

Experiences of rangatahi Māori with mental health services in Aotearoa

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: Teina Rihari

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Dated: 08/11/22

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ABSTRACT

Currently, there is a distinct lack of research on rangatahi Māori and mental healthcare in Aotearoa. Research on mental healthcare in Aotearoa has predominantly explored Pakeha and adult experiences. This present research pursued to fill this gap in the literature by investigating the experiences of rangatahi Māori with experiences with mental healthcare in Aotearoa. From these interviews, information will be extracted to add to the limited available research and uncover prospective topics for future research with rangatahi Māori.

Māori-centric qualitative methodology was employed in the current study. Data was collected through semi-structured interviews with rangatahi Māori who have experiences with mental healthcare in Aotearoa. Thematic analysis was used to examine the data collected. Two overarching themes were identified: barriers and enablers. These overarching themes comprise eight emergent themes: 1a) Health literacy, 1b) Stigmatism, 1c) Time, 1d) Financial and socioeconomic factors, 2a) Whakawhānaungatanga, 2b) Transparency, 2c) Satisfaction with service, 2d) Incorporation of Māori culture/models. The findings from these themes provided recommendations for service providers and future research into rangatahi Māori mental health.

INTRODUCTION

The aim of the present study is to explore the lived experiences of rangatahi Māori with mental healthcare. The primary topics of investigation included the significant barriers and enablers to engagement with mental healthcare providers in Aotearoa. It was hypothesised that through studying these themes, a more comprehensive understanding of the experiences of rangatahi Māori will be acquired. The objectives of the present study is timely because youth mental health and Māori mental health is an area of concern in Aotearoa.

This study focused on the unique experiences of Māori participants; and so a Māori-centric qualitative methodology was appropriated. In qualitative methodologies, the participant is considered an expert in their experience with a phenomenon, and this is why the data collection process is collaborative. The researcher guides the participant; however, it is a collective effort. The participant responds to questions from the researcher, and their responses are analysed. Reflexive thematic analysis was used to examine the collected data.

This introduction has described the objectives of the present study, its research context, and a brief depiction of the methodology. A literature review follows, which gives the background information on mental health in Aotearoa, Māori in Aotearoa, and the barriers and enablers to mental healthcare in Aotearoa. The subsequent chapter provides an in-depth report of the methodological approach, the data collection method, participant data, ethical considerations, cultural considerations, and data analysis. The findings chapter provides a brief of the findings, a thematic construction of the analysis, and briefly describes each theme with supporting quotes from the participant transcripts. And lastly, the discussion chapter provides critical analysis of the findings in the perspective of the current research, a brief of the research implications and recommendations, and possible limitations.

LITERATURE REVIEW

This chapter reviews the literature regarding the experiences of rangatahi Māori with mental healthcare in Aotearoa. The state of mental health is described which includes youth mental health and mental healthcare in Aotearoa. Māori and indigenous communities are described and, Māori mental healthcare in Aotearoa is described along with the prevalence of mental illness among Māori in Aotearoa. The experiences of Māori with mental healthcare is described, most specifically, the experiences of rangatahi Māori. Lastly, enablers and barriers to mental healthcare in Aotearoa for rangatahi Māori are described.

Mental Health in Aotearoa

Mental health is essential to the overall wellbeing of individuals in Aotearoa. Globally, mental health issues are steadily increasing. Aotearoa is no exception to this finding. In the 2019/20 Ministry of Health New Zealand Health Survey (NZHS) it was reported that 7.5% of adults experience psychological distress (Ministry of Health, 2019). In the 2020/21 report this had increased to 9.6%. Furthermore, adults living in the most deprived areas seem to experience psychological distress at a higher incidence than those in the least deprived areas. In the most deprived area 15.2% of individuals experience psychological distress compared to 6.1% in the least deprived. Additionally, disabled individuals (27.3%) experience mental health issues at a significantly higher rate than abled individuals (7.9%) (Ministry of Health, 2021). Anxiety and mood disorders are the most frequent diagnosed mental disorders in Aotearoa (Wells, 2006). These statistics heighten the concern at which mental health issues are impacting individuals in Aotearoa.

Youth Mental Health

Globally, youth mental health issues have become increasingly more prevalent over the last decade. Psychological distress in this age group has markedly increased. It has been theorised this trend reflects the increasing magnitude and multitude of challenges faced by young people currently, and Aotearoa is no exception to this trend. Aotearoa has some of the highest rates of mental illness in young people globally (The Organisation for Economic Cooperation and Development, 2018). In Aotearoa, 15- to 24-year-olds are more likely to experience long term psychological distress that impacts daily functioning in comparison with older age groups. Around 30% of individuals in this age group report psychological and emotional distress of conditions that impede their ability to complete everyday activities. In contrast, 10% of individuals between the ages of 25 and 64 years old reported difficulties with long term emotional or psychological distress (Health Promotion Agency, 2018). Additionally, over a third of young people experience difficulties with socialising and

communicating with others caused by emotional or psychological distress, significantly higher than the 10% of individuals over 24 years old (Health Promotion Agency, 2018). There seems to be an underestimated urgency around this issue which has been significantly perpetuated by the global covid-19 crisis. This is of concern considering the significant impact the pandemic has had on youth mental health issues (Menziés et al., 2020). The rise in mental health issues and subsequent mental health morbidity among young people in Aotearoa demonstrates how their right to positive mental health and wellbeing is not being acknowledged or addressed. The prolonged failure to do so will inevitably result in detriment to the overall wellbeing and prosperity of Aotearoa.

Mental Healthcare in Aotearoa

Mental health services can be accessed in a variety of ways in Aotearoa. Most commonly they begin with a referral from a general practitioner (GP) whereby the GP explores local options for mental healthcare for their patient (Ministry of Health, 2022). Mental health services can present in many forms: counsellors, psychologists, psychotherapists, psychiatrists, community support centres, rehabilitation centres, etc. In 2012, the Mental Health Commission established a ten-year plan to improve the mental wellbeing of New Zealanders. This was done with the rationale of improving access to mental health services. The main goals of the new blueprint was to reduce wait times for access to services, incorporate whānau into treatment processes, have services that can be tailored to each individual and their different needs, to identify mental health or addiction issues early to prevent life time impacts, reduce the health inequities across cultures, and increase accessibility of services (by reducing costs) (Mental Health Commission, 2012). This blueprint seems to have made some progress in accessibility and quality of mental health services, however, the prevalence of mental illness still seems to be rapidly increasing annually (Health Promotion Agency, 2018; Ministry of Justice, 2019; New Zealand Government, 2018).

A common primary focus of mental health and addiction services in Aotearoa is to reduce symptoms of the presenting individuals (Mulder et al., 2017). These services are mostly offered through district health board (DHB) or non-governmental (NGO) organisations. However, district health board organisations (147,972 clients) are accessed at higher rates than NGO's (71,362 clients). District health board mental health services are most often provided by community teams (67% of DHB clients) and the next most common is drug and alcohol teams (17% of DHB clients). Similarly, for NGOs the most clients were seen by community teams (52% of NGO clients) and alcohol and drug teams were the next most common (32% of NGO clients) (Ministry of Health, 2018). In 2017/18, over 180,000 individuals were seen by mental health and addiction services, in which, 52% of these individuals were male and 48% female. Of the ethnic groups reported to have accessed mental

healthcare in Aotearoa, Māori were most likely to seek help whereas, Asian and Pasifika individuals were least likely.

Māori in Aotearoa

Māori are the tangata whenua of Aotearoa. The overall population of Aotearoa is around 16.5% Māori (Statistics NZ, 2020). As indigenous peoples, similarly to international indigenes, Māori are characterised by unique traditions and beliefs. Many Māori hold social, economic, political, tribal affiliations, and cultural practices that are distinct from non-Māori in Aotearoa (Shaw et al., 2013). The hauora of Māori is heavily embedded in cultural identity and iwi/whānau connectedness. Connection to cultural identity manifests differently across Māori individuals and, it can be connected to self-identification, whakapapa, connection to marae, connection to whenua, connection to other Māori, and the use of te reo Māori (Durie, 1997). When Māori are able to engage in these culturally enhancing practices it seems to improve hauora. In contrast, when these cultural connections are hindered it seems to negatively impact hauora. Furthermore, cultural embeddedness seems to be an accurate indicator of hauora and a significant protective factor (Durie, 1997).

Māori Mental Health

Māori adults have the highest lifetime prevalence of mental health disorders (50.7%) in comparison with non-Māori in Aotearoa (Health Promotion Agency, 2018). For Māori adults, the most common lifetime disorders were anxiety disorders (31.3%), substance use disorders (26.5%), mood disorders (24.3%), and eating disorders (3.1%) (Wells, 2006). Māori adults in Aotearoa also have the highest rates of suicide (17%) in comparison with non-Māori adults. This seems to be perpetuated by the trend that states that individuals living in the most deprived areas in Aotearoa are more likely to experience psychological distress (15.2%) in comparison with those living in the least deprived areas (6.2%). Due to a multitude of contributing factors, Māori adults often live in poverty, are low socio-economic status, and live in the most deprived areas in Aotearoa (Menzies et al., 2020). This increases their vulnerability to developing psychological distress which then evolves into mental illness and addiction.

Rangatahi Māori Mental Health

Internationally, statistics show that youth are experiencing concerningly poor mental health (World Health Organisation, 2021). Similarly to Māori adults, rangatahi Māori seem to be disproportionately affected by mental illness in comparison with non-Māori in Aotearoa. The He Ara Oranga report described high levels of stress, self-harm, risk-taking, anxiety and suicide amongst youth (New Zealand Government, 2018). In 2018, over 20,000 rangatahi Māori accessed mental health or

addiction services in Aotearoa. Similarly, the Te Oranga Hinengaro report found that rangatahi Māori aged between 15 and 24 are the most likely age group to report issues with coping with life stressors (Health Promotion Agency, 2018). This is mirrored in a Waitangi Tribunal Report that found Māori have the highest rates of mood disorders, anxiety disorders, and suicide mortality in Aotearoa (Ministry of Justice, 2019). Lifetime prevalence for mood and anxiety disorders among rangatahi Māori has more than doubled in the past decade. Suicide is also of concern as rangatahi Māori are twice as likely to experience mortality through suicide in comparison with their non-Māori peers (Ministry of Justice, 2019). The same report also noted that rangatahi Māori have the highest addiction risk in relation to alcohol, tobacco, and other substances. Rangatahi Māori reporting the highest incidence of hazardous drinking and tobacco use in comparison with non-Māori (Ministry of Justice, 2019).

Mental Healthcare and Māori

The majority of health and disability services in Aotearoa have been developed upon Western health models. This creates a barrier for Māori who are help seeking in Aotearoa as it reduces the cultural competency of health services (Ministry of Health, 1999). Similarly, the colonial history of Aotearoa perpetuates the health disparities between Māori and non-Māori. Colonisation has had a profound lasting influence on the livelihood of Māori. Māori experience substantial disparities in a variety of important facets of life; employment, education, and healthcare (Ministry of Health, 1999). It is evident that the intergenerational trauma of colonisation has impacted the relationship between Māori and all provisional governing systems, including mental healthcare. Most significantly, Māori are subject to institutional/systemic racism and economic disparities which impedes their access to mental healthcare in Aotearoa (Barnes & McCreanor, 2019). The literature suggests that Māori with mental illnesses are at a higher risk of experiencing lesser supports than non-Māori in Aotearoa (Came et al., 2020; Nikora et al., 2004).

Māori adults are admitted to psychiatric hospitals at twice the rate of non-Māori adult (Ministry of Health, 2018). Similarly, Māori individuals are committed to psychiatric hospitals under the Mental Health Act more frequently than non-Māori in Aotearoa. Moreover, although Māori seem to have a greater need for mental health services, they are frequently admitted/committed once the need has escalated to severe. Māori are also more likely to experience delays in diagnosis which can hinder their access to treatment (Ministry of Health, 2018). The unequal access to, and lack of cultural safety within, mental healthcare services has also influenced this delay. Cultural safety is steadily being explored more in the healthcare context and has shown to be highly influential in the relationships between indigenous communities and healthcare/health disparities. This suggests Māori individuals with mental illnesses in Aotearoa are more likely to experience poorer health

outcomes than non-Māori in Aotearoa (Came et al., 2020). Furthermore, the incorporation of Māori models of health and Māori principles or values in mental healthcare seems to have significant impacts on the engagement with, and the success within, mental health services (Durie, 1999).

Mental Healthcare and Rangatahi Māori

Rangatahi Māori experience psychological distress at significantly high rates in comparison with non-Māori in Aotearoa. In 2018, over 18,000 rangatahi Māori accessed mental health or addiction services in Aotearoa (Ministry of Health, 2018). However, contrary to non-Māori youth, rangatahi Māori are proportionately less likely to access mental health services (Youthline, 2020). Of the limited research regarding rangatahi Māori experiences with mental health services in Aotearoa, some have identified key barriers. Youthline reported embarrassment, not wanting to talk about problems, and a lack of cultural competency as some of the main barriers for Māori youth seeking help related to mental health (Youthline, 2020). Furthermore, it seems to be a cultural attitude amongst Māori to experience whakamā when experiencing poor mental health. This seems to impede rangatahi Māori from reaching out for help and feeling comfortable discussing relevant issues when they do access mental health services (New Zealand Government, 2018). Additionally, the research suggests Māori are quick to dismiss a service or service provider if they feel their cultural identity is being compromised (Durie, 1997). Furthermore, if rangatahi Māori feel a service is not meeting their expectations culturally, they will disengage with the service. This issue has led to a plethora of disparities for Māori seeking access to services (Durie, 1997). A report published by Koi Tu emphasized the need for youth-responsive and culturally-specific services due to the dire need within the Māori and Pasifika youth populations. It was also highlighted that there is a need for supports and services in schools and communities to further promote rangatahi Māori. Furthermore, to address this need extensive flaxroots research with rangatahi Māori is pertinent to better understand what is needed to support the mental wellbeing of rangatahi Māori who are disproportionately impacted by mental illness (Menzies et al., 2020). This would be most adequately achieved by consulting and co-designing with iwi, cultural leaders, and the key stakeholders (rangatahi Māori) in this area. This will ensure policy and practice is culturally responsive and sustainable for rangatahi Māori.

Barriers to Mental Healthcare for Rangatahi Māori

Socio-Cultural and Socio-Economic Factors

Rangatahi Māori experience a variety of systemic disparities that inherently impact their ability to access mental healthcare. National statistics demonstrate that amongst the young population in

Aotearoa, Māori are the fastest growing youth demographic (Statistics NZ, 2020). Additionally, rangatahi Māori live predominantly in poorer and more deprived areas in Aotearoa (Health Promotion Agency, 2018). This means they experience social and economic challenges. Most specifically, Māori report that the cost and financial means to access a GP and mental healthcare services is a meaningful barrier. This seems to exacerbate the higher prevalence of mental illness and substance use. However, it also impacts their access to, and education around, mental healthcare.

In the Mental Health Service Use report, it was noted by Kaupapa Māori NGO's that there has been a move away from contracting Māori-specific providers in Aotearoa. Mainstream NGO providers have been contracted more frequently than smaller kaupapa Māori organisations (Ministry of Health, 2021). This has negatively influenced the development and prosperity of kaupapa Māori services, which has been detrimental to the acquisition of funding for these services. It has also limited the parameters and availability of kaupapa Māori services (Ministry of Health, 2021). As Māori are more inclined to achieve positive outcomes with kaupapa Māori services and they have shown to provide a variety of important services, this social barrier has impacted the access to mental health services for rangatahi Māori.

The coronavirus pandemic has shown to be a significant socio-cultural factor that has influenced rangatahi Māori. Globally, the pandemic has impacted vulnerable young person's due to family pressure, job losses, increased poverty rates, and decreased employment opportunities (Menzies et al., 2020). A significant number of Māori already experience these socio-economic difficulties and therefore, the pandemic has perpetuated systemic intergenerational disadvantages, which has acted as a barrier for rangatahi Māori to access mental health services (Menzies et al., 2020).

Another socio-cultural factor that is a barrier for rangatahi Māori is stigmatism. Māori have varied perceptions of healthcare systems and mental health, and many seem to have a distrustful relationship with healthcare systems in Aotearoa. This is often related to systemic racism, colonial systems, and negative experiences with service providers (Came et al., 2020). Additionally, some Māori have varied perceptions of mental health which influences their hesitancy to seek help through mental healthcare. Some Māori believe mental illness to be related to tapu and makutu and believe then that mental illness should be relieved through visiting a Tohunga as opposed to state care (El-Badri & Mellso, 2007). This means rangatahi Māori have to experience two-fold stigmatism due to the displacement in healthcare in a Western society and the dispossession in their own whanau for those who experience prejudiced views within their culture (Rosen, 2003).

Health Literacy

The concept of health literacy has been readily researched in relation to Māori in Aotearoa. This has been triggered by the notion that Māori are somewhat indifferent towards maintaining good health. This notion has been attributed to Māori having a lack of well-rounded knowledge about preventative health and help-seeking practices (Durie, 2001). Māori in the 16-18, 19-24, and 50-65 age groups have the poorest health literacy in New Zealand compared with non-Māori groups (Ministry of Health, 2010). Furthermore, this finding has influenced the perception that Māori lacking health literacy cannot make good decisions regarding their health. This is largely due to the fact that functional health literacy allows individuals to better understand their health and, subsequently, make better decisions for their wellbeing. Health literacy also refers to an individual's ability to identify abnormal symptoms or issues within themselves or their whanau. Additionally, it relates to knowing the best avenues to receive help for health-related issues. Without good knowledge of the mental healthcare and supports, Māori individuals seem to struggle to overcome financial, waitlist, and socio-economic barriers to mental health services (Durie, 2001).

Cultural Competency

There is a broad spectrum of literature that outlines where current models of health and mental healthcare in Aotearoa impede cultural competency for rangatahi Māori. A most significant shortcoming of mental healthcare is its individualistic focus. Whanau, as opposed to the state, is the primary support system for rangatahi Māori (Te Puni Kokiri, 2015). Furthermore, mental healthcare in Aotearoa tends to focus on how to treat the individual and seeks to reduce their symptoms (Came et al., 2020). As Māori consider whanau central to overall wellbeing, and their sense of identity and purpose is derived from whanau, this premise is detrimental to the help-seeking behaviour of rangatahi Māori experiencing mental health issues (Came et al., 2020).

Another issue in relation to cultural competency with mental healthcare in Aotearoa is that research regarding psychological tests, assessments and treatments is mostly conducted on non-Māori (Durie, 2001). There is a distinct lack of research regarding the use of psychological treatments on Māori in Aotearoa. There is a building repertoire of studies on the use of cognitive behavioural therapy (CBT) with Māori, however, there is very little research regarding other forms of therapy styles. Additionally, all psychological tests are normed using non-Māori participants. Community-based services have also reported implementing imported models of health in mental healthcare without the consultation of tangata whenua. Bicultural research, consultation, and training should be implemented to reflect the bicultural nature of Aotearoa (Johnstone & Read, 2000). Furthermore, this demonstrates a variety of ways that cultural competency is impacted in mental healthcare in Aotearoa, which acts as a barrier for rangatahi Māori who are seeking help.

Enablers to Mental Healthcare for Rangatahi Māori

Whakawhanaungatanga

Whakawhanaungatanga is the concept of building and nurturing connections or relationships. Employing whakawhanaungatanga practices has shown to be significantly beneficial when working with Māori clientele. This has been attributed to the authentic facilitation of a warm and inviting atmosphere that allows individuals to feel heard and understood (Shaw et al., 2013). Similarly, given the often-long-term relationship between service provider and mental health patient, it is paramount to establish a strong therapeutic relationship as soon as possible. This is a key engagement strategy when working with rangatahi Māori who are seeking to access mental healthcare in Aotearoa (Wepa, 2016). Māori also value collaboration and collectivism. When achieved, these values can support the outcomes for Māori in healthcare systems. Furthermore, whakawhanaungatanga inherently facilitates these concepts (Austin, 2018).

Māori Workforce

Having Māori present in mental health services has shown to be a significant enabler for rangatahi Māori seeking help regarding mental health issues. Although mainstream services and non-Māori workers are still accountable for their own cultural competence, the presence of Māori improves access for rangatahi Māori seeking help (Sokratov & O'Brien, 2014). Due to the influence of intergenerational trauma and systemic racism many Māori have been deterred by state mental healthcare. The presence of Māori staff allows Māori clients to make a cultural connection to a service that opposes these fears and barriers to seeking help. The reality is that Māori health issues can only be adequately addressed by Māori. This is further reinforced by the concept of *whakawhanaungatanga*, for Māori, with Māori. Durie (2001) also noted that the inclusion of Māori in mental healthcare not only benefits Māori, but the nation as a whole. Drawing on Māori models of care, *tikanga*, and *kawa* provides a supportive and trusting environment for not only Māori, but all clients (Came et al., 2020). Māori staff can aid in facilitating this process. Similarly, cultural supervision and bicultural training for non-Māori staff also supports this notion.

Cultural Competency

Cultural competency is a significant enabler for rangatahi Māori who are seeking to access mental health services. Many reports regarding the access to mental health services for rangatahi Māori have commented that bicultural training and supervision should be prioritised to meet the needs of Māori who are help-seeking (Johnstone & Read, 2000). Additionally, it has been reported that Māori often encounter mental health professionals who are ignorant to, and uncaring of, Māori

perspectives of mental health. This significantly impairs the relationship between rangatahi Māori and mental health services (Johnstone & Read, 2000). One of the fundamental factors of successful mental healthcare is the building and fostering of relationships or whakawhanaungatanga. The development of rapport to support these relationships are best upheld through the acknowledgment of, and care towards, cultural identity. Furthermore, to achieve this with rangatahi Māori there needs to be a base knowledge of and respect for Māori culture (Te Puni Kokiri, 2015).

Incorporation of Māori Culture

Cultural identity is a combination of personal views, cultural knowledge, and participation in your cultural society (Durie, 1997). For Māori, there is a specific focus on self-identification, whakapapa, participation in cultural activities, contact with other Māori, and the use of te reo Māori. Secondary to these main factors, the connection to land, whanau, marae, and language are also key in connecting to, and fostering, a secure cultural identity (Shaw et al., 2013). A secure cultural identity has shown to be a protective factor for mental health issues, and aids in fostering resilience in rangatahi Māori (Fox et al., 2018). Furthermore, the incorporation of Māori culture, models, and practices has shown to be effective in building stable relationships with Māori accessing mental health services (Capital & Coast District Health Board, 2017).

The incorporation of Māori culture can be done in a variety of ways, however, for it to be successful it is important for it to be consistent and authentic. For mental health professionals this may be achieved by implementing Māori models of health and practice. A key example of this is the use of Te Whare Tapa Wha as an assessment tool (Pistacchi, 2008), and similarly, the inclusion of whanau and the understanding of the centrality that whanau hold in overall wellbeing for rangatahi Māori (Shaw et al., 2013). This also involves understanding the hierarchical role that exists for Māori whanau. In contrast to some non-Māori cultures, a hierarchy exists in Māori whanau whereby the kuia and kaumatua are the pinnacle of the whanau structure. This is important to understand when discussing family issues with rangatahi Māori. Additionally, Māori values can be incorporated into mental health services to create a welcoming atmosphere for rangatahi Māori: values such as manaakitanga, tino rangatiratanga, and whanaungatanga (Durie, 1999). Inherent in Māori values is the incorporation of tikanga and kawa is innate. The inclusion of karakia, waiata, te reo Māori, and kai (where appropriate) are some examples of tikanga Māori that are forms of whakanoa that lift the tapu and whakamā around discussing mental health issues (Capital & Coast District Health Board, 2017).

Conclusion

The present study focuses on rangatahi Māori and their experiences with mental healthcare in Aotearoa. The primary purpose of the study is to explore contemporary barriers and enablers to mental healthcare for this demographic. A secondary objective is to differentiate between the personal, interpersonal, and societal barriers and enablers. The existing literature on rangatahi Māori experiences with mental healthcare covers breadth, however, very few studies explore the barriers and enablers in depth. The present study seeks to do this by investigating the subjective experiences of rangatahi Māori.

METHODOLOGY

The aim of the present study was to develop an understanding of the experiences of rangatahi Māori with mental healthcare. A qualitative descriptive design was implemented as the purpose of the qualitative methodology is to define and expand knowledge on poorly understood phenomenon (Colorafi & Evans, 2016). This methodology is appropriate because qualitative descriptive aligns with the rationale of this research as it seeks to contribute to the lack of available literature regarding rangatahi Māori and mental healthcare. Furthermore, this methodology will allow for the identification of rich data and contribute to the existing research which may lead to the generation of new perspectives around the phenomenon (Colorafi & Evans, 2016). This research will also be undertaken using a Māori-centric approach to ensure cultural competency when working with rangatahi Māori.

Methodology

The qualitative descriptive methodology coincides seamlessly with the aim of the present study as it seeks to obtain information about the subjective experiences of rangatahi Māori with mental healthcare as it has naturally occurred. In addition, this methodology is advantageous to use when the phenomenon being explored has very little research already available (Colorafi & Evans, 2016) (Russell, 2000). Mental healthcare itself has been extensively researched in Aotearoa, however, the experiences of young people, and specifically rangatahi Māori, is a demographic that has been rarely focused upon. Hence, the use of a descriptive qualitative methodology design will allow for a deep investigation of the subjective experiences of rangatahi Māori with mental healthcare in Aotearoa.

In order to fully acknowledge the values and systems of Te Ao Māori, I have incorporated a Māori-centric approach which aligns well with the qualitative descriptive methodology. A Māori-centric approach refers to acknowledging the place Te Ao Māori holds in Māori research and working through a Māori worldview (Henry & Pene, 2001). This framework is suitable to implement when working with Māori participants, ensuring that Māori maintain conceptual governance in the research as it is portraying their experiences. Furthermore, a Māori-centric methodology will be achieved by acknowledging and utilising matauranga Māori, te reo Māori, and Māori health models/paradigms (Walker et al., 2006).

Ontological and Epistemological Positions

Research frameworks are underpinned by ontological and epistemological stances. Ontology refers to the beliefs of the nature of reality and epistemology refers to the theory of knowledge (Gelo et al., 2008). Māori-centric research seeks to understand the experiences of Māori through a Māori

worldview. The use of te reo and tikanga Māori, where appropriate, supports the facilitation of this process. Māori ethics and philosophy drive Māori epistemology; this includes living in accordance with tikanga Māori and what is tika (true) (Pihama et al., 2004). The Māori principles that help to reinforce Māori-centric methodology in this study are tino rangatiratanga, manaakitanga, and whakawhanaungatanga. In addition, Māori-centric methodology provides a framework of kawa and tikanga to follow throughout the research process (Pihama et al., 2004).

Participant recruitment

I utilised a snowball sampling method whereby employing social media to advertise the present study. Individuals were invited to register their interest by contacting the primary researcher. The advertisement was posted to Facebook group pages and Twitter (Appendix A) In addition, convenience sampling was employed whereby individuals who fit the criteria were specifically sought out and invited to consider participating in the research. Snowball sampling and convenience sampling were both chosen because the eligibility criteria was fairly niche. Therefore, it was most suitable to advertise to groups and individuals who are rangatahi Māori and fit the research objectives. These advertisements permitted me to locate participants who were willing and able to provide subjective information around the phenomenon of interest.

Individuals who saw the advertisement, or were contacted regarding the research, were invited to contact me via email, and I was then able to send through participant information sheets, pending they met the eligibility requirements. This allowed for me to formally invite them to participate in the research whilst also briefing them of the purpose, costs, and benefits of their participation. Similarly, this document explained the scope of the study and the topics that will be discussed in the interviews.

The inclusion criteria for the research study were:

1. Are Māori
2. Are between the ages of 18 and 24
3. Have experiences with mental healthcare in Aotearoa
4. Reside in Aotearoa

Table 1

Participant demographics

Pseudonym	Ethnicity	Gender
Tama	New Zealand Māori	Female
Emma	New Zealand Māori	Female
Marama	New Zealand Māori	Female
Taylor	New Zealand Māori	Female
Andrew	New Zealand Māori	Female
Anahera	New Zealand Māori	Female

Data Collection

Each of the six rangatahi Māori participated in a 30–60-minute semi-structured interview. These interviews occurred over a three-week period. A semi-structured approach was taken in the interviews as it allowed broad questions to guide the participants in sharing their stories with some topical direction. This approach also allowed for us to take time in each interview. Time is a significant construct that can be used to benefit the relationship between researcher and participant when working with Māori. Taking time before each interview for whakawhanaungatanga, and during each interview to allow participants to ruminate and think without interrupting their thought process is highly advantageous in allowing participants to tell their story. This concept of working with Māori helps to build a deeper connection and opens a safe space for vulnerability between participant and researcher (Elder, et al., 2016). Furthermore, using a semi-structured interview approach meant each interview varied in regard to order of questions, and follow-up questions differed depending on what was shared by the participant. It also allowed for the pursuit of

clarification and specific questions where necessary. The interview schedule included questions about what services they had accessed, enablers and barriers to mental healthcare, and cultural and systemic factors that impact their experiences with mental healthcare (Appendix C).

All interviews were conducted *kanohi-ki-te-kanohi*. This was the most appropriate option as it has shown to be the most effective form of interview to use with Māori. *Kanohi-ki-te-kanohi* allows for a better development of rapport and a trusting atmosphere, which ensures participants are comfortable to be open (Elder et al., 2016). Before commencing interviews, I made sure to prioritise *whakawhanaungatanga* where the participant and I could introduce ourselves in an informal *pepeha*, use *karakia* where necessary, and have some informal chat and address any questions or worries before beginning. This also aided in developing rapport and creating a warm atmosphere for rich discussion.

The interviews were audio recorded and written notes were taken. The interviews ranged from 30-50 minutes. Once the interviews were finished the recordings were transcribed verbatim by the primary researcher. The transcripts were repeatedly reviewed by the primary researcher. After transcribing each interview, the transcripts were sent to each participant to check for accuracy and any clarification they deemed necessary. All names were taken out or replaced by pseudonyms.

Ethical considerations

The integrity of the present study is maintained by ethical approval which was gained from the Auckland University of Technology Ethics Committee on the 23rd of August (AUTEC: 22/157). Many ethical considerations were addressed prior to commencing the present study, these are described below. The ethical decision-making process was guided by *Te Tiriti o Waitangi* which ensured the obligations to the treaty were honoured.

Privacy and Confidentiality

The privacy and confidentiality of the participants was an important factor in the present study. We sought to protect privacy and confidentiality by removing all identifying participant information in both the data and the report. Additionally, pseudonyms were used throughout the transcripts to protect the participants' identities.

Transcripts and consent forms were the only documents kept after the report was finalised. Consent forms are kept in a sealed folder in a securely locked cabinet in the primary supervisor's office. The

transcripts are stored on a memory stick in a separate securely locked cabinet. After six years the consent forms will be shredded, and the transcript data will be permanently deleted.

Informed and Voluntary Consent

Individuals who were interested in participating contacted the primary researcher who then sent through the participant information sheet (Appendix B). These individuals were encouraged to ask any questions they may have and were given one month to determine whether they would like to participate in the research. Interview dates and times were then discussed via phone call and email. Prior to each interview I discussed the purpose of the study and costs and benefits for the participant at length. After this, I asked if we had a mutual understanding and obtained written consent. I made certain the participants were aware they could withdraw from the study at any time up until the data analysis was completed. I also ensured that participants knew they were only required to share what they were comfortable with disclosing. After transcription, each participant was sent a copy of the transcript to review.

Cultural Considerations

Research with Māori commenced shortly after colonisation. However, research on indigenous peoples has often proven problematic due to the research paradigm being predominantly Westernised. Most methods, design, methodologies, and ethics of research are developed through a Western cultural lens. This has often led to the promotion of Western cultural superiority and hinder the validity of Māori cultural integrity. In the present study, we accounted for this by forming the research design through a Māori-centric approach. Furthermore, Māori-centric principles such as tino rangatiratanga, social justice, and Māori empowerment are the primary motivations that underpin this research (Walker et al., 2006). As a Māori individual, my own cultural embeddedness has also influenced this research to ensure cultural competence and safety.

Treaty Obligations

The EA1 outlined how the treaty principles of Partnership, Participation, and Protections were integrated in the present study. The Waitangi Tribunal Hauora review (Waitangi Tribunal, 2019) revealed that these three principles of Te Tiriti o Waitangi are predominantly Western and the following Māori concepts have been emphasised when working with Māori: Preamble (whakawhānaungatanga), Tino rangatiratanga, Kāwanatanga, Ōritetanga and Wairuatanga (Ministry of Justice, 2019). As the present study is focussed on Māori and their experiences these five principles have been implemented as illustrated below.

Preamble (whakawhānaungatanga)

The preamble refers to the relationship between the crown and Māori that existed before the signing of the treaty. This is meant to give context to the meaning and signing of the treaty (Berghan, et al., 2017). Whakawhanaungatanga translates to the building and fostering of relationships. This was implemented in this study by purposefully including whakawhanaungatanga into the loose agenda for each interview. This allowed for development of a deeper connection between researcher and participant which helped participants to feel heard and comfortable.

Tino rangatiratanga

Tino rangatiratanga is related to Article 2 of the treaty (Berghan, et al., 2017). Tino rangatiratanga is a primary concept of matauranga Māori, or the knowledge of Māori. Conceptually, it relates to the way of being in Te Ao Māori. It also refers to the concepts of self-determination and sovereignty. The incorporation of this construct in the present study means Māori values and perspectives can be expressed and protected. This was done by using a Māori-centric research design.

Kāwanatanga

Kāwanatanga refers to the establishment of systems that promote Māori wellbeing and reduce inequities, it relates to Article 1 of the treaty (Berghan, et al., 2017). The present study achieved this by allowing rangatahi Māori to share their experiences with mental healthcare in Aotearoa. The findings help to assess the quality of this governing system in relation to its suitability and success with Māori clients.

Ōritetanga

Ōritetanga is a concept that connects to equity; it relates to Article 3 of the treaty. This concept encompasses the significance of health promotion for Māori as Māori experience health disparities in comparison with non-Māori in Aotearoa (Berghan, et al., 2017). This study ensures this by implementing a Māori-centric approach to provide a platform for rangatahi Māori to share their experience in the mental healthcare system.

Wairuatanga

Wairuatanga is a concept in Te Ao Māori that refers to spirituality. This is relevant to the fourth spoken Article of the treaty (Ministry of Justice, 2019). Māori spirituality is underpinned by the concept that all life has mauri. This means all life is interconnected and sacred. This element of connectedness relates to the connections between whenua, whakapapa, and whanau. This concept is particularly significant in the preservation of Māori tikanga and matauranga through pūrākau and mauri. This study sought to ensure this by honouring the links between mind, body, and spirit. This was done by

allowing open expression of emotion and sharing of experiences related to wairua and cultural identity.

Data Analysis

Qualitative analysis is employed to convert narrative data into conveyable findings (Patton, 2002). Reflexive thematic analysis was the form of qualitative analysis utilised to develop the findings of the present study. Thematic analysis seeks to reduce large quantities of raw data into manageable data. This data is presented as patterns or themes which articulate the story being conveyed by the participants (Braun & Clarke, 2006). As this is a subjective experience, it is what one researcher perceives to be the story of the data, and this perspective may differ from another researcher.

Thematic analysis involves collecting, analysing, coding, and recording themes within the data. Data is then organised into common codes or themes which seeks to convey the meaning and intent of the data (Braun & Clarke, 2006). Thematic analysis is appropriate to use in a descriptive qualitative research design because the analysis involves comparing participant data, sorting the data into categories, naming themes that appear and applying them to illustrate the experiences of the participants (Braun & Clarke, 2006). Reflexive thematic analysis centres around meaningful knowledge production, acknowledging researcher subjectivity, and organic and dynamic coding processes. This means that reflexive thematic analysis allows for deep reflection on the data (Braun & Clark, 2019). Furthermore, building a holistic, subjective perspective of the participant experiences.

Braun and Clarks' (2006) guide was used for the thematic analysis of the data. Braun and Clarks' (2006) reflexive thematic analysis framework follows six steps (Braun & Clarke, 2006):

- 1) **Familiarisation**; this involved reading through and listening to the data while taking notes on the content. Reading and rereading of the six transcripts was done to fully immerse myself in the experiences of the rangatahi Māori. While I read the transcripts, key and common patterns/themes emerged across the transcripts, which illustrated the experiences.
- 2) **Coding the data**; this involved making semantic and latent codes of the data with guidance from the research question.
- 3) **Construct prototype themes**; this involved clustering together similar codes into potential themes.

4) **Review potential themes**; this involved testing themes to ensure they are making up the rich story of the data and that it is a theme present within the data.

5) **Define and label themes**; this involved giving the themes labels and developing a description for the theme.

6) Produce a report.

Therefore, I implemented thematic analysis to analyse the data collected in the present study. The analysis generated several themes which created the framework utilised to illustrate the essence of the experiences of the participants (Patton, 2002).

FINDINGS

This chapter presents findings of the thematic analysis of the data from semi-structured interviews with six rangatahi Māori who have experiences with mental health services. The identified themes are presented and depicted with quotes from the participants. Participants were asked questions about their experiences as a rangatahi Māori accessing mental health services. The interview schedule included questions about what services they had accessed, enablers and barriers to mental healthcare, and cultural and systemic factors that impact their experiences with mental healthcare (Appendix C). As the interview structure was flexible it allowed for disclosure of other significant aspects of their experiences such as insufficient health literacy, stigmatism, and mental health/illness in general. The themes identified are presented in Table 2.

Table 2

Overarching and emergent themes

Overarching Themes	Emergent Themes
1. Barriers	1a. Health Literacy
	1b. Stigmatism
	1c. Time
	1d. Financial and socioeconomic factors
2. Enablers	2a. Whakawhānaungatanga
	2b. Transparency
	2c. Satisfaction with service
	2d. Incorporation of Māori culture/models

Theme 1: Barriers to mental healthcare for rangatahi Māori

This overarching theme describes participants' experiences with barriers to engagement with service providers of mental healthcare for rangatahi Māori. Mental healthcare is significant to rangatahi with the rapid rise in mental illness among youth populations internationally. Therefore, these experiences contribute fundamentally to youth wellbeing. Participants discussed navigating healthcare systems that were difficult; stigmatised perspectives of mental illness; rushing of appointments and rapport development, and; negative experiences with socioeconomic influences and feeling disconnected from service providers. This overarching theme includes four emergent themes: health literacy, stigmatisation, time, and financial/socioeconomic factors. Each will now be discussed in turn.

Theme 1a: Health Literacy

This theme identifies the issues rangatahi Māori have accessing mental healthcare, understanding the jargon that service providers use, and having a functional understanding of mental health in general. This included conversations around difficulty navigating healthcare systems, a lack of psychoeducation, and feelings of confusion and whakamā.

Navigating the healthcare systems and services was commonly discussed as challenging and confusing. Participants described feelings of not being sure where to start when accessing mental healthcare.

P4: "I think I waited so long to actually reach out for help because I didn't even know where to start... Like I wasn't sure whether to start with a counsellor or therapist or just go to a doctor and see what they think."

All participants discussed beginning their mental healthcare journey with a visit to their GP for some insight into their options, this beginning point was usually encouraged by whanau members.

P2: "I talked to some family, mostly like my mom and they were the ones who were like yeah this is what you should do.. I was embarrassed at first to talk to people about it but once I did I was pointed in the direction of my GP for like a referral of meds or something to help."

All participants discussed feeling uninformed or misinformed by their service providers at one time or another. This seemed to create more confusion and discouragement for participants. This participant also disclosed that they felt uncomfortable questioning their misinformation.

P2: "My GP was quite blasé about the side effects of the medications they were suggesting... like I was asking quite a lot of questions about side effects and saying you know I'm prone to headaches I'm prone to nausea... what does that mean for me and they would just say oh it's not really it's not a common side effect don't worry about it stuff like that so yeah I don't think so... and there was one doctor I had when I tried to go talk about my mental health and he told me that people in my generation are on our phones too much so I just need to get off my phone... and I think he said something about you know and like you're a girl too so it might just be that... and I tried to ask like well are there any like other avenues I can try... 'cause I said that I had tried to counseling and it didn't really work and he said that was it... that was after the first counselor and he was like... Oh well if you tried counseling and it didn't really work there's not much else I can do."

Participants also mentioned feeling unsure as to why they were referred to different people. One participant in particular described an experience whereby they had been on a waitlist for a long time to see a counsellor and in the second session they stated that they should be referred on to another counsellor with very little explanation as to why.

P1: "Honestly it was a bit of a shock and was confusing... but I didn't really care that much um... But it did turn me off counselling for a while which is why I put off seeing another person for so long. And it was like the inconvenience of then having to open up to a whole new person again, and I still wasn't really motivated to be open and talk to anyone about my stuff cause I didn't think that was gonna help me..."

These quotes demonstrate the experiences of rangatahi Māori with health literacy barriers in mental healthcare. It emphasised that the primary issues in this area are around understanding how to navigate healthcare services and systems, a lack of knowledge around psychoeducation, and feeling confused and whakamā when engaging with service providers. These quotes also display the significance of having service providers who take their time to communicate and explain clearly to their clients.

Theme 1b: Stigmatism

All participants discussed having experienced stigmatised views of mental illness and mental healthcare. These included discussions around the stigma of medications (particularly anti-depressants), of seeking help, and mental illness itself. There were also many discussions around where these stigmatised views were learned: society, whanau, and culture were the most salient origins.

The participants described a variety of experiences related to how society has influenced their feelings of whakamā around accessing mental health and being mentally ill.

P1: "...feeling iffy about being seen weak as a man."

P5: "...it makes me feel crazy"

P3: "...It is kind of embarrassing yknow?"

Culturally, participants discussed distrust between Māori and healthcare systems, and the somewhat negative views of mental illness within Māori culture.

P1: "I think navigating mental health care was hard... It was confusing and not always explained well to me. I think that not knowing how to go through the healthcare system is kind of a result of my culture and us not being too trustful of healthcare systems and all that. I also think the stigma around mental health doesn't help. That's more of a society problem but it is also in Māori culture too. And in my whanau a little bit. Like it was good I had my mum and uncle but some other families were not supportive or understanding... I'm not sure if this is only cultural. Like maybe its just society's views but the whole idea that men are not meant to open up and talk about problems or have emotional problems. I'd say like yeah I think when I was younger it was probably like we were meant to kind of harden up about that stuff. Because of being a boy yeah, our family was pretty into the idea that the males should be tough guys. Yeah all of my uncles are quite macho. Gotta be hard."

Most participants discussed their whanau and their perspectives on mental health and illness. They discussed how this influenced their delayed or expedited entrance into mental healthcare.

P3: "Yeah to be honest mental illness or health isn't really talked about in my family... or even really in Māori culture I guess... or at least not in those words... it's more like we talk about emotions and stuff but and not feeling good but sometimes diagnoses are like brushed off or swept under the carpet... so I always felt a bit crazy for thinking there was something wrong with me... especially when its related to depression and PTSD... because I think heaps of my family deal with the same stuff but it doesn't seem to affect them as much."

These quotes describe the experiences participants have had with the stigmatisation of mental illness and subsequently, mental healthcare access. The most salient themes were socio-cultural influences on the perceptions of mental illness and how these were a barrier to accessing mental healthcare. For

all participants it seemed to delay them from entering mental healthcare systems which prolonged their experiences with mental illness.

Theme 1c: Time

This theme identifies the variety of experiences rangatahi Māori have had with service providers. This included conversations around rushed appointments, inadequate explanations, lack of whakawhanaungatanga, and the protracted nature of referral waitlists.

Participants discussed that some service providers were quick to rush through appointments which left them feeling discouraged and unheard.

P6: "I went to my GP first because I kind of thought that's what you have to do to get a referral or get on the waitlist or something... but my GP kind of said my symptoms weren't that bad and suggested I go on birth control or antidepressants if I am still feeling them for a while but I didn't want to go on any meds before trying therapy... and I figured if I couldn't get a referral I would just contact someone and try to find a psych... it actually took quite a few months to find someone local who had an opening..."

Many participants also discussed feeling like whakawhanaungatanga was often overlooked by service providers. This meant it took a lot longer for them to feel comfortable and confident with them.

P1: "After a while my GP found me a new person but I just got put off by them because they rushed through a lot and wanted me to spill my guts without any like getting to know each other... Yeah, I feel like when you know they are just going off like, I don't know the other guy just seemed like he was listing off questions off of a like a list of questions that all psychologists are supposed to ask or something. Just seem pretty formatted really like it wasn't actually directed towards me it was kind of just asking me random psychologist questions... like a script."

All participants vehemently discussed how the tedious and protracted nature of waitlists to see a specialist (e.g., psychologist, ADHD assessments, psychiatrist, and counsellor) was incredibly discouraging. This was especially emphasised by individuals who were experiencing severe depressive symptoms

P2: "The first time I saw a doctor about it I was really really depressed and it took about two months for a referral to a counsellor and I remember just thinking like imagine if I was suicidal and close to ending it and then I had to wait two months to get a referral... so yeah I don't

know if I would have even gone if I knew it was gonna take that long... it had already taken me a long time to work up the courage to go because I was embarrassed about seeking help..."

These quotes demonstrate the experiences Māori patients have had throughout their engagement with mental healthcare service providers. It was mentioned that their biggest challenges were with rushed appointments and lack of explanation, lack of rapport development, and the overwhelmed mental healthcare system which influences the lengthy waitlist for specialists.

Theme 1d: Financial and socioeconomic barriers

All the participants mentioned experiences with challenges related to socioeconomic and financial factors. These included discussions around costs of appointments, access to specialists, and systemic barriers.

Participants discussed the cost of a GP or specialist appointment being a barrier to accessing or maintaining mental healthcare.

P4: "I was actually referred on to a counsellor that I really vibed with. We got along really well. She did a great job of not rushing me and establishing some rapport. But I could only get six free sessions and after that sessions were \$150. I couldn't afford that as I am a student... and I actually still help out by sending money to my mum to help with my siblings while I am away at uni in Auckland."

Participants also described that they had to visit the GP multiple times which often included referrals for multiple visits to varied specialists.

P2: "There weren't heaps of obvious challenges but I do think the system isn't made as accessible for Māori... Like to keep going to GPs and changing places and having to travel a bit further sometimes for an appointment made it incredibly expensive which is inaccessible for some Māori... especially in Whangarei where the poverty rate is high among Māori..."

One participant described her experience with ADHD assessment whereby she had to travel from Auckland to Tauranga to have an assessment.

P5: "I recently had an ADHD assessment and apparently to get a sooner appointment I could go to Tauranga to a specialist. A psychologist, I think. The session itself was \$450 and I had to travel to Tauranga from Auckland for the appointment. I was lucky that my parents offered to

help out with the costs, but I was very apprehensive to have the appointment. But since the appointment I am now of ADHD medication that has made a huge difference for my studying.”

Many participants also discussed their experiences with medications prescribed for mental illnesses and the costs of these being a barrier at times.

P6: “Yeah, I am on antidepressants now. And for some reason I have to go to the GP each time I need a refill and stuff but my GP costs \$60 for each appointment. One time I went 6 weeks without my meds because I didn’t have the extra money to go to the GP. I live rurally so I don’t have another choice for a GP.”

One participant also discussed that during her upbringing her understanding was that therapy was a privilege for people who were wealthy.

P3: “um I think...like... that inherent systemic racism... and I think like.. I really tried to find a Māori psych or counsellor but couldn’t find any local to North Shore in Auckland... I think having more Māori service providers... even like GPs would be helpful because I would feel more comfortable opening up to them and kinda fighting for myself instead of being delayed and stuff”

These quotes demonstrate the experiences of rangatahi Māori with financial and socioeconomic barriers to mental healthcare in Aotearoa. It was emphasised that the biggest challenges were related to costs of mental healthcare, access to specialists, and issues within the system that exclude individuals who are low socioeconomic status.

Theme 2: Enablers to mental healthcare for rangatahi Māori

This overarching theme describes enablers to mental healthcare for rangatahi Māori. Accessing mental healthcare can be challenging and daunting for rangatahi Māori. This means that factors that can improve experiences and outcomes with mental healthcare are incredibly important. Participants often discussed positive experiences related to feeling heard and understood, experience progress with their mental illness, and the implementation of Māori culture. This overarching theme is broken down into four emergent themes: whakawhanaungatanga, transparency, satisfaction with service, and incorporation of Māori culture/models.

Theme 2a: Whakawhanaungatanga

All participants discussed experiences with service providers whereby a warm and inviting atmosphere was established due to whakawhanaungatanga practices. These experiences included descriptions of service providers who took their time to introduce themselves well, used an open format which allowed for them to take charge, and self-disclosed throughout counselling sessions.

Most participants described a service provider who took their time to introduce themselves and offered that space for their client as well.

P4: "I have seen four therapists now by referral from my GP. I didn't get along well with the first three. I kind of felt like they were rushing things and expecting me to be super open before even really knowing me or anything. But the fourth therapist introduced herself really well and even told me a little bit about her own struggles with PTSD [which is why I was there]. And then she kinda just opened the floor for me to introduce myself in any way I wanted. And she didn't really prompt or ask much. She just allowed me to say what I wanted so our first session was really open and comfortable."

One participant described an experience whereby their counsellor introduced themselves using a pepeha and allowed the client to do so as well if they wanted too.

P5: "I was so surprised when my pakeha counsellor opened with a pepeha...with awesome pronunciation... and then allowed me to do mine. It just made me really happy to be honest... Made me feel comfortable to talk."

All the participants stated that they felt most comfortable with counsellors, psychologists, or therapists who did not seem like they were reading off a script, and who employed an open format therapy style where the client could somewhat take the lead.

P2: "My other counsellors were quite pushy and just suggested things without really trying to understand my situation... and with my last counsellor like she was really validating but she didn't... I don't know how to explain it... like it was quite open format... I feel like I sometimes it can almost seem like counsellors are either running off a script or they're trying so hard to kind of know what's going on with you rather than asking or just like allowing you to tell yeah..."

Most participants discussed feeling more trusting of their counsellor or therapist when they intermittently self-disclosed relevant personal information throughout the sessions. This helped them to feel more comfortable and confident in sharing themselves.

P3: "My latest therapist actually told me a lot about her own struggles with mental health. This was really helpful because I know I had some reservations about mental health and feel kinda crazy even having to seek help for my own stuff."

These quotes demonstrate the experiences that participants have had with service providers who employ whakawhanaungatanga practices. Participants described these experiences as incredibly helpful in creating a more comfortable and open atmosphere. This was especially emphasised in relation to experiences with counselling or therapy.

Theme 2b: Transparency

For many of the participants transparency was a significant enabler in mental healthcare. All participants discussed times where they had experiences with service providers who were thorough in their explanations and in clarifying their options. These experiences were often discussed around how transparency alleviates the existing feelings of confusion, whakamā, and anxiety due to their own stigmatised perceptions of mental healthcare.

Participants discussed how having a service provider who took their time to explain their options was a significant enabler.

P1: "Pretty easy I can pretty much talk to him about anything, he's real open and just pretty much lets me know that I can call whenever and can kind of come in whenever and contact him whenever about anything. Um, like pretty clearly set out all my options and stuff for counseling or meds or anything like that... like pretty much from the first time I saw him. It was really helpful...I think the whakawhanaungatanga concept that we mentioned before would have helped more. Like I had it good with my GP and that one counsellor and it made a big difference for keeping me engaged and stuff. And just like doctors and counsellors and stuff explaining more about what is happening. Not just saying like "oh you have depression" and then not explaining what that means and stuff."

This was also often discussed in relation to GPs who were describing different medications and their side effects in depth as opposed to briefly.

P5: "My GP went real in depth explaining to me anti depressants and the couple of options I had and their pros and cons and stuff. I was really hesitant to even try meds because of the stigma and stuff around them and like my family call them my crazy or happy pills. So having a good understanding of them kinda helped with my anxiety."

Most participants stated that having a service provider who was transparent and took their time reduced their negative feelings around seeking help and engaging the mental healthcare system.

P4: "My GP was really patient with me the first time I ever came in for mental health reasons. I was beyond nervous and really embarrassed to be honest. But he just took his time with me and try to like reassure me that what I was feeling was common and that I had heaps of options to help me feel better."

This theme was also described by participants who were passed on readings or sources of information to do their own research and develop their understanding.

P6: "My counsellor told me that she thought I had depression and that's just like a word to me, yknow. I've known what it feels like and stuff but I don't really know what it is. So she gave me some readings and stuff and it really helped me to understand what was going on for me."

These quotes reveal the influence that transparency has in reducing stress for rangatahi Māori accessing mental healthcare. During diagnosis processes and treatment options it is especially beneficial to rangatahi Māori to have a service provider who takes their time to ensure they understand what is happening for their client. The participants were very forthcoming in their descriptions of service providers who were transparent and how it was a significant enabler in their mental healthcare journey.

Theme 2c: Satisfaction with Service

Satisfaction with service was discussed by all participants. Satisfaction was characterised by progress with their mental illness, feeling comfortable with their service provider, and feeling motivated to continue treatment or diagnosis processes. Experiences with reduced symptoms and increased motivation were most common among participants. Satisfaction with service was positive for their mental illness and their experiences in mental healthcare.

All the participants discussed how noticing progress with their mental illness was their greatest enabler throughout their mental healthcare journey.

P3: "I have been seeing this amazing ACC counsellor for PTSD and I have slowly been noticing I deal with triggers better and better with all these new strategies she has given. I used to feel kinda like I would be this way forever and now I feel like I could feel kinda normal again one day."

Participants who were taking medications for their mental illness particularly emphasised how life changing medications were when they found the right type.

P4: "I actually noticed quite quickly that my antidepressants were making a huge difference for me. I don't know... it could be placebo but I feel so much lighter than I did before. It actually made the biggest difference in my anxiety... I feel like it changed my whole life to be honest. Like I have always had insane anxiety and these meds have minimised my anxiety so so much."

Similarly, for those who had engaged in counselling or therapeutic services described how having a strong connection with their service provider made a significant difference for their progress and engagement.

P2: "I had this one counsellor who was Māori and because she was Māori I felt really comfortable and open so I kept seeing her just because of that... I had been looking for a counsellor who was Māori for quite a long time too so it was lucky I got referred to her.."

Most of the participants stated that they became more motivated and engaged with mental healthcare when they started to feel better and their symptoms lessened.

P1: "My family was really encouraging of me seeking help, my mom and uncle mostly. They got me ready and motivated to seek help and then I went because uncle had gone and he liked it and made progress. So I saw I could actually get something from it. And then when I found the counsellor I got along with I think making progress with him actually made me wanna keep going. Cause I actually felt like, I got well, I just felt good. And I learned some more stuff about depression and myself."

These quotes show how satisfaction with service was a catalyst for rangatahi Māori to continue with a service(s). For these participants this related to experiences of decreasing symptoms, feeling better, and improved motivation while in treatment. These feelings were also perpetuated by service providers who were Māori or who employed kaupapa Māori practices to relate to their Māori clientele.

Theme 2d: Incorporation of Māori Culture/Models

All participants discussed the incorporation of Māori culture and health models as enablers in their journeys with mental healthcare. Although it was mentioned by all participants that it was rare for Māori culture/models to be incorporated, when it was, it made a significant positive difference. The incorporation of cultural elements was achieved through the employment of karakia, te reo Māori, and Māori assessment models.

One participant stated that they had a counsellor who began their first session by asking if they would like to start with karakia and proceeded to competently pronounce te reo Māori in the karakia they recited.

P4: "I actually had this one counsellor who I only saw three times, but she started by asking me if I would like to start with a karakia... I usually say no to that sort of stuff when it is pakeha because it seems a bit tokenistic but I thought why not. And she ended up reciting it by heart and had great pronunciation. It really made my day to be honest."

Most participants discussed that oftentimes the use of te reo could seem tokenistic but where it did feel genuine it made for a positive and comfortable atmosphere.

P5: "Sometimes I do actually feel like service providers who use te reo with Māori clients... it can like seem kinda fake or put on yknow...? But when you can feel its genuine or authentic or whatever it really makes me feel more at home aye?"

Participants also stated that the acknowledgement of socio-cultural factors and their impact on mental health for Māori helped them to feel understood.

P6: "I did have one therapist who like... mentioned a lot about intergenerational trauma and colonisation and was just really understanding and recognised how that impacts mental health for young Māori. That really meant a lot to me because of my own activism traits."

Most participants discussed feeling disheartened by service providers who didn't seem culturally competent. It was mentioned that having Māori service providers made a huge difference for this.

P3: "...and I cant say that counsellors and stuff I saw knew much about Māori culture or the difference in life experiences for Māori and non-Māori... but I am quite white passing which I think is why I haven't experienced any outright discrimination of prejudice or anything but I know a lot of my whanau have..."

P1: "I also think it would have been cool to have a Māori counsellor or something. Or someone who incorporated Māori culture a bit more, like with karakia? It would have probably made me more comfortable a bit faster."

These quotes display how the incorporation of Māori culture/models is beneficial to rangatahi Māori in the mental healthcare system. Participants mentioned it making them feel more comfortable, open, and welcome in services.

DISCUSSION

This qualitative study aimed to address a gap in the literature around the experiences of rangatahi Māori with mental health services. The interview data was thematically analysed, and eight themes were identified. These themes were organised into two overarching themes: barriers and enablers. The themes are critically discussed in this chapter in relation to the objectives of the current research and are used to derive five recommendations (see Table 3).

Barriers

Barriers to mental health services for rangatahi Māori were broken into four emergent themes: health literacy, stigmatisation, time, and socioeconomic status/financial barriers.

All participants discussed the struggle to navigate and understand mental healthcare systems due to their own limited health literacy. Participants expressed that they were unsure where to go first to access mental healthcare. All participants described that they sought advice from their whanau which was a distressing experience for some of the participants. This distress was influenced by the negative views their whanau had of mental illness and seeking professional help. However, for some of the participants their whanau were very encouraging and shared their own experiences with mental healthcare to encourage them to seek help through their GP. Research suggests that whanau have a strong influence on how comfortable Māori feel when accessing mental healthcare services (Missen et al., 2012). Furthermore, this emphasises the importance of Recommendation 5, which centres around improved understanding of Māori conceptualisation of mental health and mental illness (see Table 3).

All participants met with their GP to commence their journey in seeking mental healthcare. This led to starting medication for their symptoms and/or referral to counselling or a specialist. In the cases where participants were referred on, the waitlists were a significant barrier. All participants described that waiting to see a counsellor was a tedious and discouraging experience. This was especially emphasised by the participants who disclosed seeking help for severe depressive symptoms. A systematic review of suicide prevention treatments in indigenous peoples found waitlists to be a significant barrier to engagement and progress with treatments (Leske, et al., 2020). Three participants also discussed that after a couple sessions with a counsellor they received an additional referral because the severity of their symptoms was out of the practitioner's scope. These participants expressed that this experience of triage was quite disheartening and made them delay seeking further

help. They recounted that they did not understand the motive for multiple referrals and were too whakamā to inquire further.

And lastly, participants discussed that during appointments they would be exposed to jargon or terminology without having it explained to them. This left many of the participants feeling confused and whakamā by their lack of knowledge. Māori value specialists who take their time to explain concepts and processes by exercising transparency and psychoeducation. The research suggests that Māori are more receptive and receive better outcomes from service providers who do not rush and are transparent in their delivery of services (Elder, et al., 2016), which supports Recommendations 2 and 3 (see Table 3).

Stigmatisation

A common discussion point across the participants was that the stigmatisation of mental illness and seeking help was a barrier to accessing mental healthcare. Furthermore, cultural identity influences how you perceive social structures and in return how you are perceived societally. Many participants discussed that their whanau and culture did not feel welcome in healthcare systems, and this influenced their delayed entrance into mental healthcare. These discussions were around whanau feeling rushed by GP's, feeling misunderstood in services, and negative feelings centred around the costs and accessibility to services.

Most participants reported that their whanau initially urged them to seek emotional help within the whanau before accessing professional help. This was described as being related to their whanau feeling whakamā and distrustful of healthcare systems. Māori are more comfortable to seek support from their whanau, culture, or iwi as opposed to healthcare services for a variety of reasons: systemic inequalities, cultural incompetency, and dissatisfaction with service (Sokratov & O'Brien, 2014). Similarly, many participants discussed that their whanau views of mental illness deterred them from accessing help for mental illness symptoms. Some of the views discussed included thinking mental illness doesn't exist, that it is crazy, and that you should toughen up and deal with it yourself, which may reinforce future generational stigma. A further exploration into these stigmatised conceptualisations would be beneficial for service providers to better understand the barriers to mental healthcare for rangatahi Māori (Recommendation 5, Table 3).

Time

Time, in varied contexts, was described as a barrier for rangatahi Māori in their pursuit of mental healthcare. Time was discussed in reference to service providers rushing through appointments and

explanations, lack of time spent on whakawhānaungatanga protocols, and protracted waitlist times for referrals to specialists. Participants reported that they felt they often had to fight to be heard and understood by their GP. This lengthened the diagnosis and treatment process. Some participants mentioned having to change their GP multiple times because they were minimising their concerns around their mental illness symptoms. These factors negatively impact the development of rapport and whakawhānaungatanga, which prolongs the need for mental healthcare for rangatahi Māori. Whakawhānaungatanga has shown to be highly beneficial for Māori seeking help for mental health issues as it keeps them engaged and more likely to experience progress with the service (Shaw et al., 2013; Ministry of Health, 2014; Durie et al., 2018).

Additionally, participants described that with some service providers they were shocked by being asked to disclose personal information so quickly. They stated they would have preferred some whakawhānaungatanga first to establish some rapport and comfortability. The concept of whakawhānaungatanga has shown to be incredibly valuable in creating a comforting atmosphere for Māori clientele (Shaw et al., 2013). Improved whakawhānaungatanga practices were raised frequently by all participants which supports Recommendation 3 (see Table 3). And lastly, all participants reported that after visiting a GP they had to wait at least a month before seeing a counsellor or specialist. This was particularly distressing for participants who were experiencing severe depressive symptoms. This is likely due to the overburdened mental healthcare system, however, this notion was not translated to the participants which left them feeling bereft and confused.

SES and financial barriers

Participants talked about the financial and socioeconomic barriers to accessing mental healthcare. All participants disclosed that their first point of contact in their mental healthcare journey was with a GP. The cost to see a GP for these participants ranged from \$25-\$60, which was entirely inaccessible for some individuals. The two participants that reported having to pay \$60 for a GP visit disclosed that they were very hesitant to go through their GP because of the cost alone. They exhausted other sources of information to figure out if there was a faster, more economical pathway to a counsellor but struggled to find one without a GP's referral. Additionally, for some participants they had to visit the GP multiple times for referrals, medications, and mental healthcare. This increased the cost significantly. One participant discussed that they had to forgo renewing their antidepressant prescription because they did not have the money for the GP visit, and they already owed money on their account. This meant he went without his medication for a month before he could pay his bill and visit again to renew his prescription. Another participant also discussed that to attend a specialist ADHD assessment she was required to travel to Tauranga. This was the closest appointment available

with the shortest waitlist. The appointment itself was incredibly expensive and she had to add travel costs on top of that.

Māori experience substantial disparities in socio-economic status, employment, and education in comparison with non-Māori (Ministry of Health, 1999). Thus, it is important to consider these disparities when working with Māori in mental healthcare which supports Recommendation 4 arguing for improved understanding of the systemic and sociocultural factors that challenge Māori entering the healthcare system (see Table 3). Some of the participants discussed that during their upbringing they thought services, like therapy, were for wealthy individuals. This was an idea that was socialised into their childhood through societal and cultural views of low socioeconomic status Māori families. They had no idea that there were inexpensive and charge-free options. The influence of socio-cultural climate is not always recognised by service providers, however, it is an important factor to consider when working with rangatahi Māori.

Enablers

Enablers to mental health services for rangatahi Māori were broken into four emergent themes: whakawhanaungatanga, transparency, satisfaction with service, and incorporation of Māori culture/models.

Whakawhanaungatanga

Each participant mentioned the concept of whakawhanaungatanga in reference to how it improved their experience with mental healthcare. These experiences were often related to a specific service provider(s) who took their time to build rapport with the participant. This was particularly evident in discussions around service providers who introduced themselves well and utilised some self-disclosure to build trust. It was also helpful if they then eased the participant into revealing their own stories instead of expecting them to be willing and ready to disclose immediately. These narratives relate to much of the available research around the positive correlation between whakawhanaungatanga and health service engagement/progress (Berghan, et al., 2017; Came et al., 2020; Kidd et al., 2020).

Many participants also described service providers who were willing to extend their services beyond their role expectations. For example, one participant stated that, while waiting to be referred on to a counsellor, their GP gave them their personal number to call any time they were feeling overwhelmed

by their depressive symptoms. This authentic concern and support built a strong connection between the participant and the service provider while also easing many of their worries and symptoms in the interim. Elder and colleagues (2016) have analysed this theme and explained how deeper connections between practitioners and clients is the best practice in mental health services. This emergent theme relates directly to Recommendation 2 which argues that whakawhanaungatanga practices need improvement in mental healthcare to support engagement and progress for rangatahi Māori (see Table 3).

Transparency

Transparency was another theme that emerged regularly in discussions with all participants. Most participants described instances when they had felt confused, whakamā, and anxious in the mental healthcare system. Each participant had a positive experience to disclose whereby a specific service provider had helped to alleviate these negative emotions. The main theme of these experiences was having a service provider who was transparent and incorporated psychoeducation throughout. Furthermore, participants reported experiences whereby service providers would use psychological terms or jargon, and there was an expectation that they knew what was being discussed. However, when service providers were proactive in explaining each term, diagnoses, treatment model, or tried to simplify explanations, it made the participants feel more at ease. It also made them feel more comfortable in asking follow up questions when they did experience confusion or anxiety. Taking time and being patient with Māori clients seems to help with this whakamā (Wepa, 2016). This gives weight to Recommendation 2 which holds that transparency between service providers and clients' needs improvement (see Table 3). Additionally, all participants reported that they had done their own research after many of their GP or therapy appointments. They described that having service providers who directed them to reliable and accurate sources of information was hugely beneficial in their experiences with mental healthcare and understanding themselves better. Kanohi-ki-te-kanohi is considered best practice when working with Māori and this can be supplemented by reading resources or links to reliable sources of information (Campbell-Knowles, 2012).

Satisfaction with service

All participants discussed how their satisfaction with the service was a significant enabler. Participants discussed that noticing they were making progress made them far more encouraged to continue engaging with mental healthcare. This was specifically emphasised by participants who have noticed positive outcomes from counselling services or medications. These satisfying experiences were attributed to a variety of factors: positive experiences with service providers, symptoms lessening,

and feeling better. One participant discussed that having a psychologist who took their time to understand them, led to them trying an anxiolytic that has since made an immense positive impact on their mental health. There are ethnic differences with satisfaction with service in healthcare in Aotearoa. Māori are typically less satisfied than non-Māori, however, when satisfied with their service experience immense progress and improvement in engagement (Harris et al., 2019). Additionally, all participants discussed that due to their own reservations and the stigma around mental healthcare they were unmotivated when first accessing mental healthcare. However, once they started to notice they were feeling better or making progress it improved their motivation substantially which seemed to influence positive outcomes.

Incorporation of Māori culture/models

When participants discussed cultural competency within mental healthcare there was an overwhelming sense of disappointment. All participants discussed that there was either no incorporation of Māori culture/models or very little. This evoked many negative emotions from participants. These included feelings of frustrations, confusion, and exclusion. Participants mentioned cultural competency when discussing service providers lacking cultural knowledge, services having socioeconomic barriers, and using models of health that have limited applicability to rangatahi Māori. The available literature negatively critiques delivery of mental healthcare in relation to cultural competency. Most healthcare services employ Western models that do not wholly resonate with Māori or that work well with Māori. This negatively impacts the outcomes for rangatahi Māori from these services (Durie et al., 2018). All participants acknowledged times where Māori culture or models were incorporated and how that was a significant enabler in their experience. For some participants this included providers competently using te reo Māori, incorporating karakia, or Māori models of health. Te whare tapa wha was specifically mentioned by many participants as an assessment tool that was employed and made a positive difference in their experience. Te whare tapa wha was the only Māori model of health that these participants have experienced, which is of concern. These factors support Recommendation 1 which stipulates the need for improved cultural competency for service providers in mental healthcare in Aotearoa (see Table 3).

Another cultural factor mentioned was that participants felt profoundly understood when service providers recognised how socio-cultural factors influence mental illness and experiences with mental healthcare. What was mentioned by most of the participants was the presence or absence of Māori service providers. For the participants who had experiences with Māori counsellors or psychologists they reported that they felt an immediate connection to them. As evidenced by research and the present study, this facilitated the whakawhanaungatanga process which helped in the development

of rapport and creating a warm and open atmosphere (Elder, et al., 2016; Shaw et al., 2013). This allowed the participants to confide in these service providers and make progress with their mental health problems.

Research Implications and Recommendations

Taking the findings explored above into consideration, the following recommendations, presented in Table 3, are proposed.

Table 3

Recommendations for service providers and further research

Recommendations for Service Providers
1) Improve cultural competency individually and systemically
2) Improve transparency between service providers and clients
3) Improve whakawhanaungatanga practices

Recommendations for further research
4) Improves understanding of the systemic factors that influence Māori mental health
5) Better comprehension of the conceptualisation of mental health and mental illness for Māori

Previous research has shown how health literacy has negatively influenced rangatahi Māori in navigating healthcare services. The present study identified that participants felt confused within the mental healthcare system and anxious/whakamā to seek help until their situation became extremely distressing. Figuring out the best services to begin with, managing multiple appointments, and feeling comfortable in the healthcare system were all factors that were mentioned by the participants. It was discussed that some individuals felt uncomfortable in specialist waiting rooms, did not feel

comfortable to question service providers, felt whakamā when advocating for themselves, and did not feel welcome in healthcare services. These barriers for rangatahi Māori could be alleviated by improving the cultural competency of mental healthcare services. This could include the implementation of kaupapa Māori health models, cultural supervision for non-Māori service providers, and employing a personal/community-based approach to service delivery to facilitate whakawhanaungatanga with whanau (Durie et al., 2018). These changes have the potential to create a more welcoming and comfortable environment for rangatahi Māori who are accessing mental healthcare in Aotearoa.

A lack of transparency between service providers and clients was a common theme in the present study. Negative experiences included a lack of communication from service providers, a lack of explanations, too much jargon, and a lack of resources for personal research. The available research suggests Māori require transparency, good communication, and consistent psychoeducation to aid in their engagement and motivation during treatment. This could be achieved through kanohi-ki-te-kanohi appointments with supplementary reading resources or links to research. It is also important for service providers to explain in layperson's terms and define any jargon as previous research and the present study suggests that rangatahi Māori are not always comfortable questioning service providers (Campbell-Knowles, 2012). Better communication can be facilitated through service providers taking their time with whakawhanaungatanga and diagnostic processes. Whakawhanaungatanga has shown to create a comfortable and open environment for rangatahi Māori to share and be vulnerable. This is important for young people discussing their mental health. Furthermore, these strategies will help to improve communication and transparency between rangatahi Māori clients and mental healthcare service providers.

For future research, it is important that the experiences of Māori with mental healthcare services are documented as Māori are disproportionately impacted by many mental illnesses in comparison with non-Māori. The present study found a variety of systemic factors that influence Māori mental health. Financial barriers to mental healthcare were mentioned by all participants in the present study. Existing research suggests those who are of low socioeconomic status or live in more deprived areas in Aotearoa experience poorer mental health. Similarly, they are more likely to experience difficulties accessing mental healthcare due to costs and transport. Furthermore, as Māori seem to live in more deprived areas and are of low socioeconomic status, this is a significant issue for rangatahi Māori (Menzies et al., 2020). The existing research and this present study suggest that many service providers do not seem to acknowledge these systemic factors which perpetuates that barrier-like impact. To address this issue, it is important to continue to explore and elucidate the experience of

Māori with mental healthcare. This will help to identify barriers and enablers that can be alleviated or nurtured, respectively. This is especially important with Māori in Aotearoa because of the personal, interpersonal, and societal nature of the influences that impact their experiences with mental healthcare. Moreover, developing a deeper understanding of the systemic issues that impact rangatahi Māori will help to rectify these barriers as it helps to facilitate authentic caring and strengthens the therapeutic relationship.

The conceptualisation of mental health for Māori is another line of inquiry that has limited research. The findings show that Māori seem to have polarising understandings of mental health and how to address mental health issues. This lack of knowledge influences the misdiagnosis of Māori, the delayed access of mental healthcare, and pluralistic understandings of mental illness and mental health. The present study highlighted an overwhelming need for cross-cultural research around mental health and mental health services to address the existing barriers for rangatahi Māori.

Limitations

Some of the limitations to this study provide further lines of inquiry for future research on this topic. Due to the limitations of a practice research project this study was constrained to a small sample size. Similarly, this study included only female participants, and this may dilute the applicability of the results to rangatahi Māori. Although six participants is acceptable for a Master's level Practice Research Project, it restricts the generalisability of the findings from the study.

Additionally, this study focussed on individuals who were not currently residing in inpatient facilities and did not include anyone with historical experiences with inpatient facilities. This restricts the scope of the study which consequently restricts the generalisability of the findings. Thus, for a broader understanding of the experiences of rangatahi Māori with mental healthcare in Aotearoa it would be beneficial to include participants with inpatient experiences.

The method of recruitment is another limitation of this study. Due to the adoption of a snowballing recruitment method, self-selection bias is a factor in this study. Participants indicated their interest through their own resonance with the advertised eligibility criteria. Furthermore, Individuals who believe they have more to disclose about their experiences may be more interested in participating. These factors can influence the generalisability of the findings because it impacts the randomisation of recruitment and participation.

CONCLUSION

This study has delved into the narratives of rangatahi Māori around mental healthcare in Aotearoa and has provided broad insights into the experiences of the participants. The majority of mental healthcare research done in Aotearoa does not include deep exploration into the experiences of rangatahi Māori. The present study sought to fill this gap by focusing on their experiences. Through this approach this study has drawn attention to the barriers and enablers that exist for rangatahi Māori who are accessing mental healthcare in. Participants divulged mixed experiences with services, describing barriers such as health literacy, stigmatisation, time, and socioeconomic status/financial constraints. Additionally, the participants described enablers such as whakawhanaungatanga, transparency, satisfaction with service, and incorporation of Māori culture/models. These findings have provided insights for future research and recommendations for service providers. The present research has achieved a thorough and unique investigation of rangatahi Māori experiences with mental healthcare in Aotearoa. This is significant as Māori are rarely the focal point of such research and due to the high rates of mental illness among Māori it is important for their voices to be heard and their experiences to be portrayed accurately.

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APPENDICES

Appendix A: Advertisement



Rangatahi (young) Māori who have accessed mental healthcare in Aotearoa to take part in AUT University research.

Do you have experiences with mental healthcare? Do you identify as Māori? Are you between the ages of 18 and 24? Take part in an interview process to help us explore the experiences of rangatahi Māori with mental healthcare.

This is a student-led study aimed at investigating the experiences of rangatahi Māori with mental healthcare in Aotearoa

The interview will take approximately 1 hour to complete online or at a location and time that suits you.

Please contact Teina Rihari or Daniel Shepherd for more information and to take part

[Email – rrw4458@autuni.ac.nz](mailto:rrw4458@autuni.ac.nz)

daniel.shepherd@aut.ac.nz

Appendix B: Participant Information Sheet

Date Information Sheet Produced: 07/08/22

Project Title

Experiences of rangatahi Māori who have accessed mental health services in Aotearoa

An Invitation

Tena koe, my name is Teina Rihari and I am a Master of Health Science student and the Primary Researcher for this study. I am interested in ensuring that whānau are supported with resources in supporting their help seeking journey when accessing mental health services. Mental health services include specialist mental health services, community mental health services and/or general practice mental health services in Aotearoa. For this purpose, I am interested in hearing your experiences as a rangatahi Māori who have accessed mental health services in Aotearoa. The information you provide will be valuable as I seek to ensure more information is available around Māori experiences with mental health services in order to understand and inform practice and provided supports.

What is the purpose of this research?

The purpose of this research is to document rangatahi Māori experiences with mental health services in Aotearoa. Interviews will be conducted to examine your experiences. Questions will be focussed on your experiences as a rangatahi Māori accessing mental health services.

All data will remain confidential, and examples used in the final report will be by way of pseudonym and will not include your name or give information that would enable your information to be identifiable.

How was I identified and why am I being invited to participate in this research?

You have been identified as a potential participant because you meet the inclusion criteria. The inclusion criteria includes:

- Being a rangatahi Māori
- You reside in Aotearoa
- You have accessed mental health services in Aotearoa
- You are not currently using inpatient services for mental distress

You have responded to an initial post inviting you to participate in the research either from Facebook or through Comprehensive Care.

How do I agree to participate in this study?

To take part in this study please make direct contact with Teina Rihari within two weeks from the initial invitation, as the Primary Researcher, via email or phone (see below), who will address any questions you may have about the research. Once you have agreed, we will arrange an interview at AUT University offices (City, North Auckland or South Auckland) or by video conference. You may choose to have your whānau as support for the interview process (advising us prior to the meeting). Researchers will utilize putangitangi to investigate clients cultural home, and appropriate greetings from this will be used. This can include but not limited to traditional tikanga such as karakia and pepeha.

If requested, for a video conference interview we can decide on a date and time that best suits both you and I and a zoom link invitation will be sent through to you via email. The interview will not be video recorded but it may be voice recorded (with your express permission).

Your participation in this study is voluntary (it is your choice), and participation will neither advantage nor disadvantage you. You may choose to withdraw from the study at any time. If you choose to withdraw from the study, you will be offered the choice between having your data removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

A Consent Form has been forwarded with this Participant Information Sheet and must be signed and returned just prior to being interviewed.

What will happen in this study?

This project requires you to participate in a one-hour one-on-one interview. There will only be yourself, the participant, and Teina Rihari present at the interview, unless you would prefer a support person, or whānau member, of your choosing to be present.

The interview structure itself will involve some simple questions relating to our topic and will allow for additional questions if elaboration is needed. The general topics of discussion are: experiences as a rangatahi Māori with mental health services, any barriers, difficulties or negative influences you encountered, and enablers or positive influences you encountered, experiences with any related provided supports, the diagnostic process, and cultural factors. The information you provide is private and confidential and will not be used for any other purposes other than the analysis relating to this research topic. To further protect your privacy, I will use pseudonyms in any correspondence and publications relating to this research. The research findings may be used for academic publications and presentations.

What are the discomforts and risks?

I will take all reasonable precautions to ensure that you do not experience discomfort or risk whilst participating in this study. I will conduct the interviews at a neutral venue and ensure the rooms are quiet and private. I will endeavour to word the interview questions in a clear and respectful manner, however, you only need answer questions if you feel comfortable. You may withdraw from the study at any time.

How will these discomforts and risks be alleviated?

If for any reason you feel this experience has caused personal issues to arise, and you believe this is as a direct result of participating in the research please contact the AUT Health, Counselling and Wellbeing service.

AUT Health Counselling and Wellbeing can offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet

You can find out more information about AUT counsellors and counselling on <http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling>.

What are the benefits?

Your participation will provide information regarding experiences with mental healthcare in Aotearoa for rangatahi Māori. This will be a benefit to you because you are able to share your story and contribute to the limited research around rangatahi Māori experiences with mental health services. The findings will be of interest to other Māori individuals, families, policy makers and health service providers and allow them to develop programmes and supports to better meet the needs of young Māori people in Aotearoa. Additionally, this research will contribute towards the primary researcher's Master of Health Science degree.

How will my privacy be protected?

You will be asked to provide a pseudonym by which you will be known in the study or I can provide a pseudonym for you. Only the research team will have access to data during the data collection and analysis stage. Only the project supervisor, Assoc Prof Daniel Shepherd, will have access to the data after the final reports are produced. Audio-recordings of interviews will be destroyed following transcription. Consent forms and transcripts, using only pseudonyms, will be kept for six years in a locked filing cabinet in the Psychology Department on AUT premises.

What are the costs of participating in this study?

I estimate the total time investment for each participant will be three hours. I anticipate that interviews will take no longer than one and a half hours plus your travel time. If you wish to review your transcript prior to the completion of the research this will take an estimated additional hour of time.

What opportunity do I have to consider this invitation?

Once you have completed the Consent Form, it is requested that the forms be returned to the researchers at the interview. If you have any questions regarding these forms, you are encouraged to contact the research team. Receipt of these completed and signed forms acts as your acceptance to participate in this evaluation.

Will I receive feedback on the results of this study?

As a participant you will be provided with a summary report of the research findings via email at the conclusion of the study.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Assoc Prof Daniel Shepherd, daniel.shepherd@aut.ac.nz, ph. 09 921 9999 extension 7238

Whom do I contact for further information about this study?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Teina Rihari, rrw4458@autuni.ac.nz

Project Supervisor Contact Details:

Assoc Prof Daniel Shepherd, daniel.shepherd@aut.ac.nz, ph. 09 921 9999 extension 7238

Approved by the Auckland University of Technology Ethics Committee on **23/08**, AUTEK Reference number **25/157**.

Appendix C: Indicative Questions and Schedule for Interviews

Experiences of rangatahi Māori who have accessed mental healthcare in Aotearoa

A descriptive account

Interview Schedule

The interview aims to explore:

- Experiences as a young Māori with mental healthcare
- Barriers to/within mental healthcare
- Enablers to/within mental healthcare
- The diagnostic process
- Additional provided supports or resources
- Cultural factors

Introduction

Background Information

- Introduce self and AUT University
- Purpose of study - to understand rangatahi Māori experiences with mental healthcare in Aotearoa. Interviews will be conducted to examine your experiences. Questions will be focussed on your experiences with mental health services, any barriers and enablers, provided supports or resources, the diagnostic process (if appropriate) and cultural factors.

Interview Format

- Format of semi-structured interview (Open questions, follow up questions, hearing their views)
- No right or wrong answers – their views are important as they are the experts in their field
- Confidentiality
- Withdrawal at any time from interviews as whole, or in not answering particular questions
- Timing of interview (around one hour)

Recording of Interview

- Digital recording of interviews – check they are alright with this
- Report, use of quotations, anonymisation
- Check if they have any questions

- Check if they are happy to proceed

Consent

- Obtain signed consent

Questions

1. Can you tell me a bit about your experiences with mental healthcare in Aotearoa?
2. Can you identify any enablers that you encountered in your experiences with mental healthcare in Aotearoa?
3. Can you describe some of the challenges you face as a Māori navigating mental healthcare in Aotearoa?
4. What has your experience been in terms of diagnostic processes and seeking help regarding mental health?
 - a. Can you identify any barriers or enablers to diagnosis?
 - b. Did you know much about your diagnosis beforehand?
 - c. Have you done anything specific to develop your knowledge on your diagnosis? Such as workshops or research?
 - d. If so, how difficult was developing your knowledge?
5. Through mental health services were you provided/referred to any additional supports or resources?
 - a. If so, how were your experiences with those?
 - b. Could you suggest any provided/referred supports or resources that would have improved your experiences?
6. Can you identify any cultural factors that have affected your experiences with mental healthcare in Aotearoa?
 - a. Do you think you have experienced anything differently as a result of your cultural identity?
 - b. Can you think of any systemic or societal issues you encountered in the process of accessing, or when you accessed mental health services?
 - c. Have you accessed a service that incorporated Māori culture? How was that experience?
 - d. Can you suggest any cultural factors that would have improved your experiences with mental healthcare?
7. What additional support or recognition do you think might be helpful for you as a rangatahi Māori?

Closing questions

AUT

TE WĀNANGA ARONUI
O TĀMAKI MAKĀU RAU

Opportunity for the participant to add anything

- Is there anything else you would like to add?

Any other comments/questions?

- Thank participant for their time
- Reassure their confidentiality in this research and ask if there is anything they would not like to be discussed/ quoted in the final report
- Confirm that their transcript will be available for them to check and clarify
- Check if participant has any questions concerning participation

Auckland University of Technology Ethics Committee (AUTECH)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

Appendix D: Ethics approval

23 August 2022

Daniel Shepherd
Faculty of Health and Environmental Sciences

Dear Daniel

Re Ethics Application: **22/157 Experiences of rangatahi Māori with mental health services in Aotearoa**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 23 August 2025.

Non-Standard Conditions of Approval

1. Amendment of information sheet as follows
 - a. Inclusion in “What opportunity do I have to consider this invitation” section advice that the participant has 2 weeks to consider the invitation.
 - b. Inclusion of the standard statement regarding contacting the AUTECH Secretariat if any concerns, from the AUTECH Information Sheet exemplar.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by AUTECH before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTECH in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTECH prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTECH Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTECH Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTECH grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTECH Secretariat

Auckland University of Technology Ethics Committee

Cc: rrw4458@autuni.ac.nz