoa New Zealand's Health Care 2019.* Retrieved from https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/publications-and-resources/publication/3721/

Hopkirk, J. (2010). *Whitiwhitia i te ora! Culture and Occupational Therapy: A Māori Case Study.* (Master of Philosophy), Massey University, Palmerston North.

Hunter, C., Funderburk, J., Polaha, J., Bauman, D., Goodie, J., & Hunter, C. (2016). Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action. *J Clin Psychol Med Settings, 25*, 127-156.

Initial Mental Health & Wellbeing Commission. (2021). *Mā te rongo ake: Through listening and hearing.* Retrieved from https://www.mhwc.govt.nz/the-initial-commission/progress-reporting/

Jackson, M. (1987). *The Māori and the Criminal Justice System: A New Perspective - He Whaipaanga Hou*. Wellington, New Zealand: Department of Justice.

Jansen, P., & Smith, K. (2006). Māori experiences of primary health care. *NZFP, 33*(5), 298-300.

Johnstone, L., & Boyle, M. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Retrieved from https://www.mhwc.govt.nz/the-initial-commission/progress-reporting/

Kaiwai, H., Allport, T., Herd, R., Mane, J., Ford, K., Leahy, H., . . . Kipa, M. (2020). *Ko Te Wā Whakawhiti, It's Time For Change A Māori Inquiry into Oranga Tamariki*. Retrieved from https://whanauora.nz/assets/6f126cc001/ORANGA-TAMARIKI-REVIEW-REPORT.pdf

Keddell, E. (2018). The vulnerable child in neoliberal contexts: the construction of children in the Aotearoa New Zealand child protection reforms. *Childhood, 25*(1), 93-108.

Kopua, D. (2019). Factors that facilitate and constrain the utilization of a Kaupapa Māori therapeutic approach with Mahi-a- Atua *Australasian Psychiatry, 27*(4), 341-344.

Kopua, D. (2020). *Te Ora Oration: Dr Maarire Goodall Award*.

Kopua, D., & Kopua, M. (2021). *Turning the waka and creating change with Mahi A Atua (Unpublished Paper)*.

Kopua, D., Kopua, M., & Bracken, P. (2020). Mahi a Atua: A Māori approach to mental health. *Transcultural Psychiatry, 57*(2), 375-383.

Kopua, D., Levy, M., & Cherrington, L. (2019). *What are we wating for? Actualising Whānau Ora in Mental Health*. Retrieved from https://www.mahiaatua.com/blog/

Lancet Global Mental Health Group. (2007). Scaling up services for mental disorders – a call for action. *Lancet, 370*, 1241-1252.

Lavoie, J., Kornelsen, D., Wylie, L., Mignone, J., Dwyer, J., Boyer, Y., . . . O'Donnell, K. (2016). Responding to health inequities: Indigenous health system innovations. *Global Health, Epidemiology and Genomics,, 1*(e14).

Levy, M. (2007). *Indigenous Psychology in Aotearoa: Realising Maori Aspirations.* (D.Phil D.Phil), University of Waikato, Hamilton.

Love, C. (2008). An Indigenous Reality Check: "Steering by Matariki and the Southern Cross: Plotting Clinical Psychology's Course in New Zealand". *New Zealand Journal of Psychology, 37*(3), 26-32.

Maltest International. (2019). *Pregnancy and Parenting Service (Draft Evaluation)*.

Māori Affairs Committee. (2013). *Inquiry into the determinants of wellbeing for tamariki māori: Report of the Māori Affairs Committee* Retrieved from https://www.parliament.nz/en/pb/sc/reports/document/50DBSCH_SCR6050_1/inquiry-into-the-determinants-of-wellbeing-for-tamariki

Mikaere-Hall, A. (2017). Constructing research from an indigenous Kaupapa Māori perspective: An example of decolonising research. *Psychotherapy and Politics International, 15*.

Milne, M. (2005). *Māori perspectives on Kaupapa Māori psychology: A discussion document*.

Ministry of Health. (2002). *He Korowai Oranga: Māori Health Strategy*. Retrieved from Wellington: https://www.health.govt.nz/system/files/documents/publications/mhs-english.pdf

Ministry of Health. (2016). *Fit for Future Update*. Retrieved from https://www.health.govt.nz/system/files/documents/pages/fit_for_the_future_-_update_dec_2016.pdf:

Modernising Child Youth and Family Expert Panel. (2015). *Expert Panel Final Report: Investing in New Zealand's Children and their Families*. Retrieved from https://www.msd.govt.nz/about-msd-and-our-work/work-programmes/investing-in-children/eap-report.html:

National Iwi Leaders Technical Working Party. (2016). *Modernisation of Child, Youth & Family - National Iwi Māori Response*. Waitangi: National Iwi Leaders Forum.

New Zealand Productivity Commission. (2015). *More effective social services*. Retrieved from https://www.productivity.govt.nz/

Ngamane-Harding, R. (2021). *Te Korowai Hauora o Hauraki: Responding to the Mental Health Needs of Rangatahi in Hauraki*.

O'Sullivan, D. (2019). *Waitangi Tribunal: Wai 2823 - Brief of Evidence*.

OECD. (2018). *Mental Health and Work: New Zealand*. Retrieved from https://www.oecd.org/newzealand/mental-health-and-work-new-zealand-9789264307315-en.htm

Parahi, C. (2020). Life or death' challenge for Government to declare racism a public health crisis. *Stuff*. Retrieved from https://www.stuff.co.nz/national/health/119617077/life-or-death-challenge-for-government-to-declare-racism-a-public-health-crisis?cid=facebook.post&fbclid=IwAR1RjVd3dNePNAQ2UvYm6iKQG1RY_dVE1KsT9reWuj5cWD1Ykp2y5gcn91k

Pihama, L. (2001). *Mana wahine as a Kaupapa Māori theoretical framework.* (Doctor of Philosophy in Education), Univeristy of Auckland, Auckland.

Pihama, L., Cram, F., & Walker, S. (2002). Creating methodological space: a literature review of kaupapa Maori research. *Canadian Journal of Native Education,, 26*(1), 30-43.

Pohatu, T. (2005). *Āta: Growing Respectful Relationships.* Retrieved from http://www.rangahau.co.nz/assets//Pohatu/Pohatu T.pdf

ProCare. (n.d.). Te Tumu Waiora: *Easy access to local wellbeing support for your and your whānau (An Overview).* Retrieved from https://www.procare.co.nz/media/1752/procare_overview_te-tumu-waiora_v1.pdf

Raine, R., Carter, S., Senky, T., & Black, N. (2005). Referral into a Void': Opinions of General Practitioners and Others on Single Point of Access to Mental Health Care. *Journal of the Royal Society of Medicine, 98*(4).

Ramsden, I. (2015). Towards Cultural Safety. In W. D (Ed.), *Cultural Safety in Aotearoa New Zealand* (pp. 5-25). Melbourne: Cambridge University Press.

Rangihuna, D., Kopua, M., & Tipene-Leach, D. (2018a). Mahi a Atua: a pathway forward for Māori mental health? *New Zealand Medical Journal, 131*(1471).

Rangihuna, D., Kopua, M., & Tipene-Leach, D. (2018b). Te Mahi a Atua. *J PRIM HEALTH CARE, 10*(1), 16-17.

Reid, P., Cormack, D., & Paine, S. (2019). Colonial histories, racism and health—The experience of Māori and Indigenous peoples. *Public Health, 172*, 119-124.

Reid, P., & Robson, B. (2007). Understanding Health Inequities. In B. Robson & R. Harris (Eds.), *Hauora:Māori Standards of Health IV - A study of the years 2000-2005*. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare.

Reid, P., Robson, B., & Jones, C. (2002). Disparities in health: common myths and uncommon truths. *Pacific Health Dialog, 7*(38-47).

Robertson, P. J., Haitana, T. N., Pitama, S. G., & Huriwai, T. T. (2006). A review of work-force development literature for the Māori addiction treatment field in Aotearoa/New Zealand. *Drug and Alcohol Review, 25*(3), 233-239. doi:10.1080/09595230600644707

Robinson, P. (n.d.). *Behavioural Health Consultancy: Application and Evidence*. Retrieved from https://static1.squarespace.com/static/57a93203d482e9bbf1760336/t/5ad0036e1a e6cf72ec1d767d/1523581818511/Dr+Patricia+Robinson+-+Behavioural+Consultancy-Application+and+Evidence.pdf

Robson, S. (2021). Plunket admits is had been failing Māori and Pacific Babies (14 July). *Radio New Zealand*. Retrieved from https://www.rnz.co.nz/news/national/446851/plunket-admits-it-has-been-failing-maori-and-pacific-babies

Rua, M. (2015). *Māori men's positive and interconnected sense of self, being and place.* (PhD), University of Waikato, Hamilton, New Zealand.

Rua, M., Hodgetts, D., Stolte, O., Cochrane, B., Karapu, R., Neha , E., . . . Groot, S. (2019). *Precariat Māori Households Today (Te Arotahi Series)*. Retrieved from http://www.maramatanga.co.nz/node/1153

Russell, L., Levy, M., & Cherrington, L. (2018). *Whakamanawa. Honouring the voices and stories of Māori who submitted to the 2018 Government Inquiry into Mental Health and Addiction in Aotearoa.*

Russell, L., Smiler, K., & Stace, H. (2013). *Improving Māori Health and Reducing Inequalities between Māori and Non-Māori: Has hte Primary Healthc Care Strategy Worked for Māori?* Retrieved from https://www.wgtn.ac.nz/health/centres/health-services-research-centre/our-publications-archived/reports/phcse-maori-report.pdf

Sheehan, D., & Jansen, D. (2006). The development of a national bicultural and interprofessional programme in clinical teaching and supervision in New Zealand. *Journal of Interprofessional Care, 20*(6), 591-601.

Smith, G. (2003). *Kaupapa Māori Theory: Theorizing Indigenous Transformation of Education and Schooling*. Paper presented at the Joint AARE/NZARE Conference, Auckland.

Smith, L. T. (2011). Story-ing the development of kaupapa Māori - a review of sorts. In J.Hutchings, H.Potter, & K.Taupo (Eds.), *Kei Tua o te Pae Hui Proceedings: the challenges of Kaupapa Māori research in the 21st century (Pipitea Marae, Wellington, 5-6 May 2011)* (pp. 10-16). Wellington: NZ Council for Educational Research.

Smith, L. T. (2012). *Decolonizing Methodologies : Research and Indigenous Peoples (2nd Edition)*. ProQuest Ebook Central: Zed Books.

Smith, L. T. (2015). Kaupapa Māori research- Some Kaupapa Māori principles. In L. Pihama, S. Tiakiwai, & K. Southey (Eds.), *Kaupapa Rangahau A Reader: A Collection of Readings from the Kaupapa Maori Research Workshop Series* (pp. 46-52). Hamilton: Te Kotahi Research Institute.

Smith, V., Moore, C., Cumming, J., & Boulton, A. (2019). Whānau Ora: An Indigenous Policy Success Story In J. Luetjens, M. Mintrom, & P. t. Hart (Eds.), *Successful Public Policy: Lessons from Australia and New Zealand*. Canberra, Australia: ANU Press.

State Services Commission. (2019). *Impact statement: State sector reform.* Retrieved from https://ssc.govt.nz/assets/Legacy/ resources/Impact-Statement-State-Sector-Act-Reform. pdf:

Taitimu, M., Read, J., & McIntosh, T. (2018). Ngā Whakāwhitinga (standing at the crossroads): How Māori understand what Western psychiatry calls "schizophrenia" *Transcultural Psychiatry, 55*(2), 153-177.

Taskforce on Whanau-Centred Initiatives. (2009). *Whanau Ora: Report of the Taskforce on Whanau-Centred Initiatives.* Retrieved from https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/planning-strategy/whanau-ora/whanau-ora-taskforce-report.pdf

Te Kurahuna Ltd. (2019). *Business Proposal*. Te Whare Wananga o Te Kurahuna. Gisborne.

Te Kurahuna Ltd. (2021). *Te Korowai Hauora o Hauraki - Te Kurahuna. Implementation of Mahi A Atua Processes and Systems Post Project Review*.

Te Pae Pae Arahi Charitable Trust. (2018). *Our Services*. Retrieved from https://www.tepaepae.co.nz/our-services

Te Puni Kōkiri. (2015). *Understanding Whānau-centred Approaches: Analysis of Phase One Whānau Ora research and monitoring results*. Retrieved from Wellington: https://www.tpk.govt.nz/en/a-matou-mohiotanga/whanau-ora/understanding-whanaucentred-approaches-analysis-of

Te Puni Kōkiri, & The Treasury. (2019). *An Indigenous Approach to the Living Standards Framework.* Retrieved from https://www.treasury.govt.nz/publications/dp/dp-19-01

Te Tumu Waiora. (2021). *Te Tumu Waiora.* Retrieved from https://www.tetumuwaiora.co.nz/

Te Uepū Hāpai i te Ora. (2018). *He Waka Roimata: Transforming our Criminal Justice System*. Retrieved from Wellington: https://www.safeandeffectivejustice.govt.nz/assets/Uploads/fa55462d44/teuepureport_hewakaroimata.pdf

Te Uepū Hāpai i te Ora. (2019). *Turuki! Turuki! Move Together: Transforming our criminal justice system. The second report of Te Uepū Hāpai i te Ora. Safe and Effective Justice Advisory Group.* Retrieved from https://www.justice.govt.nz/assets/Documents/Publications/turuki-turuki.pdf

Te Whare Wānanga o Te Kurahuna. (2021). *Mahi-a-Atua - Te Kūwatawata Operations Manual (V2)*. Te Whare Wānanga o Te Kurahuna. Gisborne.

ThinkPlace New Zealand Ltd. (2017). *Fit for the Future: a framework to guide the prototype of a person-centred primary and community mental health model of care*. Retrieved from https://static1.squarespace.com/static/57a93203d482e9bbf1760336/t/5ac44d5eaa

4a99f8e1608855/1522814378783/Fit+for+the+future+Report_Final_single+page+ve rsion.pdf

Timimi, S. (2013). Non-diagnostic Practice. *Context 127*, 21-26.

Tipene-Leach, D., Able, S., Hiha, A., & Matthews, K. (2019). *Rangahaua Te Kūwatawata Final Report*. Hawkes Bay: Māori & Indigenous Research, Eastern Institute of Technology.

Trafford, W. (2021). Racist Plunket has 'no place' in hauora overhaul - Dr Rawiri Jansen (15 July) *Te Ao Māori News*. Retrieved from https://www.teaomaori.news/racist-plunket-has-no-place-hauora-overhaul-dr-rawiri-jansen

Waitangi Tribunal. (2018). *Wai2725 Psychology in Aotearoa Claim*. Retrieved from https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_137601344/Wai 2725%2C 3.1.001.pdf:

Waitangi Tribunal. (2019). *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575 Waitangi Tribunal Report)*. Retrieved from https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora W.pdf

Walker, S., Eketone, A., & Gibbs, A. (2006). An exploration of kaupapa Maori research, its principles, processes and applications, 9:4, 331-344, DOI: . *International Journal of Social Research Methodology,, 9*(4), 331-344. doi:10.1080/13645570600916049

Welfare Expert Advisory Group. (2019). *Whakamana Tāngata: Restoring dignity to social security in New Zealand*. Retrieved from Wellington: http://www.weag.govt.nz/weag-report/whakamana-tangata/

Whānau Ora Review Panel. (2019). *Whānau Ora Review. Tipu Matoro ki te Ao. Final Report to the Minister of Whānau Ora*. Retrieved from https://www.tpk.govt.nz/docs/tpk-wo-review-2019.pdf

Wharewera-Mika, J., Cooper, E., Wiki, N., Field, T., Haitana, J., Toko, M., . . . McKenna, B. (2016). Strategies to reduce the use of seclusion with tāngata whai i te ora (Māori mental health service users). *International Journal of Mental health Nursing, 25*(258-265).

Wilson, D., McKinney, C., & Rapata-Hanning, M. (2011). Retention of Indigenous nursing students in New Zealand: A cross-sectional survey. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 38*(1/2), 59-75.

World Health Organisation. (2020). *Equity.* Retrieved from https://www.who.int/healthsystems/topics/equity/en/