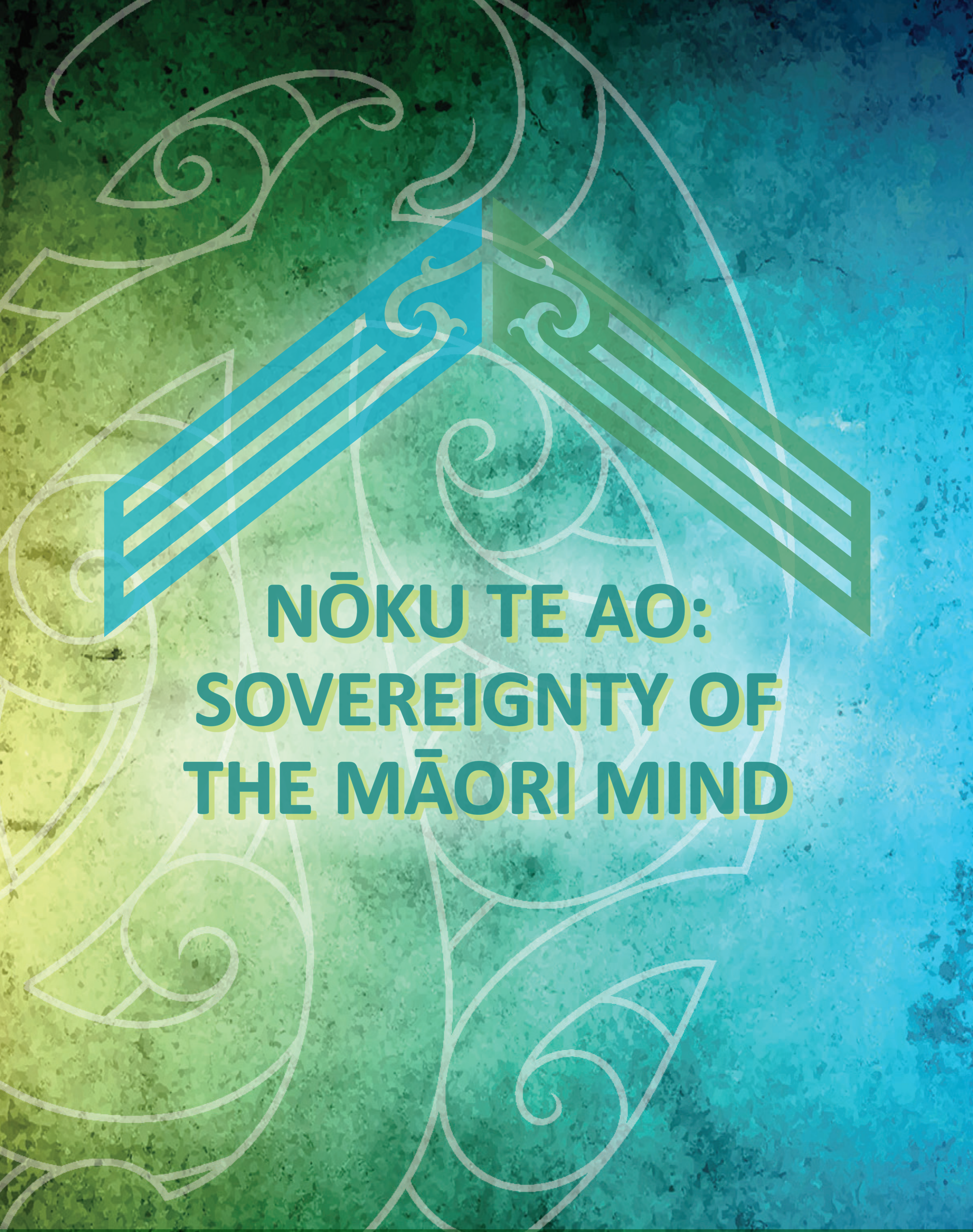

NŌKU TE AO: SOVEREIGNTY OF THE MĀORI MIND

IVY LEAGUE LTD
MĀORI HEALTH RESEARCH

NŌKU TE AO
LIKE MINDS

Te Whatu Ora
Health New Zealand

AUTHORS

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HE MIHI

Ko Ranginui ki runga rawa
Ko Papatuanuku e takoto ana ki raro
Ko te hunga mate ki te hunga mate, haere, haere, haere atu rā
Haere atu ki Hawaiki nui, Hawaiki roa, ki Hawaiki pāmamao
Ko te hunga ora ki te hunga ora
Kei ngā mana whenua o te ao
Ngā mihi.

He mihi maioha ki a koutou e manaaki, e tiaki tēnei mahi rangahau. We extend our thanks and appreciation to those who contributed to this report, from te pō to te ao mārama. We especially thank the Nōku te Ao partners who identified the need for this research, the kaupapa Māori researchers who gave their input in the design phase, and those who gave their time generously to review the final version. We are also thankful to Harley Rogers and the Tangata Whenua Advisory Group for your overarching vision of Nōku te Ao.

ABSTRACT

The purpose of this report is to present a Māori world view of factors that contribute to discrimination of people who have experienced — or continue to experience — mental distress.

The focus in this research is on Māori and recognises that discrimination associated with mental distress has many causative factors including colonisation, racism, socioeconomic deprivation, different perspectives on ‘mental distress’, historic separation of mental health from other health problems, and the longstanding societal disregard for people who experience mental distress. A critical Kaupapa Māori collation of relevant literature is presented that unpacks the root causes and institutional drivers of discrimination against Māori who experience mental distress. This research aims to inform a Kaupapa Māori approach to Nōku te Ao that prioritises Māori.

GLOSSARY

TERM	TRANSLATION
Aotearoa	New Zealand
Mate pāpōuri	Depression
Whakahāwea	Discrimination
Ngā kare-ā-roto	Emotions
Aukati	Exclusion
Kaitiakitanga	Guardianship
Mamae	Physical or emotional pain
Manaakitanga	Hospitality, kindness, generosity, showing respect and care for others
Māuiui	Weary, sick, fatigued
Taumaha-ā-roro	Mental illness
Pākehā	Non-Māori European
Pōuri	Deep sense of sadness or psychological pain
Whakatoihara	Prejudice
Auhi – Tapu/mamae/mauiui/mana pouri	Psychological distress
Rangatahi	Youth
Mauritau	Relax
Manawaroa	Resilience
Riri	Angry
Kīritau	Self-esteem
Poapoataunu	Stigma
Hiki tāmitanga	Stress relief
Te Taiao	Natural World
Haumanu	Therapy
Ngaukino	Trauma
Mahi rata	Western Medicine
Whakaaro	Thoughts/Perspectives
Whakaiti	To belittle, to make someone feel small
Whakaiti	Worry

CONTENTS

INTRODUCTION

INTRODUCTION

People who experience mental distress are often treated differently by others. When this treatment is harmful, it is unfair and unjust and therefore constitutes discrimination.

Mental distress is a blanket term that includes a wide range of experiences of mental ill-health that can be happening now or have happened in the past. Differential treatment of people who experience mental distress is a breach of human rights. Whilst institutions such as mental asylums have now shut down, discrimination of those with mental distress has not been eliminated. The former Like Minds Like Mine programme operated for 25 years and was tasked with ending prejudice and discrimination against people with mental distress. The programme involved a range of strategies including social movements, national marketing campaigns, research, and interventions that promoted contact with those who experience mental distress.

Although public perception about mental illness had shifted, and it is now much more acceptable to talk about mental health, rates of both discrimination and mental distress continue to rise. Moreover, inequities between Māori and non-Māori have been present for some time and strategies to date have failed to deliver improvements for Māori, likely contributed to by evidence-informed approaches that reflect international best practice yet lack focus on and with Indigenous peoples. This is despite Māori experiencing higher rates of both mental distress and discrimination compared to non-Māori, and differential treatment of Māori being a breach of the rights of Indigenous peoples. Much of the national and international anti-discrimination work related to mental distress has been devoid of Indigenous input, participation, or leadership. It is therefore likely that New Zealand interventions to date have been more reflective of non-Māori world views and understandings.

The 2018 national review of mental health and addiction services in Aotearoa called for drastic change. In 2021, Like Minds Like Mine underwent a re-brand and re-launch with fundamental changes in the way the programme is organised and delivered. Now re-named Nōku te Ao Like Minds (Nōku te Ao), the new programme was launched on 6 July 2021, during Matariki, having completed a structural overhaul, instilling Māori leadership, and embedding Kaupapa Māori principles throughout.

Nōku te Ao is a public awareness programme that aims to end discrimination and prejudice, encourage social inclusion, and uphold the mana and human rights of people with lived experience of mental distress. Rather than historical 'one size fits all' approaches, the new direction targets those most affected (i.e., Māori and Pacific peoples), and aims to enact and monitor realistic (rather than tokenistic) implementation of the principles of Te Tiriti o Waitangi. It ensures that Tiriti partnership approaches are meaningful, that outcomes are beneficial to Māori, and that programme design, delivery and governance reflect Māori world views. In addition to these structural, leadership and governance changes, Nōku te Ao Like Minds partnered with Māori-led organisations such as Te Rau Ora and Hāpai te Hauora (jointly with Te Kete Pounamu, the Mental Health Foundation and Ngā Hau e Whā), and Te Whare Wānanga o Awanuiārangi who will deliver research, insights, and evaluation through a range of Kaupapa Māori-informed initiatives.

This report responds to this new direction by bringing together a Māori world view of Nōku te Ao.

Specifically, this report (research, literature review) collates information about te ao Māori, Māori experiences of mental distress, Māori experiences of discrimination, and Māori experiences of mental distress-related discrimination.

This knowledge base aims to support Nōku te Ao partners in the design and delivery of their respective initiatives, as well as the overall programme approach. It is also expected to inform other organisations, who might collaborate with or support the wider Nōku te Ao programme. In a wider context, this report contributes a unique Māori / Indigenous perspective to the current knowledge base.

The purpose of this research is to inform the Nōku te Ao programme as it sets out to achieve the recently released Rautaki 2021-2026 (1). This research presents a co-designed literature review that incorporates the current knowledge base available to inform Nōku te Ao. The literature review draws upon a critical Kaupapa Māori lens that foregrounds Māori and Nōku te Ao realities, aspirations, and world views.

This report provides insight into the root causes of discrimination of Māori with mental distress.

We take a critical Kaupapa Māori approach to theory, prevention, and causation. It looks at the root causes of discrimination of Māori, and of Māori mental distress. We signpost critical systemic factors that are likely to be causative. This report applies the theory of fundamental causes, thereby providing insight into factors such as colonisation, intergenerational trauma, and institutional racism as key determinants of discrimination of Māori and Māori mental wellbeing. Importantly, this includes the deliberate deconstruction and critical anti-colonial analysis of Western medical concepts of mental distress, and associated discrimination experienced by people who suffer from mental distress, with a particular focus on Māori experiences. This review is structured into ten sections:

Section 1 will provide a brief historical background to Nōku te Ao that can contextualise the importance and need for this literature review.

Section 2 reflects upon the theoretical notion of a Kaupapa Māori lens and the epistemological basis that underpins Kaupapa Māori as a critical approach.

Section 3 defines some key concepts to ensure clarity relative to mental distress, and discrimination and Māori / Indigenous peoples.

Section 4 considers the history and evolution of mental health understanding, practice and service, and importantly, Māori notions of mental health, distress, and discrimination.

Section 5 presents an overview of literature related to the previous Like Minds Like Mine approach in relation to mental distress-related discrimination

Section 6 proposes a structural model for conceptualising Māori experiences of mental-distress related discrimination that can inform unique solutions.

Section 7 unpacks the many ways by which Māori experience mental distress-related discrimination, and highlights racism as the predominant form of discrimination

Section 8 discusses the report findings, applies a Kaupapa Māori lens and links Māori experiences of mental distress-related discrimination to the wider Aotearoa context

Section 9 proposes seven levers of change that inform a comprehensive system-wide approach.

Section 10 makes concluding comments

NOTES ABOUT THIS REPORT

Severity – unless otherwise stated, no attempt is made to focus on acute or severe mental distress as opposed to other levels of 'severity'. This report refers to mental distress in general and includes severe, moderate, and low rates of distress.

Kupu Māori – Te reo Māori is utilised throughout this report where appropriate. Te reo Māori is not translated where common kupu Māori are used. A glossary is provided particularly important kupu Māori and kupu Pākehā.

A BRIEF HISTORY OF NŌKU TE AO – LIKE MINDS

A BRIEF HISTORY OF NŌKU TE AO – LIKE MINDS

Prejudice and discrimination against people with experiences of mental distress are common, and in New Zealand, are more prevalent for Māori.

Nōku te Ao Like Minds is a national programme that aims to bring an end to prejudice and discrimination of people with lived experience of mental distress. Re-launched on 6 July 2021, Nōku te Ao sets a new direction for the previous Like Minds Like Mine programme of work, which aligns with the 2022 New Zealand health system reforms. With a 25+ year history, the Nōku te Ao Like Minds programme has evolved alongside new research insights and the changing landscape of mental health and discrimination in New Zealand.

Prior to the late 1980s, several mental asylums operated in New Zealand. As described by Cohen, the story of the rise of 'colonial psychiatry' in Aotearoa identifies key historical milestones (2). In the late 1800s and early 1900s, the development of psychiatry services and institutions in Aotearoa, as part of the colonial project, claimed 'medical authority' (i.e., the authority of colonial medicine). This was affirmed when the Tohunga Suppression Act 1907 was passed – outlawing traditional Māori healing practices of Tohunga. Cohen notes that "Tohunga had become a political threat to colonists" (p. 323) (2). This example of suppression of Māori knowledge and practice systems is one of many that forcibly removed and outlawed Māori infrastructure that enabled autonomy, particularly of thought (3). Despite this, Cohen identifies that Māori rates of admission to mental hospitals remained low, and certainly lower than that of Pākehā until the late 1950s. During this post-war period with a dramatic urbanisation shift, Māori psychiatric admissions (and incarceration rates) rose steadily, overtaking that of Pākehā in the late 1970s. Importantly, rates of psychiatric incarceration were particularly high for Māori aged 20 – 29 years (2). Māori mental distress and admissions to Pākehā mental institutions appear to be a recent phenomenon, increasing as a direct result of colonisation (4). A review of early mental health case notes identified:

> **Unequal power relations, they argue, have left New Zealand and other settler colonies with two legacies: evidence that the ongoing impacts of colonisation have caused Indigenous peoples to suffer mental illness; and health services that continuously fail to deliver mental health services that are suitable and appropriate for Indigenous peoples (p. 5) (5).**

Durie (2022) outlined the severe and harmful ways that mental health patients were 'treated' within these institutions (6). Utilising Pākehā psychiatry as a catalyst, these mental asylums, hospitals, and borstals inflicted trauma, abuse, and torment for many patients. These methods included, for example: seclusion, multiple electrotherapies, excessive physical restraint, disrespect, communal showering, and over-medication.

The 'Survivor movement' called for recognition of the harmful way that those within the mental 'health' system were being treated and called for enquiries into mental health services. Alternatively understood as the ‘consumer movement’, the movement of people with experience of mental illness was both social and political, and aimed to change society’s perception and treatment of those with mental illness. Cunningham et al. (2017) also note that public perception of mental illness was heavily influenced by the media and included negative stereotypes and stigma (7). The Mason inquiries between 1987 – 1996 and 1995 – 1996 investigated procedures used in psychiatric hospitals. The reports called for drastic mental health service reform and identified serious shortcomings in the mental health sector. Of note were systemic failures in mental health services, particularly for Māori, reporting on ethnic inequities in admissions between Māori and non-Māori, a call for Māori leadership, and the embedding of Māori world views and tikanga Māori (5). These landmark inquiries importantly identified the need to uphold the human rights and reduce the discrimination of those with mental distress.

Established in 1997, the Like Minds Like Mine programme responded to the Mason inquiries (8) and aimed to address the prejudice and discrimination associated with mental distress. Adopting a behaviour change approach, the programme delivered a range of award-winning television and other media campaigns and communication activities, community action and education. Like Minds has evolved over its 25-year history to partner with — and be led by — those with lived experience, and those of Māori and Pacific ancestry.

Over this time, the social position of mental health has changed. Mental health is now a well established priority area in Aotearoa, with noted improvements in the social acceptability of ‘talking about mental health’. Although Like Minds seems to have contributed to improvements in public attitudes to those with experiences of mental distress, discrimination is ongoing and occurs commonly within family, workplace, education, employment and social environments, as well as in the healthcare, social services, and justice systems (7).

Māori are significantly more likely than non-Māori to report discrimination in relation to personal safety with regards to the police, and experience higher rates of compulsory treatment and seclusion (1). Further, discrimination is a core determinant of wellbeing, requiring specified interventions. The 2018 Government Inquiry into Mental Health and Addiction identified ongoing and significant mental health-related discrimination against those with experiences of mental distress (9).

The subsequent He Ara Oranga Report described the nature of mental health-related discrimination, its impact on whānau, their mental wellbeing and sense of isolation (9). It was noted that discrimination continued to be present, common, and widespread in Aotearoa and within the mental health system. In addition, the intersectionality of discrimination of peoples by gender, ethnicity, age, sexual orientation, and mental state was foregrounded as inseparable and amplified. The report noted:

> **Sexual orientation, gender identity or expression and intersex status are not the cause of the elevated risk of mental health problems, addiction, and suicidality among the rainbow population. Rather, the increased risk is due to stigma, discrimination, prejudice, and exclusion (p. 43) (9).**
>
> **47% of New Zealanders will experience mental illness or distress in their lifetime. Evidence shows one in five New Zealanders and one in four Pacific people experience mental distress. However, one in three Māori are affected by mental distress. To that end, the chances of prejudice and discrimination impacting on Māori with lived experiences of distress is extremely high (para. 4) (10).**

Mental distress is a prevailing concern in Aotearoa, with Māori twice as likely as non-Māori to face social inequities, unfairness, judgement, and bigotry (1).

Whilst many will lead healthy lives, socially exclusive behaviours and practices often hinder those from living with and or recovering from severe mental distress. Addressing prejudice and discrimination can provide people with “a greater sense of self-worth, better whānau and community connections, improved employment prospects, a liveable income and a longer, healthier life” (para. 5) (10). The 2018 inquiry called for targeted de-stigmatisation and mental health promotion programmes for Māori and Pacific communities. Specifically, recommendation 35 of the He Ara Oranga report:

35. Encourage mental health advocacy groups and sector leaders, people with lived experience, families and whānau, professional colleges, DHB chief executive officers, coroners, the Health and Disability Commissioner, New Zealand Police and the Health Quality and Safety Commission to engage in a national discussion to reconsider beliefs, evidence and attitudes about mental health and risk (p. 20) (9).

The He Ara Oranga report was the basis for the 2021 re-launch of Nōku te Ao which aims to apply recommendation 35 of He Ara Oranga by destigmatising attitudes and environments, ending prejudice and discrimination, and increasing inclusion for people with experience of mental distress. Evidently, Nōku te Ao aims to benefit those most affected by discrimination and those most impacted by social exclusion — particularly Māori and Pacific communities — by changing social attitudes and setting the basis for a more inclusive society (10). Launched by Minister Andrew Little in Wellington in 2021, the 2021-2026 Rautaki (Nōku te Ao strategy) outlines this new direction, with Te Tiriti o Waitangi, human rights, lived experience movements, intersectionality, government policy and best practice making up the foundations of the overall programme. The strategy:

- **Reaffirms** that while some population groups are more affected by discrimination and prejudice, bringing an end to discrimination and prejudice is a national priority that affects all New Zealanders
- **Involves** several kaupapa partners who play key roles in achieving the programme's goals
- **Acknowledges** Māori as Te Tiriti o Waitangi partners as well as New Zealand citizens, and therefore, the right of Māori to equitable health outcomes and wellbeing in mind, body, spirit and within the whānau
- **Acknowledges** people with lived experience of mental distress, and that ending prejudice and discrimination is likely to improve access to participation in society, improved quality of life, and importantly, the upholding of their mana and identity
- **Acknowledges** the critical role of whānau and whanaungatanga in supporting and enabling a collective approach to wellbeing
- **Has a key focus** on critical consciousness of those who have the potential to discriminate, and removes organisational, policy and interpersonal barriers, and identifies the need to uphold the rights of those with mental distress within health and social services as critical to systems change.

Nōku te Ao (2021) marks a turning point within the context of mental health-related discrimination in Aotearoa and includes a range of components (11). These include:

- Leadership (programme governance, management, procurement, and capacity building)
- National activities (national campaigns, social inclusion awards, structural discrimination work)
- Community activities (education, social movement, media monitoring, social action grants), and Research (research the problem, investigate best practice, evaluate Nōku te Ao Like Minds).

Unique characteristics of Nōku te Ao include:
- A focus on those most affected by mental health-related prejudice and discrimination,
- 'Lived experience' leadership, decision-making and delivery,
- Embedding of Kaupapa Māori principles, and
- A focus on those who have the potential to discriminate.

Nōku te Ao positions those with lived experience at the centre of inquiry and changes it strategic direction towards the overall New Zealand health system goal of Pae Ora (12). Collectively, the vision of Nōku te Ao and achieving its aim, will contribute to the advancement of Aotearoa. The philosophies underlying Nōku te Ao are based on Māori principles. They have generic parallels that are not identical but carry similar meanings. The Māori principles are strongest when considered within a Māori context.

- **Tino rangatiratanga** is a principle that recognises Iwi autonomy, Māori leadership, and Māori decision-making. It has sometimes also been applied to the independence of whānau collectives and Māori individuals but is more often a statement about Māori as a people **Free Will** is a not dissimilar principle that has application to all individuals in Aotearoa, both Māori and non-Māori; it recognises the rights of individuals to live with confidence and to be included in society. Both principles are about the right of all people to be self-determining in their cultural, political, economic, and social aspirations.

- **Taonga Tuku Iho** is a principle that recognises the transfer of Māori traditions, language, taonga, protocols, and land across many generations. The principles of **Cultural Identity and inheritance** also recognise the distinctive histories and traditions that define all peoples in New Zealand, both Māori and non-Māori. While the two principles have different origins and values, they both recognise the importance of the past to the present, and the hurt that discrimination can cause when the values associated with each are ignored.

- The principle of **Mātauranga Māori** underpins distinctive Māori concepts, Māori world views, and Māori wisdom. The principles associated with **Knowledge and Learning** have similar connotations that endorse the importance of understanding, awareness, and gaining skills within all our communities. Although coming from different perspectives, Mātauranga Māori and Knowledge and Learning are both important for understanding the impact and management of discrimination in Aotearoa.

- **The Whānau principle** values ongoing connections based on whakapapa and, increasingly, connections within whānau-like groups (kaupapa Whānau). For all New Zealanders, **Family Connections** help define relationships that are critically important and carry with them a strength that can endure over time. While the Whānau principle is closely aligned to te ao Māori and Family Connections carry multi-cultural origins, both principles are all too frequently disregarded by discriminatory actions.

- The principle of **Mana Tangata** recognises the strength, integrity, confidence, and pride that stem from earlier generations and can be recognised in modern times for people who are proudly Māori. **Human Rights** is a similar principle that is applicable to all people and recognises self-respect and esteem, as well as self-worth. Although the principles of Mana and Human Rights emerge from different perspectives, they both recognise human qualities that enable people to live with dignity but are undermined by discrimination.

As noted by Aikman (2022), Nōku te Ao is a paradigm shift that is lived experience-centred and led. This has involved recognising that the old Like Minds programme was "built on a Western worldview, unable to adequately support Māori or Pasifika people" (p. 9) (11).

He further identifies that "while this was mitigated to some degree by having Māori and Pasifika providers deliver Like Minds-related services in the early years of the programme, it did not solve the core problem of the programme's overarching worldview" (p. 9) (11). This report supports this paradigm shift and the structural changes made to date by presenting an overarching Māori world view.

This section has provided an overview of the evolution of the movements in Aotearoa that aim to end discrimination of those with mental distress and ensure their mana and human rights are upheld. This has been possible through a combination of survivor voices, government reviews, commitments to change, and specific investment in this kaupapa.

Nōku te Ao brings a Kaupapa Māori approach to the national campaign, is framed within a Māori world view, and aims to be strategic, specific, to prioritise those most affected, and to deliver unique, innovative, and targeted initiatives to achieve this overarching goal. This report provides fundamental Information for Nōku te Ao partners to carry out their bespoke mahi. The following section brings together information about Māori, a Māori world view and Kaupapa Māori.

UNDERSTANDING A KAUPAPA MĀORI LENS

UNDERSTANDING A KAUPAPA MĀORI LENS

MĀORI EPISTEMOLOGY

Te ao Māori, or Māori world views are linked to traditional Māori knowledge or Mātauranga Māori (2), and are represented in traditional Māori stories (3, 4). A Māori world view, like many Indigenous world views, is founded on the story of creation. Indigenous creation stories are evidence of Indigenous understanding of the environment (5, 6).

A common Māori creation story, as told within the *He Hīnātore ki te Ao Māori* report by the Ministry of Justice (7) begins with Te Kore: from Te Kore comes Te Pō, and from Te Pō comes Te Ao Mārama. Te Kore refers to a nothingness, a void, and energy and potential. Te Kore is described as the void in which nothing is possessed, felt, unified or bound (7). Te Pō refers to the night or darkness. Te Pō is the phase in which Ranginui (male element) and Papatūānuku (female element) (the primordial parents) come into being. Their presence is described as a long and loving tight embrace in which they produce many children.

In Te Pō, the 70 children of Ranginui (Rangi) and Papatūānuku (Papa) reside in the cramped and dark space between their parents. Tāne, Tāwhirimatea, Tangaroa, Tūmatauenga, Rongomātāne, and Haumiatiketike are some of the many children of Rangi and Papa and are 'revered ancestors' of the forest, elements, sea, war, peace, kūmara and cultivated plants, and fern root and uncultivated foods, respectively. The children (also considered atua) are unhappy in the dark space between their parents, and Tāne suggests that Rangi and Papa should be separated for light, growth, and life to develop. Tāwhirimatea does not agree, but the others do, and after various attempts, Tāne lays on his back on Papatūānuku and stretches his feet skyward, pressing his feet against Rangi and forcing them apart. Despite resistance from Rangi and Papa, Tāne is successful, and light enters te ao Māori. Te ao mārama refers to the emerging of light through an initial glimmer, followed by the brightness of day, and eventually, life (7).

In another story (8), Māori beliefs attribute Tāne-nui-ā-Rangi (or Tāwhaki) with obtaining Mātauranga Māori from the whare wānanga (learning institution). This story tells of Tāne's journey of ascent (that incidentally involved many challenges) to reach the highest 'realm', from which he obtained three kete (baskets) of knowledge and brought them back down to 'earth' (Papatūānuku). Among other things, with this knowledge, Tāne was able to endeavour to create a 'female' element and subsequently the line of human descent. Māori world views and creation stories provide the philosophical framework through which Māori understand the structure and behaviour of the physical and natural world.

Built into the traditional Māori knowledge system are complex understandings of geographical, ecological, meteorological, and astronomical patterns, trends, and interactions (9-11).

Traditional Māori knowledge was/is also drawn upon when learning about social skills, relationships, communication, values and wellbeing (12, 13). Therefore, mātauranga Māori and Māori world views support Māori thoughts, consciousness, teaching and learning, relationships and connections, social systems, protocols and practices (14).

KAUPAPA MĀORI

This research utilises a Kaupapa Māori paradigm of inquiry. Graham Smith explains that "Kaupapa Māori evolved out of the long and arduous struggle for the revitalisation of Māori language and …forms of alternative education" (para. 3) (15).

Kaupapa Māori provides the theoretical foundations, themes, values, assumptions, and beliefs of the Māori world view (2, 16-18). Pihama et al. (2020) describe kaupapa as a way of framing and structuring how we think about ideas and practices (19). Kaupapa Māori is the approach taken to this paper and underpins the Nōku te Ao strategy. Kaupapa Māori principles are applied differently depending on the kaupapa or nature of the issue.

Here, we provide a **Te Ao Māori rangahau framework** that draws on and brings together

- The four elements of Te Whare Tapa Wha (te taha hinengaro, te taha whānau, te taha tinana and te taha wairua)
- Māori ways of knowing (mātauranga), being (whakapapa) and doing (tikanga), and
- Kaupapa Māori principles (as defined / explained by Graham Smith)

Examples of how this framework can be applied to Nōku te Ao are given.

Te Taha Hinengaro

Te taha hinengaro (mental wellbeing) is concerned with the mind and Māori ways of knowing (20). As it relates to Nōku te Ao, te taha hinengaro can refer to anything to do with knowledge, thinking, theories, and the mind, and how we interact with our environment based on our thinking. Te taha hinengaro signifies the importance of normalising, affirming, and supporting Māori thoughts, ideas, learning, teaching, knowledge, and understanding. Te taha hinengaro can be related to Kaupapa Māori principles of Taonga Tuku Iho (cultural aspiration), Ako Māori (culturally preferred pedagogy) and Kaupapa (collective philosophy).

- **Taonga tuku iho** takes for granted the validity and legitimacy of Māori knowledge (mātauranga), language (te reo Māori) and processes (tikanga) that are passed on through generations. For example, Māori explanations for hearing voices, dream interpretation, and creation stories are normalised as credible and do not require non-Māori justification.

- **Ako Māori** prioritises and normalises the use of traditional Māori teaching and learning methods and concepts. For example, understanding whānau relationship dynamics by referring to traditional narratives of atua Māori, and teaching and learning through oral mediums rather than writing.

- **Kaupapa** prioritises and works towards Māori community aspirations. For example, ensuring that health interventions and initiatives (such as Nōku te Ao) are consistent with, and contribute towards Māori community goals and priorities.

Te Taha Whānau

Te taha whānau (whānau wellbeing) is concerned with belonging, connectedness, and Māori ways of being. As it relates to Nōku te Ao, te taha whānau can refer to anything to do with the collective, with family structures, whakapapa (relational connections between things), inclusion, diversity, whanaungatanga and hononga (togetherness). Te taha whānau signifies the importance of affirming one's identity, roles, and responsibilities in relation to others, and thereby, belonging. Te taha whānau is linked to the Kaupapa Māori principles of

Whakapapa, Ata (respectful relationships), Whānau (extended family), Tino Rangatiratanga (Māori control), Te Tiriti o Waitangi, and Kia piki ake i ngā raruraru o te kainga (socioeconomic mediation).

- **Whakapapa** encapsulates Māori ways of viewing the world and emphasises where and how things are positioned and their relationships within and between each other. For example, Māori cultural identity is continually reaffirmed through recitation of pepehā that connect us to our ancestral homes, lands and families. Whakapapa allows us to understand natural hierarchy and our reliance on the natural universe for our wellbeing (4).
- **Ata** emphasises the building and nurturing of respectful relationships when engaging with Māori. For example, operating in accountable, trustworthy, transparent, and respectful ways.
- **Whānau** acknowledges Māori relationships with one another and to the world. Whanaungatanga is a critical part of tikanga that underpins all relationships and allows sharing of identity and connections to each other.
- **Tino Rangatiratanga** affirms Māori sovereignty, autonomy, control, self-determination and independence over our own wellbeing, aspirations, and futures. For example, Māori autonomy over one's wellbeing decision-making, and having rights to lead and control kaupapa that affect us.
- **Te Tiriti o Waitangi** recognises the special relationship between Māori and the Crown and affirms Māori rights and mana as tangata whenua and New Zealand citizens. For example, Te Tiriti also recognises the historical impacts of colonisation on Māori. It also guarantees Māori rights to equitable health outcomes as well as the right to hold the Crown accountable to its Tiriti responsibilities.
- **Kia piki ake i ngā raruraru o te kainga** acknowledges the lived realities of Māori including our socioeconomic position, negative pressures and disadvantages experienced by Māori communities. It identifies structural imbalances that create inequities and require Kaupapa Māori approaches to be of benefit to Māori (often aiming to decrease inequities). For example, framing Māori mental health issues within the context of colonisation, and treating Māori substance use as a health problem rather than a criminal issue.

Te Taha Tinana

Te taha tinana (physical wellbeing) is concerned with actions, practices, protocols, and Māori ways of doing. Te taha tinana normalises and promotes Māori expressions and articulations of identity, and roles and responsibilities. It signifies the importance of ensuring Māori practices are aligned with Māori values. For example, practicing of tikanga and kawa, practices in our reo (language), and ceremony. Te taha tinana can be linked to the Kaupapa Māori principles of Te Reo Māori (Māori language) and Tikanga Māori (customary practices).

- **Te Reo** is the way we communicate, using Te Reo Māori, that provides insights into te ao Māori. Te reo Māori has deep conceptual meanings that are uniquely Māori and relate to mātauranga Māori. For example, explanations for Māori lived experience have unique meaning when explained in te reo Māori.
- **Tikanga Māori** affirms the practice of customary Māori behaviours, ethical approaches, obligations, and protocols. It emphasises Māori ways of doing things that align with Māori belief systems. For example, use of karakia, whakawhanaungatanga, and tikanga when interacting with Māori as appropriate.

Te Taha Wairua

Te taha wairua (spiritual wellbeing) is concerned with interactions with 'spiritual' entities such as tupuna (ancestors) and atua (the environment). Te taha wairua signifies the importance of protecting and upholding spiritual safety and aligning actions with tohu and core values. Kawa and tikanga also generate spiritual experiences on marae (e.g., karakia, kāranga, waiata, pōwhiri, during and after childbirth, and when opening a new house). Te taha wairua can be linked to the Kaupapa Māori principles of Wairua and Māramatanga (enlightenment).

- **Wairua** affirms the importance of non-physical determinants of health and normalises connection to and interaction with spiritual and environmental entities. For example, normalising Māori experiences of matakitetanga; communicating with those who have passed away, and receiving and interpreting tohu (environmental cues).
- **Māramatanga** advances information to knowledge to understanding and then to enlightenment. Application of māramatanga is promoted through action that is emancipatory, empowering and liberatory (16, 17). For example, reaffirming Māori understandings of mental health and identifying where Western models of health are not conducive to Māori wellbeing.

TIKANGA: MĀORI CULTURAL ETHICS

Tikanga Māori ensures that processes, protocols, and actions align with Māori cultural values, principles, and aspirations. Tikanga Māori is fundamentally underpinned by the concept of tika. Closely linked to 'pono', tika ensures that our thoughts, processes, and actions are 'true and correct'. Linda Smith (21) has developed a simple set of questions that help to ensure that activities such as health interventions and research are tika to Māori and align with Kaupapa Māori philosophies. These questions were originally designed for use in Kaupapa Māori research but can also be applied to other initiatives such as Nōku te Ao. In this context, the questions might include:

1. What activities do we want to carry out?
2. Who are those activities for?
3. What difference will Nōku te Ao make?
4. Who will carry out this work?
5. How do we want the work to be done?
6. How will we know it is a worthwhile programme?
7. Who will own the work of Nōku te Ao?
8. Who will benefit?

Smith notes that answering these questions is not straightforward and requires proper consideration and deliberation. These questions and their answers can also be informed by and align with Kaupapa Māori principles (21). Thinking about and answering these questions in relation to Nōku te Ao can help to ensure that the programme is both ethical and aligned with tikanga Māori.

KAUPAPA MĀORI AND PAE ORA

As outlined above, Kaupapa Māori theories, principles and approaches help to guide us in our thinking, processes and practices in ways that align with Māori world views, aspirations and tikanga. One of the main reasons for Kaupapa Māori development is the historical dominance of Western Pākehā approaches to Māori needs that have been ineffective and culturally inappropriate. Instead, Kaupapa Māori approaches allow problems that affect Māori to be addressed in ways that are likely to be beneficial to Māori.

The 2022 New Zealand health system reforms make a clear commitment to implementation of Kaupapa Māori health services and mātauranga Māori. Many of the health system reform principles are also conducive to Kaupapa Māori principles. For example, honouring Te Tiriti o Waitangi, taking a population health approach, eliminating racism, and prioritising the elimination of inequities between population groups. When we think about inequities and discrimination, it is well understood that groups most affected include Māori, Pacific peoples, Asian, LGBTQI, females, those living in the highest deprivation areas, those with disabilities, tamariki, rangatahi, older persons, those with lower levels of education, income, employment, and those with limited access to housing, food security, and meaningful relationships and connections (22-25).

A Kaupapa Māori approach does not seek to compete with other (non-Māori) approaches, but rather, Kaupapa Māori enables collective action towards a common goal. Prioritising Māori within Nōku te Ao makes sense from a Te Tiriti, lived experience, human rights, equity, best practice, and intersectionality viewpoint. Prioritisation of Māori includes Māori leadership, decision-making and control at all stages of programme design and delivery. Notably, an absence of Māori input commonly results in increasing, ongoing inequities and disproportionately higher rates of discrimination for Māori with lived experience of mental distress. Prioritisation therefore seeks to address these inequities and thereby, responding to obligations to uphold human rights, Tiriti o Waitangi rights, and Indigenous peoples' rights.

Summary

Kaupapa Māori approaches and principles help us to differentiate between the different types of approaches and those most suitable to/for Māori.

Kaupapa Māori ethics and approaches are important to consider, so we have presented some common questions. These questions can be applied to a range of projects, initiatives, and interventions, and help Nōku te Ao partners to ensure that 'what we do' aligns with 'what is wanted, needed and preferred' by Māori with lived experience. The next section provides a high-level summary of the impact of colonisation on Māori peoples, systems and health and wellbeing. We also discuss how Māori viewed mental health in pre-colonial Māori society.

SOME KEY DEFINITIONS

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MENTAL DISTRESS

Mental distress is ill-defined within literature. There are a range of terms that are used interchangeably including, for example: mental illness, mental health, mental wellness, mental distress, psychological distress, mental disorder, and psychological disorder. Evidence shows that the language used to describe people with 'mental illness' can be derogatory and negative (26).

Despite a lack of clear definition, there is much discussion *about* terms like 'mental distress' and 'mental disorder' (27). As identified in a study of adolescents and young people, "mental disorder is common amongst young people and is associated with significant impairment and disability, particularly in relation to work, education and social interaction" (p. 983) (28). Psychological distress on the other hand, has been explained as follows:

1. "The unique discomforting, emotional state experienced by an individual in response to a specific stressor or demand that results in harm, either temporary or permanent, to the person. Psychological distress has five defining attributes: (1) perceived inability to cope effectively, (2) change in emotional status, (3) discomfort, (4) communication of discomfort, and (5) harm" (p. 270) (29).
2. "A set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people. In some cases, however, psychological distress may indicate the beginning of major depressive disorder, anxiety disorder, schizophrenia, somatization disorder, or a variety of other clinical conditions. It is thought to be what is assessed by many putative self-report measures of depression and anxiety" (para. 1) (30).
3. "The unpleasant feelings or emotions that you may have when you feel overwhelmed. These emotions and feelings can get in the way of your daily living and affect how you react to the people around you" (para. 2) (31).

Hence, psychological distress refers to non-specific symptoms of stress, anxiety, and depression (32). In literature and lay terms, psychological distress is commonly used synonymously with stress and distress. Horwitz (2007) notes that a defining feature of psychological distress is exposure to a stressful event that threatens one's physical or mental health (33). Flett et al., (2020) provided the following overview for the purposes of the Like Minds Like Mine programme:

'Mental distress' broadly refers to: those who have had an experience of mental illness and those whose scores on psychometrically validated questionnaires indicate some level of current psychological or mental distress (p. 4) (*34*).

In addition, the meaning of mental distress goes beyond medical and psychological perspectives. Mental distress is also associated with worry about lack of money, fear about losing a job, panic at being unable to find accommodation, subjection to violence at home and away.

DISCRIMINATION

Discrimination involves treatment that is unfair and often results in social exclusion, avoidance, withdrawal, segregation, or coercion. Discrimination can be experienced, perceived, anticipated and presently occurring (34). The American Psychological Association defines discrimination as "the unfair or prejudicial treatment of people and groups based on characteristics such as race, gender, age or sexual orientation" (para. 1), or rather, discrimination occurs when a person is treated unfairly or less favourably than another person in the same or similar circumstances (35).

Misinformation, stigma, attitudes, stereotypes, and prejudice are terms that are used synonymously and are linked to (and contribute to) discrimination. Sarah Gordon (2021) describes stigma as a combination of knowledge (misinformation) and attitudes (stereotypes and prejudice). Stereotypes include negative beliefs about people who experience mental distress. Prejudice is an agreement with the stereotypes, leading to negative emotions. Gordon notes that stigma then leads to discrimination, that is, a behaviour in which unfair treatment exists which results in social exclusion (e.g., reduced access to housing, healthcare and employment) (36). Nōku te Ao aims to bring an end to a type of discrimination that is related to mental distress: discrimination that happens to people with lived experience of mental distress.

Someone calls it mental illness but I think it's almost just a natural reaction or a consequence of what is happening in the whānau (p. 37) *(37)*.

Māori concepts associated with mental distress are less inclined to link distress to the mind or to psychological constructs. Terms such as *ngakau pouri*, or *mauri noho*, or *aue taukiri e*, or *āwangawanga* all reflect the discomfort associated with mental distress and are more inclined to give emphasis to the experience of distress rather than the cause. Narrow clinical understandings of mental distress exclude people who have serious mental distress but without a 'disorder' or a mental illness. It can include people who live in desperate circumstances or who, for other reasons, have been exposed to barriers that generate further discrimination. Similarly, discrimination can be better understood by Māori as *aukatihia*, or *whakatoihara*, words that reflect the impact and the action.

MĀORI/INDIGENOUS

Māori are the Indigenous peoples of Aotearoa, as well as partners with the Crown through the founding document of New Zealand: Te Tiriti o Waitangi.

Prioritising Māori within the Nōku te Ao programme requires background knowledge about both indigeneity and Māori as tangata whenua (the original inhabitants of New Zealand).

Aotearoa is the original Māori name given to the North Island of New Zealand. Māori narratives tell the story of Kupe and Kuramārōtini who arrived (estimated at around 800 years ago) by way of the waka (seafaring canoe) named Matawhaorua (a double-hulled canoe) and upon seeing the white clouds covering the land that stretched in the distance called out, "He ao, he ao, he Aotearoa" (land of the long white cloud). Kupe, Kuramārōtini and the Matawhaorua waka (as told by the Ngāpuhi tribe) are attributed to be the first to have arrived in this land of Aotearoa (9). Hence, Māori were the original inhabitants and are recognised as the Indigenous people of Aotearoa. Internationally, there are more than 370 million Indigenous peoples across 70 countries (38). Indigenous peoples have been described as:

Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their

> **own cultural patterns, social institutions and legal system (p. 2) *(39)*.**

Collectively, Māori identify as the Indigenous peoples, tangata whenua (meaning people of the land) or mana whenua (those with ‘territorial rights/powers’ of the area), of Aotearoa. Connection to ‘land’ is of central importance to Māori, and traditional social organisation was linked closely to the ways Māori occupied and connected with land (9). This is a commonality across Indigenous peoples where special significance is given to the idea of unification of humans with the natural world (40, 41). Royal (2003) notes that:

> **‘Indigenous’ is taken to mean those cultures whose world views place special significance … behind … unification of the human community with the natural world … among ‘Indigenous’ peoples the world over, whether Māori, Hawai‘ian, African … that unification with the world is the primary concern of the world views contained within their traditional knowledge (p. 3) *(41)*.**

Recognising the inseparability of people with the natural environment, Māori believe that we are directly descended from atua (Māori ancestors embodying natural environment elements) and therefore have direct whakapapa (relational links) with these entities. Identification as Māori/tangata whenua is reaffirmed through the system of whakapapa. Whakapapa, as described by Dr Takirirangi Smith, does not refer to genealogy, myth, and story. Rather, whakapapa confirms the relationships and connections between Māori and all other things in existence (42). In addition, “whakapapa kōrero text, as the discourse of tangata whenua … allows clearer understandings and provides useful insights into pre-colonial Māori philosophies” (p. 53) (42). Reaffirmation of these relationships is demonstrated through Māori protocols such as recital of ‘pepeha’ whereby a person will identify the land, mountain, water, tribe, and family group to which they have an affinity. It is important to distinguish between people who simply live ‘on’ the land and those who identify with being ‘of’ the land

> **The land itself was, and is, the source of life: Papatūānuku is the Earth Mother from whom we all come and to whom we all return. The placenta that nurtures us before birth and the land that provides nourishment in life are both whenua. The whenua provides its gifts, or taonga, to us as koha – as something which must be reciprocated. The exchange is an obligation on humans to care for the earth so that its resources will continue to be available. With this obligation goes a realisation that the iwi and the whenua are interdependent and exist in harmony only as long as their relationship is in balance. Thus, Māori are tangata whenua. Not people in the land or over the land, but people of it *(43)*.**

BACKGROUND TO MENTAL HEALTH IN AOTEAROA

BACKGROUND TO MENTAL HEALTH IN AOTEAROA

This section focuses on Māori mental health data. Mental health inequities between Māori and non-Māori are presented for issues such as mental and psychological distress, depression, anxiety, behavioural disorders, bipolar and suicide. Information is also presented about inequitable prescription of substances such as antidepressants and antipsychotics.

SNAPSHOT OF MENTAL HEALTH IN AOTEAROA

Health inequities are differences in health that are avoidable, unfair, and unjust. Equity, on the other hand, is the absence of avoidable or remediable health differences among groups of people (44). Inequities between Māori and non-Māori are unfair, unjust, and in breach of Te Tiriti o Waitangi (22, 23).

In 2019, the Health Quality and Safety Commission noted that, "Māori are over-represented in almost every type of illness and every known determinant that leads to poor health" (p. 6) (22). Further, in 2019, life expectancy was 7.5 years lower for Māori males and 7.3 years lower for Māori females than for non-Māori (45). It is well-documented that health inequities between Māori and non-Māori are widespread, ongoing, and demonstrated across a wide range of health conditions (22, 23, 46, 47). Inequities in mental health status between Māori and non-Māori are of primary concern and demonstrate the extent to which Māori and non-Māori mental wellbeing is (or is not) protected. In 2019, Prime Minister, Rt Hon Jacinda Ardern described mental health and suicide in Aotearoa as a national tragedy, and one of the biggest long-term challenges we are facing as a nation (48).

Mental distress is common and affects Māori at higher rates than non-Māori. Estimated to affect 50 – 80% of people in Aotearoa in their lifetime, mental distress affects 20% of New Zealanders annually (including increasing rates for tamariki (children) and rangatahi (youth)) (49). One estimate showed that whilst 79% of the adult population had low or no mental health and addiction need, 16% had mild to moderate need, and 5% had severe need (50).

Māori experience psychological distress at almost double the rate of non-Māori (51). While making up just 15% of the national population, Māori represent 28% of all mental health service users (49). Those most at risk of mental distress include those living in high deprivation, on low income, those with histories of abuse, neglect, trauma, isolation and loneliness (49).

The annual cost of mental illness in New Zealand is estimated at $12billion (49). Despite increasing prioritisation of mental health in Aotearoa (50, 52) over the last decade, rates of psychological distress have increased in both volume and severity. Between 2011 and 2021, New Zealand's rates of low (or no) psychological distress have decreased from 84.8% to 76.3%, whilst moderate distress increased from 10.6% to 14.1%, and high distress more than doubled from 4.6% to 9.6% (51). Māori rates over this same period were consistently higher than non-Māori. For example, Māori rates of low (or no) psychological distress decreased from 79.6% to 65.2%, whilst moderate distress increased from 13% to 18.9%, and high distress increased from 7.3% to 15.9% (51). In addition, Māori experiencing cultural alienation and deprivation are also at higher risk of mental distress (50).

More specific indicators of mental health problems (i.e., depression, anxiety) show further inequities between Māori and non-Māori. Over the last decade (2011 and 2021), the total rates of depression and anxiety in New Zealand increased from 14.2% to 17%, and 6.1% to 12.4% respectively, whilst Māori rates of depression and anxiety increased from 14.9% to 20.6%, and 6.6% to 17.4% respectively.

For children (aged 0 – 14), rates of emotional or behavioural problems also increased from 3.3% to 5.7% for the total population (51). In 2021, Māori females were between 1.3 – 2.4 times more likely, and Māori males were between 1.1 – 2.1 times more likely to report an anxiety disorder, bipolar disorder, or depression than non-Māori. While the rates of anxiety and depression were significantly lower in Māori boys than in non-Māori boys, their diagnoses of Autism were 1.5 times higher. Māori girls on the other hand were more likely to report anxiety and depression at rates 1.3 – 1.4 times higher than non-Māori girls (51).

Mental health inequities are further demonstrated in suicide data. Rates of suicide in New Zealand have been rising for some time (53, 54). In 2015, New Zealand suicide rates were the highest in the OECD, with 20,000 suicide attempts annually and 545 people dying by suicide (50). In 2020, New Zealand suicide rates were 13.01 deaths per 100,000 population, including 20.24 deaths per 100,000 population for Māori, just under double that of Pākehā (non-Māori) (55). Two-fifths (42%) of Māori suicide-related deaths were rangatahi Māori (55). The importance of taking care of hapū māmā (pregnant women) and new mothers' mental health and wellbeing is also pertinent. A recent report (2022) identified that "suicide is the leading cause of death for pregnant women and new mothers in Aotearoa … and … more than half of pregnant or new mothers who have died by suicide since 2006 have been Māori" (p. 27) (56).

Despite the significant mental health inequities identified here, Māori are less likely to receive timely, appropriate, and effective mental healthcare and treatment. Māori are more likely presented to primary care with mental health needs yet are less likely to receive a diagnosis or be prescribed antidepressant medication compared to non-Māori.

Alongside increases in mental health problems, dispensations of mental health medications in New Zealand are increasing annually. Between 2016 and 2020, the number of people filling an initial prescription in New Zealand annually for: antidepressants increased from 486k to 554k, antipsychotics increased from 111k to 140k, stimulants/ADHD treatments increased from 20k to 31k, and sedatives and hypnotics increased from 265k to 271k (57). Moreover, of all psychiatric medicines dispensed in 2017, Māori were less likely to be dispensed antidepressants, ADHD treatments, sedatives, anxiety medication, or hypnotics, but more likely to be dispensed antipsychotics than New Zealand European (58).

Māori are also more likely to be admitted to hospital for mental health reasons, to be forcibly secluded, and to receive compulsory mental health assessment and treatment (49, 50).

In addition to the mental health data provided here, Māori mental health is influenced by the broader social, economic, political, cultural, and historical determinants of health (22, 23, 50, 59-61). Detailed investigation of inequities between Māori and non-Māori related to broader determinants of health is outside the scope of this report, however, there is substantial literature linking factors such as poverty, unemployment, financial and food insecurity, cultural alienation, and historical trauma to mental and wider health problems (19, 62-68).

From a Māori perspective, mental well-health is not just the absence of illness; more effective work must be undertaken to address those issues which directly impact upon mental wellness such as housing, unemployment, and cultural isolation. They require a constructive, co-ordinated approach in order to achieve positive changes in Māori mental health status (p. 55) (69).

Inequities in health outcomes indicate that underlying systems are discriminating against some groups, whilst privileging others. In this case, the inequities between Māori and non-Māori demonstrate unfair and unjust differences in access to and through the determinants of mental health, including participation in society. This is not the same as discrimination against those with lived experience of mental distress. However, this is likely to be a contributing factor.

Health inequities, mental health and suicide mortality have become a critical issue faced by *te ao* Māori. The disparities in mental health and suicide continue to escalate year in, year out, with decades of strategic action rendering ineffective (53). The increasing rates of prescription medicines targeting mental illness also demonstrates the extent of mental health concerns and point towards a health (pharmaceutical) system that is designed to increase rather than decrease reliance on medical treatment. For Māori to have optimal vitality in all levels of health, solutions must be found to combat the broad determinants of inequities. The next section looks at policy commitments that aim to achieve equity, and end discrimination.

HEALTH SYSTEM COMMITMENT TO MĀORI MENTAL WELLBEING

The mental health inequities presented in the previous section call for an immediate, robust response that creates realistic change towards achieving health equity. As explained in the Hauora report (2019), the principles of equity and active protection under Te Tiriti o Waitangi are closely linked to discrimination. That is, the presence of conscious or unconscious discrimination is evident when inequities in health outcomes, access to health services, access to the determinants of health, and funding are examined. Hence, inequities are the result of discrimination.

The principle of equity, linked to Article 3 of Te Tiriti, guarantees Māori ‘access to all the rights and privileges of British subjects’ (New Zealand citizens), including the right to health. It obligates the Crown to provide systems, structures and services to Māori that meet Māori needs and eliminate inequities. Hauora further notes that ongoing inequities reflect inaction in the face of need and hence constitute a breach of the principle of active protection that requires the Crown to act to the fullest extent possible in order to eliminate inequities (23). Whether the discrimination occurs at individual, organisational or institutional level, the presence of inequities remains a breach of Tiriti principles.

At its core, the principle of equity broadly guarantees freedom from discrimination – conscious or unconscious (p. 34) (23).

Nōku te Ao makes a clear commitment to addressing discrimination and prejudice towards Māori with lived experience of mental distress. Nōku te Ao is further supported by Māori and Government commitments to addressing racism, health inequities, Māori health and mental health needs, and upholding Te Tiriti o Waitangi, human and Indigenous peoples’ rights. This section considers the legal and strategic policy work that supports Nōku te Ao. We present an overview of **strategic documents** that 1) identify issues; 2) call for change and transformation; and 3) set future directions and commitments.

The last decade has seen a change in direction in how the Government approaches Māori health. Notable Government documents supporting this direction change include:

- He Korowai Oranga (2014)
- Whakamaua – Māori Health Action Plan 2020 - 2025 (2020)
- Whātua: Engagement for the development of Whakamaua (2020)
- Health & Disability System Review (2020)
- Pae Ora (Healthy Futures) Act (2022)
- New Zealand Health Sector Reforms (2022)
- Interim Government Policy Statement on Health (iGPS) (2022-2024)

Since 2002, He Korowai Oranga (New Zealand's Māori Health Strategy) has supported the health sector to achieve better health outcomes for Māori, accompanied by the New Zealand Health Strategy (2016), the New Zealand Disability Strategy (2001) and the New Zealand Public Health and Disability Act 2000 (70). The 2020 Health and Disability System Review recommended a range of legislative, structural and culture changes to produce more equitable health outcomes. Most notably, we saw an upheaval of the New Zealand health system, a need for the establishment of a separate Māori health authority and reaffirmation of the critical role of Kaupapa Māori and mātauranga Māori in healthcare (71).

As of July 1st, 2022, the Pae Ora Act makes legislative change that enacts these commitments. One of the key fundamental shifts has been the establishment of Te Aka Whai Ora (Māori Health Authority) as an equal partner within the new health system, with a co-commissioning role in conjunction with Te Whatu Ora (Health New Zealand). It instituted its own Kaupapa Māori services and will monitor the performance of the health system for Māori. Iwi-Māori Partnership Boards are being established to represent local Māori community hauora aspirations and monitor health sector performance within localities (72). Supporting these changes are Whakamaua – the Māori health action plan (73), and its accompanying document – Whātua (74). Finally, the Interim Government Health Policy Statement (iGPS), released in July 2022, outlines the priorities for the new public health sector in the coming years (75). These changes are promising and show both strategic commitment and pathways for realising a health system in which Te Tiriti o Waitangi is embedded.

Māori mental health has also received substantial strategic acknowledgement and commitment in recent years. This has been a core component of the health system reviews, and the Kaupapa Inquiries into Māori health. Notable documents supporting this commitment include:

- He Ara Oranga Report (2018)
- Wai 2575: Māori Mental Health Report (2019)
- Every Life Matters: He Tapu te oranga o ia tangata (2019)
- Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing (2021)
- Te Hiringa Mahara - Mental Health & Wellbeing Commission establishment (2022)

The 2018 He Ara Oranga report was a critical government enquiry into Mental Health and Addiction, invoked by widespread concern around community mental health outcomes, mental health services and the mental health sector (50). The report acknowledged the dire state of these three fundamental areas. The report also acknowledged priority groups with unmet mental health needs: Pacific peoples, disabled people, Rainbow communities, the prison population, refugees, and migrants, and significantly, Māori, whose mental health outcomes were described as far "worse than the overall population" (p. 11). Māori were subject to greater use of compulsory treatment and seclusion.

The report proposed a health system transformation approach involving major changes in policy, law, and funding to improve equitable access to and quality of the mental health system, and thereby better mental health outcomes (50).

The report also resulted in the establishment of Te Hiringa Mahara (The Mental Health and Wellbeing Commission) to provide national system leadership and oversight across mental health. Evidently, the 2022 Te Hiringa Mahara Statement of Intent outlines how they are the kaitiaki of mental health and wellbeing in Aotearoa, positioning Te Tiriti at the core, and outlining their function as an institutional mechanism to hold decision-making and successive governments to action, specifically on Government response to the He Ara Oranga recommendations (76). Under the 2022 health reforms, Te Hiringa Mahara is now linked to Te Whatu Ora and Te Aka Whai Ora in their complementary roles.

Te Hiringa Mahara subsequently instituted two fundamental complementary frameworks. The He Ara Oranga Wellbeing Outcomes Framework (2021) shows how wellbeing will be achieved from both a te ao Māori and a shared perspective. It also provides a holistic and Kaupapa Māori structure for measuring performance across the whole mental health and wellbeing system (77). Furthermore, the He Ara Awhina (Pathways to support) System Monitoring Framework (2022) describes what an ideal mental health and addiction system looks like, portraying the Mental Health and Wellbeing Commission's believed aspirations for an idealistic, whānau-dynamic mental health and addiction system (78). This framework is also to be used to monitor and advocate for improvements to Aotearoa's mental health and addiction systems and services. He Ara Awhina intends to amplify and respond to the voices of tangata whaiora and whānau as leaders of their own wellbeing and recovery.

Te Hiringa Mahara has also released two critical reports. The 2021 Te Rau Tira Wellbeing Outcomes Report highlights that New Zealand's marginalised groups, particularly Māori and Pacific peoples, continue to experience consistently poorer mental health and overall health across multiple dimensions, less security, and greater discrimination and barriers to wellbeing (79). The 2022 Te Huringa: Change and Transformation, Mental Health Service and Addiction Service Monitoring Report review of mental health and addiction services showed little evidence of improvement in mental health services over the past five years (49). The report highlights that the calls to minimise coercive treatment have been rendered ineffective, with an overall increase in the use of solitary confinement (seclusion) and no decrease in the use of community treatment orders. It spotlights fundamental critical inequities for tangata whaiora Māori, with Māori disproportionately experiencing higher rates of coercive practices that are restrictive and cause harm, including both solitary confinement and community treatment orders, with persistently higher applications of the Mental Health Act. **Hence, the dire need for funding of holistic services that reflect te ao Māori world views, with the significant prioritisation of wairuatanga, is reiterated.**

Every Life Matters (the National Suicide Prevention Strategy (2019-2029)) outlines the vision of a suicide free Aotearoa and proposes strengthening: 1) national leadership; 2) evidence to make a difference; 3) workforce development; and 4) evaluation and monitoring in the mental health system. This framework also reiterates the importance of Māori leadership and decision-making throughout.

In alignment with the above documents, the Kaupapa Inquiry into Māori mental health by the Waitangi Tribunal identifies health sector developments that attempt to deliver culturally tailored services to Māori, shift mono cultural ethos, increase the Māori workforce, and deinstitutionalise mental health services. However, despite a range of developments, mental health systems continue to fail Māori and there is still not sufficient accessibility to services, nor are there Kaupapa Māori services. The report concluded that in seeking to understand mental ill health amongst Māori, a much broader lens must be adopted across the determinants of health and wellbeing (80). In 2021, the Ministry of Health also released Kia Manawanui Aotearoa – Long term pathway to mental wellbeing; another key document premised upon the He Ara Oranga recommendations (52).

The above documents contain the New Zealand Government's explicit strategic commitment to the advancement of health, Māori health, and the addressing of Māori health inequities.

These documents both implicitly and explicitly commit to Māori mental wellbeing as a critical component of Pae Ora. A systems overhaul is underway that prioritises Māori health equity. The last decade shows a trajectory towards a health system that can better address Māori health and wellbeing through the progressive cornerstones of Te Tiriti o Waitangi, enabling Tino Rangatiratanga and embedding Kaupapa Māori within policy, practice, and function. Decades of research continue to highlight the integral need for the continued implementation of Māori specific multi-dimensional health measures and processes that are attuned to te ao Māori, Māori realities, and a Māori world view (60, 66, 67, 73, 81-86).

What is still poignant is a continued prevalence of Māori health inequity irrespective of current health system and health policy advancement. Clearly, addressing the multiple aspects of Māori mental health and Māori health generally requires an inter-sectoral approach that goes beyond the health system to embrace the many other determinants that shape wellbeing. Although the advances in health systems reform are extensive, the current momentum towards honouring Te Tiriti o Waitangi and upholding tino rangatiratanga across the health system and health governance must continue to be built upon and challenged to grow. "Change will take time, and it must be sustained over a long period, but we need to start now" (p. 15) (50).

The framework's provisions, intended to improve Māori health outcomes … were not fully implemented or in some cases ceased to operate entirely. This is unacceptable (p. 161) (23).

It is also evident that the Government's pursuit of Pae Ora is not siloed within just the health sector, and an understanding is given to the integral nature that broader health determinants play in wellbeing, specifically the wellbeing and hauora of Māori. Gassin (2019) makes the significant point that government policy, specifically mental health policy, addresses only one layer of health disparity. Gassin positions that a much broader lens must be adopted and is fundamental in improving health outcomes. He believes that the full suite of government social and economic policy has profound causative effect in whether individuals and communities have a sense of security, purpose, and opportunities to lead happy and fulfilling lives. Consequently, without incorporating these broader understandings, a partial picture is painted in understanding and addressing the unfair and unjust Māori health inequities within Aotearoa (80).

COLONIAL CONSTRUCTS OF MĀORI MENTAL HEALTH

Prior to European arrival, the traditional Māori system of healing (rongoā Māori) maintained the collective health and wellbeing of Māori communities (3, 67, 87).

This system relied on Māori knowledge, beliefs and experiences to develop theory and practices that maintain health and prevent and treat illness (88). Behaviours that ensured safety, survival, meeting obligations, connectedness, and comfort were strengthened by 'Kawa', long standing conventions and protocols that guided interactions and engagement. Rongoā Māori was developed using a distinctly Māori world view (89, 90) and has been passed on through generations (9). Operating at multiple levels, rongoā Māori and Māori social structures ensured the collective survival of Māori communities. These systems operated relatively successfully such that in 1769, Cook concluded that Māori were a healthy 'race' (67). As well, early European explorers recorded that Māori were in good health, exhibited a lack of disease or illness, showed physical strength and wellbeing, and were utilising sustainable ways of living (9).

Despite well-established traditional Māori knowledge, social, and health systems (17), British imperialism and colonisation forcefully imposed Western world views, privileging 'white' 'races' and subsequently marginalised and oppressed Māori knowledge (91-94). Racially-motivated research 'on' Māori 'by' non-Māori created overwhelmingly negative impacts for Māori by representing us as the 'savage native', the uncivilised inferior warrior, and the 'other' (not the dominant/normal) group (18, 95). Colonial acts of racism located Māori at the margins of society, forcefully oppressed Māori cultural values and beliefs, and discriminated against Māori knowledge and language (95). For example, corporal punishment was used on Māori children in schools for speaking te reo Māori (Māori language) (91). Moreover, as Durie (67) describes, British settlers introduced disease epidemics through which Māori suffered large-scale mortalities. Pākehā (European peoples) considered tikanga (Māori custom) to be irrelevant and inappropriate (91) and this led to the destruction of Māori social structures and public health laws, resulting in widespread disease and infection. To a greater degree, Māori health has suffered as a direct result of colonial processes that caused Māori dislocation and dispossession from land and identity. Collectively, colonisation resulted in broad negative health and social consequences (2, 67).

> **It seems to me a matter of the deepest regret that the wonderful health laws of this ancient [Māori] race – the laws which enabled it to live happily and improve itself vastly during so many thousands of years – should have been so little understood in the past and so thoughtlessly brushed aside as valueless and even harmful (12).**

MĀORI NOTIONS OF MENTAL DISTRESS AND DISCRIMINATION

> *Māori notions of health and mental health are unique to Māori and are not the same as non-Māori views.*

Māori mental health is inseparably linked to wellbeing and the flourishing of physical, psychological, emotional, social, and spiritual wellbeing. As Durie describes, Māori wellbeing promotion is underpinned by Māori autonomy and leadership; it includes healthy lifestyles, participation in society, a strong cultural identity, and a safe physical environment (10, 67, 96).

Māori historically understood mental distress as a relatively rare concept that did not and does not resonate with Māori world views. Kingi (2018) notes that Māori likely did experience mental wellbeing concerns prior to European arrival, however, it appears that Māori 'mental illness' coincidentally occurred more recently, alongside the Western European invention of it ('mental illness') (66). Russell et al. (2018) claim that colonisation has played a key role in representing the narrative of the Māori psyche. They also note that

> *Western European psychiatry has both created and maintained the notion of mental distress (85).*

Some literature discusses the Māori 'mind' in relation to understandings of 'states of mind' (not illnesses) and the concepts of *tapu, noa and mākutu*. In these readings, it is thought that physical ailments are a manifestation of tapu, and/or a breach of tikanga (86). Terms used to identify those with disabilities are also discussed; rather than deficit framing, terms such as *hautupua* and *tangata whaikaha* denote strengths-based concepts (97, 98). Overwhelmingly, when referring to Māori concepts of mental wellbeing, the commonly used term is *whānau*.

> *Distinguishing, labelling and categorising people as mentally ill seems to be a European trait rather than, as noted by Durie, focusing on diversity and inclusion (97).*

Further, whānau Māori are simply whānau, and there is not a tradition claiming whānau as a health concern. This is not to say that mental distress is not experienced by Māori in contemporary Aotearoa. Indeed, we understand that Māori wellbeing, including states of distress, are affected by the broader determinants of health. A medicalised approach focuses on the person(s) whom might be experiencing distress, whereas a Māori approach seeks to find the cause of that distress (i.e., the *hara*, *raruraru*, or *kaupapa)*. To that end, a biomedical approach, without consideration of culture, is unlikely to lead to optimal health.

SUMMARY

This section looked at Māori traditional systems prior to the imposition of Western influences. Differentiation between Western views of mental distress and Māori concepts of health is made.

DISCRIMINATION ASSOCIATED WITH MENTAL DISTRESS

DISCRIMINATION ASSOCIATED WITH MENTAL DISTRESS

Work that aims to end prejudice and discrimination against those with mental distress has been ongoing for some time. A summary of what we have learnt through the Like Minds Like Mine programme is presented, primarily focusing on its research outputs. This includes an outline of the Like Minds survey monitoring programme and reported changes in discrimination against those with lived experience of mental distress. Other Like Minds insights are noted such as 'settings of prevalent discrimination', and the Power of Contact 'best practice' approach to addressing discrimination.

In 2018, a New Zealand survey showed that almost one-third of people reported having a personal experience of mental distress (31%). Higher rates of experiences of mental distress were present for Rainbow people (57%), Māori (38%), and young adults (36%). Conversely, Pacific peoples (20%) and Asian peoples (14%) reported lower rates of mental distress. Of those currently experiencing high mental distress, 36% reported being discriminated against because of their mental distress (85). Mental distress-related discrimination contributes to higher rates of discrimination-related fear and avoidance (34). One study has emphasised that discrimination can lead to exclusion from participation in society. Also, more than 40% of Māori report some degree of recent social isolation (loneliness) and exclusion, and this is exacerbated for those with experiences of mental distress (85).

… people … could not find a job, had lost their job, were unable to gain the education needed to get the best possible job, or had difficulty obtaining government income support. Some could not contribute to and/or were not supported by their family. Some were prevented from taking part in recreational or leisure activities; others were reluctant to seek or did not receive necessary health services because of health professionals' attitudes (p. 25) (*99*).

Discrimination of people with mental distress has been an ongoing occurrence in Aotearoa and internationally (98, 100-102) and is commonly described in the literature in relation to 'settings'. Research suggests that the settings where we spend large amounts of time with people we are close to (the workplace and among family, whānau and friends) are also the settings where mental distress-related discrimination is most likely to occur (34). Flett et al. (2020) provide the following insights:

Within health-care settings, people experiencing mental distress and their family members can face ineffective or disrespectful treatment and *experience poorer quality health care (101).*

In the workplace, people experiencing mental distress can be turned down for roles or stop themselves from looking for work due to anticipated discrimination (101, 103).

Educational settings are also places where people face mental distress-related discrimination. Youth in Aotearoa New Zealand have identified peer discrimination around mental distress and discriminatory treatment from school staff based on mental distress (104). University students go to considerable lengths to hide their mental distress from staff due to anticipated discrimination (34).

Family members, whānau and friends are other significant sources of discrimination for people experiencing mental distress. Youth in Aotearoa New Zealand reported facing bullying, family violence, neglect, and rejection in relation to their experience with mental distress (104).

Users of mental health services in Aotearoa New Zealand identified discrimination and unfair treatment from family as being the most prevalent they experienced, and mentioned difficulty in establishing friendships and relationships due to mental distress-related discrimination (105) (p. 5) (34)

In 2003, the Like Minds programme conducted a survey that sought to understand better the most common settings of mental health-related discrimination in Aotearoa. A non-random sample was recruited through Like Minds networks and included oversampling of Māori and Pacific participants. Respondents reported experiencing mental health-related discrimination in all areas of their lives, most commonly amongst friends and family, when looking for employment, and when accessing mental health services. The most prevalent settings for Māori and Pacific respondents were similar to those for Pākehā (i.e., friends and family, mental health services). However, for Māori, discrimination within government agencies was also present (99).

Another New Zealand survey reported that mental distress-related discrimination most commonly occur in the workplace and when among family and friends (85). The focus on settings implies that there are environments in which discrimination is more (or less) prevalent. This rationale has subsequently promoted a settings-based approach whereby interventions to address mental health-related discrimination have focused on settings such as employment (i.e., employers). The Nōku te Ao strategy has a particular focus on employment and health sector settings.

As noted above, Gordon (2021) poses the idea that stigma is linked to misinformation (about those with mental illness); attitudes are linked to stereotypes and prejudice, and stigma and prejudice lead to discrimination (36). Based on this idea, correction of (mis)information about those with mental distress is likely to reduce stigma, and therefore reduce prejudice and discrimination. Contact with people with mental distress is also theorised as follows: "increased social proximity with people who experience mental distress appears to be associated with a reduction of discrimination and prejudice towards people experiencing mental distress" (p. 14) (34). This approach is based on the theory of contact literature showing that having increased contact with people with serious mental distress is associated with reductions in negative attitudes about mental distress.

In psychology, the power of contact, and theory of change, theory of contact/'contact hypothesis' is posed as a decades-old, 'best practice' approach to addressing discrimination and prejudice. The theory aims to combat bias, prejudice, and discrimination between conflicting groups. Posed by Allport in 1954, the contact hypothesis states that "contact between individuals who belong to different groups can promote tolerance and acceptance, and foster more positive 'outgroup' attitudes" (p. 8) (106). In addition to contact, the 'power of contact' is theorised to be successful when certain conditions are met such as equal status; common goals; and institutional norms. This approach has been adopted by Like Minds and is heralded as the best practice approach.

Like Minds also adopted a national social movement approach through large-scale marketing campaigns to change public perceptions about those with mental illness. Campaign messages responded to negative and 'misinformed' public perceptions and aimed to normalise mental and emotional experiences and responses to stressors. Notable campaign slogans have included: 'know me before you judge me'; 'take the load off', and 'Are you ok? Just ask, just listen'.

When **Like Minds was established in 1997**, New Zealand was somewhat 'leading the way' internationally with a national programme to reduce stigma and discrimination associated with mental illness. The types of initiatives implemented included mass media campaigns (involving national role models and icons), community workers, and policy initiatives. As well, the 'lived experience' leadership of Like Minds was included.

In 2014, Thornicroft et al., reviewed the impact of the Like Minds programme. They noted that "reducing stigma involves addressing problems of knowledge (ignorance or misinformation), problems of attitudes (prejudice), and problems of behaviour (discrimination)" (p. 360) (103). They go on to identify that the impacts of stigma include reduced access to 'full citizenship', such as access to employment, healthcare, and social activities.

In 2010 and 2011, a survey of mental health service users in 10 of the 20 NZ District Health Boards (DHBs) was conducted, with sampling those in groups differentiated by ethnic group, age and gender. An 18% response rate was achieved. At the end of the discrimination prevalence survey, the participants were asked about their perception of Like Minds. Whilst 27% of respondents believed Like Minds had made 'a lot' of impact, 42% thought this was 'moderate or a little' and a further 31% did not know, did not answer, or did not think it had any impact. Respondents were not presented by ethnic group (103). Whilst the findings of this study appear promising, there are several limitations. The sampling method lacks robust systems and leaves room for the sample to not be representative of Aotearoa. None of the results are broken down by ethnic group so it is difficult to gauge whether the responses of the majority (European) group are dominating. The survey asks about 'perception' of Like Minds, but this is linked to the strong campaign message of Like Minds itself being self-promoting. Finally, this study appears to be led and conducted by the Like Minds campaign itself, leaving potential for bias in design and interpretation (103).

He Ara Oranga refers to Like Minds as a national mental health campaign and notes that "Surveys of public attitudes demonstrate that, as a result of the campaign, attitudes towards people with mental illness in the target group of 15- to 44-year-olds have improved significantly, especially among Māori, Pacific peoples and young people" (p. 154) (50). The 2014 Like Minds national plan includes 'achievements to date' in which it is noted that public attitudes from 1997 onwards were tracked using a survey (107). A report in 2012 summarised a total of 12 tracking surveys, most of which aimed to assess the impact of the Like Minds media and advertising campaign by measuring change in awareness, attitudes, and behaviours towards mental illness. Sampling for the most recent survey included random telephone number generation. Māori and Pacific respondent 'booster' samples were targeted by randomly identifying 'Māori and Pacific names' on the electoral roll. Survey results showed a mixture of findings. However, in general, a positive shift of social perceptions towards people with mental illness continues.

The Like Minds surveys described above seek to measure changes in discrimination. However, the changes in attitudes seen above do not equate to changes in actions towards those with mental distress. Further, no comment is made about whether living in close social proximity with those likely to discriminate has a positive or further detrimental effect on those discriminated against. *Experiences of* mental distress-related discrimination are easier to measure than *experiences of discriminating*. That is, whilst reported experiences of discrimination are relatively high, reported experiences of being discriminatory are absent. The common indirect method of assessment utilises the concept of the *degree of contact (social contact)* people have or are willing to have with those who experience mental dist52ress (34). This is sometimes used as a proxy for 'social inclusion' and has been a key aim of the Like Minds Like Mine programme.

SUMMARY

This section presented some of the insights that Like Minds has revealed whilst adapting to changing environments and learning about what works overtime. Whilst incremental shifts in social attitudes have been made, it is difficult to tell if that change has translated into a change in action. With increasing rates of psychological distress and exponential growth in mental health sector demands, it is timely that we consider wider factors that might contribute to this picture. We must also note that traditionally, this kaupapa has focused on mental health-related discrimination.

What seems to be missing is a 'prevention' approach that seeks to unpack the reasons for mental distress and discrimination – particularly for Māori. There also seems to be a focus at the level of the individual where we are now targeting 'excluders'. An example of this approach in action is the 'Power of Contact' method that, based on decades of work, argues for 'contact' between those who are likely to discriminate, and those with lived experience of mental distress. A critical review tells us that this approach is more beneficial for the 'excluder' than it is for the people with lived experience. The following section examines mental distress and discrimination with particular focus on Māori.

REFRAMING DISCRIMINATION OF MĀORI

REFRAMING DISCRIMINATION OF MĀORI

Discrimination of Māori has dimensions that are less evident for non-Māori and as with other groups, Māori experience multiple forms of discrimination.

Intersectionality refers to the multiple ways by which stigma, prejudice and discrimination can operate simultaneously. As well as discrimination related to mental distress, Māori experience discrimination related to ethnicity (racial discrimination) and this is a core contributor to Māori mental ill-health. As noted in He Ara Oranga, racial discrimination and mental health discrimination are inseparable.

Māori who have mental illness face discrimination as Māori and as tangata whaiora. Discrimination is a major barrier to recovery. Services for Māori need to reduce the impact of both kinds of discrimination if they are to succeed with the recovery approach (p. 59) (69).

Nōku te Ao focuses on discrimination related to mental distress. However, the He Ara Oranga report as well as the Government inquiry into mental health and addiction notes that separating the types of discrimination for Māori is not helpful, or representative of their experience. Rather, Māori experience discrimination for multiple reasons at multiple times.

The separation of mental health from oranga (health and wellbeing) is contradictory to holistic understandings of health (p. 39) *(50)*.

The predominant form of discrimination that Māori experience is racial discrimination (racism).

Racism is a manifestation of colonisation, creates differential access to health and thereby results in health inequities. Racism has been defined as “the belief that some races or ethnic groups are superior to others, which is then extended to **justify** actions that create inequality” (p. 1503) (108). Williams (1997) reiterates that racism is “an ideology of superiority that **justifies** social avoidance and domination of groups” (p. 329) (109). Curtis (2022) draws on these definitions and notes that racism includes both the ideology (belief, judgement, assumption) and the action that oppresses one group and privileges another (110).

As noted by Cormack et al., Māori experience racism at higher rates than non-Māori. When included in the New Zealand Health Survey, measures of all forms of self-reported racial discrimination in 2011/12 showed this experience for 27.5% of Māori vs. 14.7% of non-Māori (63). In addition, 7.8% of Māori vs 3.2% of non-Māori had experienced an ethnically motivated physical attack, 20.8% of Māori vs. 11.7% of non-Māori had experienced an ethnically motivated verbal attack, and 22.2% of Māori vs. 12.6% of non-Māori had experienced either physical or verbal forms of attack (111). A more comprehensive survey of Māori specific to racism revealed that most Māori (93%) felt that racism had an impact on them daily and 96% felt that racism was a problem for their whānau. This study also noted that when Māori experience racism, they are left feeling pōuri (a deep sense of sadness) or riri (anger) at their experiences of racism (112).

Camara Jones, in her seminal paper 'A gardener's tale',' describes the three types of racism: institutional (or systemic), interpersonal (or personally mediated), and internalised racism (113). Drawing on the work of Jones, Reid and Robson provide an understanding of how colonisation operates via "institutionalised ("differential access to opportunities of society and power by race"), interpersonal ("prejudice and discrimination according to 'race'") and internalised ("acceptance of negative messages about one's own stigmatised race") racism. Racism contributes to differential health outcomes (i.e., inequities) by creating differential access to the determinants of health (e.g., employment, housing), differential access to healthcare (e.g., mental health services), and differences in the quality of care received" (p. 6) (114).

Institutional racism is considered the most powerful form in which discrimination is normalised: in policies and practices, where there is no identifiable perpetrator.

It commonly refers to discrimination by the state or non-state institutions. Personally mediated racism is defined as prejudice and discrimination and is the most referred to form of racism. This form of racism manifests as a lack of respect, suspicion, devaluation, and dehumanisation. Internalised racism only occurs in the presence of other forms of racism. It involves stigma about one's own group, and manifests as helplessness, hopelessness and self-devaluation (110). Drawing on the work of Curtis, Jones, Robson, and Reid, as well as Williams, factors that contribute to Māori experiences of mental distress-related discrimination can be conceptualised as occurring at the institutional (systemic/basic/fundamental), interpersonal, and internalised levels.

FRAMING MĀORI HEALTH INEQUITIES

The gaze or lens through which we frame, see, and understand a problem determines the interventions we utilise to address it. Our gaze also informs how we interpret a problem and how we understand its causes. This research aims to broaden our 'gaze' related to Māori experiences of mental distress-related discrimination and shed light on the structural causes of inequities.

Williams and Mohammed framework for the Study of Racism and Health provides a model for understanding the causes of ethnic disparities. This has been adapted to a New Zealand context by Curtis (2022) (110). This framework emphasises the importance of distinguishing basic causes (i.e., racism and world view paradigms) from surface (or intervening) causes (i.e.. stigma, prejudice and discrimination). Williams and Mohammed (2013), assert that changes in basic causes lead to changes in health outcomes, whereas changes in surface causes are unlikely to produce long-term improvements in population health (115). Their framework argues that *ethnicity* and other social status categories including *socioeconomic status (SES), gender*, *age*, *marital status* or *poor health status* are created by larger macro forces in society (or basic causes) and are linked to health through several intervening mechanisms (110).

Historically, Pākehā discourse around Māori health inequities has adopted a victim-blame analysis based on the biomedical model; providing a narrow and superficial focus on individual behaviours (e.g., behaviour problems, substance use) that contribute to illness (116, 117). However, this type of analysis avoids consideration of the *influences of colonisation, historical trauma and the broader determinants of health on Māori health outcomes (118).*

Racism takes many everyday forms and can happen across the life course, can be vicarious (and include witnessing racism), can be intergenerational and can impact a collective – not just individuals. For Indigenous peoples, racism began with colonisation (p. 15) *(112)*.

Curtis (2022) promotes that fully understanding Indigenous health inequities involves acknowledging the social environment, and engaging with the complex 'web of causation', including exploring who designs and controls the web (119). Common explanations for health inequities frame surface causes (e.g., social transmission, stigma, prejudice) and individual level responses (substance use, withdrawal, fear) as causing differences in health outcomes.

Williams' and Mohammed's 2013 framework can be applied to Nōku te Ao to understand inequities in Māori mental health, inequities in Māori experiences of discrimination, and inequities in discrimination of those with mental distress. With a clear commitment to ending prejudice and discrimination of people with lived experiences of mental distress, we can see that the focus of Nōku to Ao Like Minds operates at the level of 'surface causes'. This has been reflected in **traditional Like Minds interventions that seek to directly address social transmission (stigma and prejudice) via interventions such as social marketing campaigns about mental health**. Other Like Minds interventions target socioeconomic status opportunities such as employment and health settings. **Curtis notes that this type of framing of Indigenous inequities provides a limited platform for in-depth understanding (119)**. A structural determinants approach incorporates issues of power, privilege, racism, and social justice as structural/basic causes of ethnic health inequities. This approach is like that of Fundamental Cause Theory which seeks to explain differences in health outcomes by examining the fundamental causes (120). Curtis further notes that the 'structural determinants' are the basic and most important causes of inequities in Māori health outcomes (82, 110, 115, 119) and that achieving health equity requires the redistribution of these factors across society. This research takes a structural determinants approach to understanding inequities in experiences of discrimination and mental health between Māori and non-Māori.

SUMMARY

This section briefly outlined how discrimination happens for Māori. It is important to understand that racial discrimination, or racism, is not separate from mental distress-related discrimination. It is also important to understand that both racism and mental distress-related discrimination happen at the internalised, interpersonal, and institutional levels. The next section provides examples of how discrimination is enacted for Māori, in ways that are commonly underpinned by mental health. That is, mental health is often the reason that contributes to racism.

MENTAL HEALTH-RELATED DISCRIMINATION OF MĀORI

MENTAL HEALTH-RELATED DISCRIMINATION OF MĀORI

A life course approach is one that looks at different stages of life and their impact on health and wellbeing. Examination of people's trajectories through life can help to prevent 'ill-health' by unpacking how issues develop and reveal critical 'time points' where interventions might be most effective (121).

Māori experiences of mental health-related discrimination happen across the life course, particularly in institutional spaces.

Evidence for this is revealed when we look at differences in data between Māori and non-Māori that are directly linked to, or are underpinned by mental health, mental illness, and other concepts related to health. Examples are presented in this section at critical stages of Māori development, including birth, the early years of school, adolescence (rangatahi), when accessing mental healthcare, and when seeking coping mechanisms. Some of these examples are unpacked to reveal the mechanisms through which discrimination is practiced.

Understanding the depth and breadth of these experiences for Māori informs the design of Nōku te Ao approaches that consider the 'machinery of discrimination' and how this operates for Māori.

Data from institutions such as Oranga Tamariki, the Justice System, housing, social services, education, and employment sectors exhibit discrimination against Māori with mental health concerns, particularly when those concerns are addressed as criminal rather than health issues. A core focus has been on mental health service users. Here, we identify discrimination of Māori in and through mental health services, including the inequitable use of the Mental Health Act. Harmful experiences such as historical, intergenerational, and current abuse, violence, neglect, trauma, isolation, and loneliness are also known to contribute significantly to Māori health and mental health issues. These experiences can operate at multiple dynamic levels, i.e., whilst these experiences are likely to contribute to acute and long-term mental distress, environments in which these experiences occur are also likely to be places where discrimination is enacted. Often, these experiences are core determinants of wellbeing for Māori, and play a pivotal role in the causation of subsequent disruptions in hauora.

Society commonly focuses on the 'behaviours' of people such as violence, crime, and substance abuse and routinely labels these people and their behaviours as 'wrong'. A systemic approach is often one of segregation, separation, punishment, and exclusion. By buying in to a victim-blame mentality, the focus remains on the behaviours that contradict societal norms, and 'ignores' wider determinants of wellbeing such as broader social, economic, cultural, and historic contributors.

The legacy and ongoing impacts of colonisation now partly manifest as a form of discrimination often termed institutional racism (p. 21) (*23*).

THE EARLY YEARS - PĒPĪ

In the early years of life, mental health-related discrimination of whānau Māori can happen via the inequitable removal of tamariki and pēpi from their parents and whānau, justified by the presence of mental illness or substance use.

Data from 2018 show that 179 new-born Māori babies (less than 3 months old) compared to 102 non-Māori new-born babies were taken into state care by Oranga Tamariki (122). Higher rates of removal of Māori babies were consistent and increased between 2008 and 2019, averaging 48 – 67 per 10,000 births compared to declining rates of between 20 and 13 per 10,000 births for non-Māori. Moreover, entry of tamariki Māori into state care has averaged five times that of non-Māori.

In 2020, the number of children in state care per 1000 children was 13.3 for Māori and 2.2 for non-Māori (a Māori: non-Māori rate of 6.05) (122).

Oranga Tamariki reporting for 2020 explained that the "nature of concerns contributing to the decisions to bring tamariki into care … were typically related to factors within the home that posed a risk to their long-term safety and wellbeing" (p. 216) (122). The top eight most commonly cited concerns (in cited cases within the Oranga Tamariki report) were substance abuse (65% of responses) followed by family violence (64%), neglect or deprivation (57%), emotional abuse (53%), unsafe adults in the home (37%), physical abuse (32%), mental ill-health (30%), and behavioural or relationship concerns (25%) (122). As a reflection of the intergenerational trauma caused by the state, 48% of pregnant women whose pēpi Māori were taken into State care before birth had been wards of the State themselves (122).

This is a breach of several child, human and Indigenous rights, and the trauma inflicted by Oranga Tamariki (the Ministry for Children) on whānau Māori has undergone recent scrutiny; notably, the urgent Waitangi Tribunal Inquiry (2021) (122). The United Nations Convention on the Rights of the Child states that: "… a child shall not be separated from his or her parents against their will" (article, 9.1) (123). The Declaration of the Rights of Indigenous peoples includes: "… the right of Indigenous families and communities to retain shared responsibility for the upbringing, training, education, and wellbeing of their children, consistent with the rights of the child" (p. 3). Article 7.2 also states: "Indigenous peoples have the collective right to live in freedom, peace, and security … and shall not be subjected to any act of genocide … or violence … including forcibly removing children" (p. 5) (124).

The stealing of Indigenous babies by Commonwealth governments has long been a theme in colonial history (125).

In Canada, removal of First Nations babies and children saw them placed in residential schools (126-128). Recently it was discovered that a large proportion of those babies were buried on those school grounds (127). In Australia, the history of the stolen generation is well-documented and involved removal of Aboriginal babies from their families (129). White rationalisation and legitimisation of such actions are commonly based on white 'concern' about Indigenous mothers and the 'safety' of their own babies being in their care, imposing methods of assimilation into 'civilisation'. This example demonstrates the use of Western medical systems to assess and label Māori mothers at disproportionate rates to non-Māori mothers, and then the use of these labels as justification for creating whānau disconnection and trauma. Many of the ‘reasons for concern’, in addition to mental-ill health, include symptoms of unmet needs such as substance use.

THE EARLY YEARS - TAMARIKI

In the early years of schooling, mental health-related discrimination of tamariki Māori can happen via the inequitable removal of tamariki from opportunities to gain an education, justified by the presence of behavioural problems or ‘disobedience’. The use of stand-downs (forced time away from school) is a common practice for schools in Aotearoa, with 91% of secondary schools and 54% of primary schools using them in 2020.

Over a 20-year period (2000 to 2020), the average rate of stand-downs for Pākehā children from school was 18.9 per 1000 students annually. Over this same period, the average for Māori was more than double that at 46.9 per 1000 students and stand-downs were higher in areas of high deprivation for both Māori and Pākehā (134).

In 2020, despite 6.4% of Māori students attending Māori medium education, almost all (99.4%) of the stand-downs received by Māori students happened within mainstream schools (a rate of 38.8 per 1000 students compared to a rate of 3.8 per 1000 in Māori medium schools) (135).

In 2020, the most common reasons for stand-downs were ‘physical assault on other students’ (32.6%) followed by ‘continual disobedience’ (16.1%), smoking and/or alcohol (9.3%) and verbal assaults on staff (7.9%) (135)

Research into Māori student and whānau experiences of stand-downs and expulsions from school reveals that

Māori students are repeatedly framed by their behaviour, and that institutional racism creates school environments that are hostile, racist and uncaring, where students must struggle to persevere and survive (136).

Māori student voices revealed “consistent themes, such as voicelessness, repeated acts of resistance, power and dominance, resiliency, alienation, social control and hopelessness” (p. 52). This research noted the existence of, and lack of discourse about teacher/adult and peer bullying of young people that often results in ‘bad behaviour’. They explain that perhaps this is because “punishment is promoted as discipline and rarely exposed for what it is” (p. 111). One student noted that repeated exposure to exclusions allowed schools to frame him as dysfunctional, and that it was easier for schools to ‘kick him out’ rather than work to find support strategies (136).

The struggle to persevere and survive often results in behaviour that is perceived as deviant, destructive and dysfunctional by observers who are operating out of different contexts than those individuals being observed and evaluated (Trueba et al., 1989) (p. 2) in (136)

This study identifies an institutional commonality that is whilst “schools claim to be inclusive, culturally responsive environments where diversity is valued …. the rhetoric and policies are not reflected in schooling practices” (p. 124). Further, being framed as ‘unsalvageable’ and exposure to disciplinary exclusion results in mistrust of schools and teachers, and feelings of anger, alienation, and stress. Bowden notes that “while we continue to have legislation that allows young people to be excluded from education, then we will also continue to have students who will challenge the system and refuse to be bullied or silenced” (p. 124) (136)

RANGATAHI

Rangatahi Māori (Māori youth) make up a substantial proportion of the Māori population, presenting with higher rates of mental health concerns, have significantly higher suicide rates, and experience unique and substantial discrimination, silencing, and denial of autonomy, decision-making, power and control (130).

Rangatahi Māori are commonly mentioned but overlooked in health research seeking to understand and address health concerns (72, 73, 131). Rates of rangatahi suicide are more than double that of non-Māori youth, and suicide was the cause of one third of all rangatahi deaths over a 15-year period (130). Rangatahi Māori and non-Māori youth in one Aotearoa study reported experiencing discrimination in multiple ways. This study highlighted that despite being unfamiliar with the *term* discrimination, youth were so familiar with *experiences* of discrimination that it was a part of their daily lives (104).

Youth understandings of discrimination and mental health issues vary significantly, are not confined to types (e.g., racial, gender-based), and can be generally understood as a ”negative judgement, put down or being shut out because of being different in some way” (p. 21) (104). This is coupled with being treated unfairly or unjustly, or ‘being picked on’.

In this study, youth examples of discrimination were dominated by stories of emotional abuse and physical violence (bullying), and were rarely related solely to mental health issues (104).

The predominant ‘setting’ of discrimination for Māori youth was when engaging with police and the justice system. Name-calling and bullying (sometimes related to mental health – e.g., mental, crazy, retard) were particularly common. Rangatahi also reported experiences of exclusion, being ignored, or being turned away in school and peer situations due to their mental health. Many reported experiencing past and ongoing forms of violence, neglect, and emotional and physical abuse, particularly at home or in foster care from parents, partners of parents, or other family members. The nature of this abuse included being singled out, ‘picked on’, treated with hostility, and parent alcohol abuse, all of which contributed to their mental health.

Schools, and government agencies such as the police, justice system and healthcare were particularly unhelpful and often created environments that facilitated discrimination. Māori rangatahi reported being harassed by police, being denied help from teachers when being bullied and physically abused, being ‘taken’ away from their whānau and isolated in detention centres, and having medical history used against them to uplift remove their children. Rangatahi experiences of discrimination in healthcare included having their experiences dismissed and minimised, being ‘locked’ up and diagnosed without proper assessment, and not being taken seriously. It was noted that healthcare experiences made rangatahi mental health ‘worse’ (104).

> **young people … spoke of multiple forms of discrimination …, when discrimination as it pertained to mental health issues was discussed, … two themes were identified … child abuse and family violence [and] emotional abuse and physical violence from peers (p. 21) (*104*).**
>
> **Almost all young people who experienced excessive and prolonged abuse at home or school reported feeling intense anger. For many, anger was expressed outwardly, leading to acts of aggression and violence. For others, mental health problems surfaced, leading to depression, and for some, voice hearing. Many of the young people ended up using alcohol and drugs to ease the intensity of emotion arising from the**

> **injustice of persistent discriminatory abuse (p. 33) (*104*).**

A Health Quality and Safety Commission report revealed the association between rangatahi who completed suicide and rangatahi who has engaged with state child, health, and education services. Notably, the report showed that two-thirds of rangatahi who had died by suicide had also accessed mental health services; nearly half had had contact with Oranga Tamariki, and two-fifths had been stood down from school (130).

A recent study by Graham (2021) sought to unpack the relationship between Māori cultural identity loss and Rangatahi Māori suicide. This research analysed the *āhuatanga* of rangatahi Māori who had committed *whakamomori*, exploring a range of complementary elements of rangatahi Māori wellbeing. The study foregrounded that in all cases investigated, rangatahi lost to suicide displayed disconnection from their Māori cultural identity, specifically, within the elements of wairua, whakapapa and whānau. This cultural disconnection was associated with a myriad of historical and contemporary discriminatory practices and hegemonic structures, disenfranchising rangatahi Māori from their whenua, dismantling generational knowledge transmission and disabling accessibility and engagement with te ao Māori (132).

ACCESS TO SOCIETY

Employment is a key determinant of Māori wellbeing; supporting financial security, wealth generation, ability to meet the costs of living and whānau financial responsibilities, and contribution to quality of life (133). Employment is also strongly linked to wellbeing, and in particular, mental health. Conversely, unemployment is linked to homelessness. There is known stigma related to homelessness that is confounded by mental illness-related stigma and discrimination, and all of these factors are linked to loneliness (134). In addition, Māori experience high rates of precariat living, contributed to by employment types that are part-time or casual (and therefore unstable), inaccessible, unfit for their skill and knowledge base, and at times, insufficient to warrant working as opposed to ‘being on a benefit’ (61).

Discrimination of Māori, Takatāpui, those with disability, and those with mental health concerns is evident when seeking and maintaining employment. We see this in higher rates of unemployment for these groups compared to their counterparts. Examples of how this discrimination is enacted in employment settings include: job application processes that are online (excluding some disabilities), lack of flexible working policies (e.g., that can accommodate performance and attendance of those with mental distress), and environments and practices that are culturally unsafe (and impact on hinengaro and wairua).

Te Mahere Whai Mahi Māori (The Māori Employment Plan) calls for workplaces that are free from discrimination, and inclusive of diverse needs and ways of working, in particular, for those that value tikanga Māori (135). The *Working Matters* action plan is an example of a strategy that deliberately encapsulates the intersectional realities of many New Zealanders. That is, although this is a strategy focused on access to employment for disabled peoples, it acknowledges the disadvantages in labour markets experienced by a wide range of disability or health issues and those who experience multiple disadvantages (e.g., Māori, older people). Some practical strategies presented in this plan include monitoring and reporting employment data by those engaged in mental health services, lived experience leadership, and working with large and government organisations to partner for inclusive employment opportunities. This approach, rather than focusing on stigma around mental health, looks at the practical capabilities of potential employees and employers, and negotiates environments that are safe and conducive (62).

In a 2006 study recording the self-reported experience of racial discrimination, Māori experienced higher rates of discrimination on all measured variables. This included experiencing unfair treatment in health-related settings at a rate of 4.5% compared to 1.5% for European; in work-related settings at 5.6% compared to 2.1% for European and in housing-related settings at a rate of 9.5% compared to 0.7% for European (136). Discrimination when accessing housing and the extent of the disparity warrants significant attention and action. As a key determinant of wellbeing, and similar to that of employment, access to affordable, safe, warm, dry and stable housing is not only a broad determinant of health, but also a basic necessity of life (133).

MENTAL HEALTH SERVICES

Discrimination within healthcare involves differential access to and through mental health services (82), where Māori experience ongoing barriers to accessing health services such as cost and transport (80). Barriers to Māori accessing mental healthcare include culturally inappropriate healthcare based on European cultural norms, which at times is culturally unsafe (80). The Waitangi Tribunal kaupapa inquiry into mental health identified that access to mental health services for mild – moderate mental 'illness' is severely underfunded, provided in a limited way for those meeting strict criteria, and is not comprehensive. For example,

> *the system approach predominantly funds 'medication', but not wider social needs or psychology (talking) approaches to wellness (80).*

In addition, many whānau seeking help are being turned away due to not meeting 'high thresholds' for care. This is particularly concerning when whānau are expressing suicidal ideation and yet being told that care is not available to them (80).

The stigma associated with mental illness operates as a significant barrier in accessing mental healthcare. Of particular importance is the way in which stigma can create barriers to Māori access to and quality of care (e.g., suboptimal therapeutic relationships, poorer quality care) (80). Fear has also been noted as a contributing barrier to accessing services, particularly for Māori who face consequences such as removal of their children by the state, incarceration, and forced mental health treatment (80). This is closely related to a fear of coercion where Māori are subject to "patronising and infantilising staff ... who need to be obeyed lest they impose compulsory treatment" (p. 130) (80). These examples are now well recognised, particularly given the recently highlighted malpractice of Oranga Tamariki and the unjustified taking of Māori babies from their whānau.

Another recent study exploring Rongoā Māori ways of healing, health and wellbeing highlighted significant conflicts between Western medical dominance in Aotearoa and Māori mental health needs. This research identified that

> *mental health services resort to labelling and medicating whānau Māori, denying their lived experience explanations (e.g., matakite), and delivering treatment methods that are neither wanted nor needed.*

One example explained that whānau Māori sometimes teach their tamariki to remain silent about their lived experiences (e.g., matakite) for fear of culturally inappropriate interpretation, unwelcome labelling of school children by teachers, and to avoid risking exposure to the harms of mental health systems (84).

He Ara Oranga highlights widespread criticism of New Zealand laws that permit the denial and removal of the human rights of those who have received a psychiatric diagnosis. This is most obvious in the implementation of the Mental Health Act (1992) (50). Information about discrimination of Māori with lived experience of mental distress (via the Mental Health Act) within mental healthcare is reported annually in the Regulatory Report of the Office of the Director of Mental Health and Addiction Services. Here, we note that in 2020, 11,146 people were subject to the Mental Health Act, with 5655 subject to either compulsory assessment or treatment under the Act.

Those more likely to be subject to the Act were male, those aged 25 – 34, and Māori (46).

The Mental Health Act allows clinicians to enforce actions of coercion and of power and control of those they deem ‘mentally ill’ through seclusion, forced assessment and treatment. These methods are considered (by many) to be outdated, harmful, traumatic, inhumane, and undermining of self-determination (50). Further, despite other options for mental wellbeing assessment and treatment being available, it has been observed that clinicians ‘opt too readily’ for coercion and control options (50).

For Māori, the implementation of the Mental Health Act is utilised at a higher rate than for non-Māori, demonstrating unfair discrimination against Māori with mental health diagnoses (50, 80). Discriminatory actions by mental health professionals towards Māori are reiterated in studies, including Māori ‘consumers’ who report the use of forced medication regimes and threats of punitive action for non-compliance (137).

The 2021 Director’s report showed that 6% of all Māori accessed mental health and addiction services compared to 3% of non-Māori. Māori made up 28.5% of all mental health service users (30% of whom were under 20 years of age) and were three to four times more likely to be subject to a compulsory inpatient or community treatment order than NZ European and were more likely than non-Māori to be secluded (seclusion events = 201.7 per 100,000 for Māori, 69.1 per 100,000 for non-Māori). As well, Māori compulsory orders were more likely to be indefinite (Māori 2.9 times more likely than non-Māori) and disproportionately affect Māori males. Of those under community treatment orders, 76% of Māori compared to 56% of non-Māori non-Pacific peoples lived in the most deprived areas (decile 8 – 10) (46).

This traumatisation and discrimination of Māori with mental health diagnoses operates as a legitimised and rationalised systemic form of racism (50).

Conversely, for addiction harm reduction methods such as Opioid Substitution Treatment (OST), of the 5542 people who received OST, 79.6% were NZ European versus 15.6% Māori (46).

COPING MECHANISMS AND SITES OF RESISTANCE

As noted previously, the discrimination of Māori and those with mental distress can cause exclusion and reduce participation in society. These experiences are also deeply hurtful, traumatic, undermining, and harmful. At some point, many Māori (and non-Māori) seek alternative mechanisms or environments that are conducive to their autonomy, coping, survival, and belonging. In the Mental Health Foundation Youth study (104), many participants reported using alcohol and other drugs as a way of coping with pain and anger experienced as a result of discrimination and experiencing injustice.

Another serious concern in Indigenous communities is mental and behavioural health issues such as alcoholism, drug abuse, depression, and suicide, particularly among Indigenous youth. These have all been linked to past and current experiences of colonization as a clear “psychopathology” and are exacerbated by conditions of poverty and marginalization (p. 169) *(138)*.

The use of legal and illegal substances, such as pharmaceutical medication, alcohol, cannabis, analgesics, and ketamine are identified by people with lived experience as a means of coping with emotional and psychological pain associated with trauma, a lack of autonomy, experiences of injustice, and an absence of support and help (139-143). Other coping strategies include, for example, gambling, shopping, smoking, eating, and online gaming (144). When these strategies are used in a way that represents abuse or reliance, they can develop into addictions and can be harmful. Gabor Mate, a Canadian professor has made substantial advancements in the reframing of addictions in the context of pain (139). He explains that addiction is ”a forlorn attempt to solve the problem of human pain" (para. 4) (145). His mantra has thus been:

> **The question is not why the addiction, but why the pain? (para. 4) (145)**

Forms of resistance and reaffirmation of autonomy are also utilised as ways of both coping and addressing the injustices that are occurring.

On an ongoing basis, Māori utilisation of protest has been a site of resistance to colonial oppression and injustice. Noted examples include Takaparawhau (Bastion Point), Parihaka, Te Tiriti o Waitangi and Ihumatao. Other forms of resistance to oppression and the active carving out of space that is conducive to Māori include Kura Kaupapa Māori, and Kaupapa Māori research.

Gang affiliation is one environment that has provided a space where some Māori have found haven from cultural dissociation, and the oppressive and racial harms of New Zealand society and institutions. Māori gang affiliation rose to prominence alongside the mass urbanisation of Māori in the 1960s. Urbanisation was a key catalyst in the alienation of Māori from our cultural practices and te ao Māori ways of life. In the context of colonial practices that disenfranchised Māori from whenua and whakapapa, gang environments offered an alternative 'kaupapa whānau'. Māori gang members have reported that these environments have allowed identity reclamation within a social hierarchy loosely modelled on collective structures found within hapū and iwi (146). Within this socio-historical context, gangs looked to combat the newfound isolation and disenfranchisement, and search for independence, autonomy, and exclusivity from postcolonial normality (147). Although contemporary factors influencing gang membership in New Zealand span the broad dimensional domains of individual characteristics, family factors, peer groups, schooling, and community conditions (148), gangs have remained a major point of protest and resistance to the discriminatory systems and structures subjugating Māori in post-colonial Aotearoa.

Rather than employing a criminogenic epistemology, Roguski (2020) argues for the need to view gangs within their socio-historical realities, specifically a genesis within the colonisation of Aotearoa (149). Roguski and McBride-Henry (149) highlight that the criminogenic framing of gangs that has been reinforced through episodes of negative societal labelling that resulted in the continued marginalisation of gang members and their whānau, without understanding broader histories and realities of gang affiliation. Continued marginalisation leading to reinforcing cycles of social exclusion and discrimination for gang affiliates have resulted in many gang members and their whānau existing within a socially marginalised space, one created by exclusionary processes and necessity. From this position of social exclusion, gang members are at an increased risk and prevalence of a range of mental health conditions including conduct disorder, antisocial personality disorder, anxiety, depression, PTSD, psychosis, suicidality and drug and alcohol dependence (150-152). Roguski and McBride-Henry (149) emphasise that gang members and their whānau are excluded from generic societal health promotional modelling, resulting in a socio-cultural environment that impedes their ability and agency to reach complete mental health and wellbeing.

> **Gang membership can be an alternative attractive option for youth who lack a clear sense of their social identity and are marginalized by their peers or community (p.137) (*153*).**

SITES OF EXCLUSION

The justice system is a prime example of normalised exclusion of those with mental distress. Prisoners and those involved in the justice system have historically been pathologised as villains, 'bad', and criminal, implying an intrinsic or deliberate nature of delinquency.

Framing people who have breached the law as intentionally ‘bad’ and punishing them by excluding them from society (e.g., prisoners) ironically mimics the approach taken when removing children from their whānau, excluding tamariki from school, and chemically and physically restraining mental health patients. These are people who are considered to operate outside social norms and ideals are excluded and removed from society. The discrimination of prisoners through forced exclusion from society, prevention of participation in elections, and heavy management of communication and connection with friends and family imitates other institutions.

Māori are overrepresented within the justice system, accounting for 49% of sentenced inmates compared to 38% European, 11% Pacific peoples and 2% Asian/Other (154). Despite the main focus being on criminal convictions, recent evidence shows that more than 90% of prisoners in New Zealand have a lifetime diagnosis of a mental health or substance use disorder (155).

Quince (156) attributes the overrepresentation of Māori criminality and incarceration to being the end-product of nearly 200 years of “dispossession and alienation as a result of the colonising process that undermined traditional Māori epistemologies and methods of dealing with harm within the community” (p. 1).

Many prisoners have been exposed to the institutions previously discussed experienced forced removal from homes for arbitrary reasons, and spending time in state care where they were subject to abuse (157).

A study of prisoners in New Zealand (2016) showed that prisoners were three times more likely to have a mental disorder and 13 times more likely to have a substance use disorder compared to the general population (155). Similar to calls for addiction problems to be treated as health rather than criminal issues (158), there are calls to acknowledge trauma and abuse experienced by prisoners (and those in state care), and to provide sufficient resources for recovery rather than punishment (157). Work towards achieving this is now underway, with increasing mental health service provision in prisons, and dedicated alcohol and drug courts taking this approach.

The Abuse in Care Royal Commission of Inquiry interim report released in 2022 provides an exceptional, yet sobering overview of the many issues that have been raised in this report. Providing much more detail and depth of exploration, the Inquiry into state care includes substantial evidence of the links between colonisation and historical trauma for Māori, Māori experiences in state care and state institutions, and Māori mental health discrimination. This inquiry includes abuse in foster care, children’s state residential care, psychiatric care, youth justice care and faith-based institutions (Churches) (157).

WHĀNAU

Like Minds survey findings have indicated that Māori report experiencing mental health-related discrimination most often in ‘friends and family’ environments. One reason for this finding is likely to be that friends and family are the people we most often spend time with, hence, a possible reflection of amount of exposure to that environment (34). As discussed by Nikora et al., (159) both Māori and non-Māori with lived experience of mental health problems report that friends and family play a critical role in the wellbeing journey. As they point out, family and friends can have both positive and negative impacts (for example, a family member may have been abusive whilst another family member may have provided safety and protection). From their research, we can infer that the impact of family and friends on the journey of mental wellbeing for both Māori and non-Māori is significantly greater, simply because family and friends mean more to us. Importantly, they clarify that

the nature of whānau Māori is different to the nature of non-Māori families, and this is a key indicator of *how family and whānau impacts might be perceived differently.*

In reflecting on the ability (or inability) of the mental health sector to support Māori with mental health problems, we must also admit that many Māori ‘patients’ by default lean on and lean in to whānau support across their healing journey. We know that whānau Māori support is often the main type of helpful support that Māori patients receive, despite the presence of relatively well-funded health services. Hence, it is highly likely that whānau struggle to provide the support required by their whānau members, and that this is a direct reflection of a lack of government and mental health support for whānau in their caring roles.

Another contributory factor is likely to be internalised racism. Here we see the outcomes of Māori assimilation, whereby whānau adopt beliefs and behaviours of the coloniser (mental health professionals) that frame whānau as the problem to be excluded. A New Zealand study investigating discrimination amongst family and friends of all ethnicities echoed the institutional and biomedical views and treatment of those with mental illness (37). For example, family members at times reiterated the belief that mental distress was fundamentally caused by a chemical brain imbalance, leading to denial of other environmental causes. Common stereotypes were perpetuated where mental illness was interpreted as intellectual disability, and normal ordinary rational behaviour, emotional expression or imagination was pathologised (37, 137). Some family actions mimicked those of institutions where ‘patients’ were excluded from decision-making about their own wellbeing (37).

The conflict between punishment and healing related to drug use and mental illness, present in social institutions, was also evident within the family setting. That is, family members found it difficult to support their family member who was experiencing both mental distress and drug use (37). Interestingly, differences were present between family focus groups (predominantly Pākehā) and the whānau focus group. The Pākehā whānau focus group talked about times they and their family members had negative attitudes and behaviours that were discriminatory towards mental health consumers in their families. Conversely, whānau focus group members (i.e., Māori), were strongly against discrimination, and their kōrero mostly centred on discrimination towards whānau by mental health services, as well as historical experiences of mental illness and psychiatric institutions (37). Whānau also recalled how clinicians in mental health services often position themselves as the experts whilst discounting whānau insights (37). One area of contention was around the removal of children from the care of mothers, or (artificial) prevention of mothers from having further children for women who were mentally ill, or were perceived to have unstable living situations. In response, a kuia in the group reiterated the importance of whakapapa and acceptance of whakapapa and discouraged artificial interventions.

SUMMARY

This section has presented multiple examples whereby Māori experience discrimination. In all of the examples, practices of exclusion are justified by psychiatric or mental health explanations and routinely applied to Māori more than non-Māori. What we uncover here is that not only are racism and mental health-related discrimination intertwined, but perceived mental state is also commonly used as the tool by which racism is justified and enacted. The next section provides additional comment around commonalities in these examples and the fundamental theories, principles and philosophies that underpin them.

DISCUSSION

DISCUSSION

This report brings together a Kaupapa Māori understanding of Nōku te Ao, provides an overview of Māori mental health and discrimination inequities, and unpacks the varying contributors to Māori experiences of mental health-related discrimination. Further, a structural approach to Nōku te Ao is proposed that considers the powerful nature of structural determinants of inequities in discrimination and mental health between Māori and non-Māori. This section discusses the key kōrero points from this report.

PRIORITISATION OF MĀORI

The previous Like Minds programme was underpinned by overarching Western world views and lacked framing of Māori experiences within colonial contexts (160) and this likely limited the effectiveness of the programme. Evidence also shows that 'one size fits all' approaches often create inequities; whereby the programme privileges the majority (i.e., non-Māori) and disadvantages minority groups (e.g., Māori and Pacific peoples). A prioritised approach for Māori is therefore required that is targeted to and tailored for ensuring positive outcomes for Māori. Redistribution of resources to prioritise equity is also necessary.

BY MĀORI FOR MĀORI

More than 30 years ago, the Mason Report and the subsequent Blueprints for mental health services made clear recommendations for the embedding of mātauranga Māori, Māori world views, Kaupapa Māori and by Māori for Māori approaches to Māori mental wellbeing services (60, 69, 161). This is echoed across the education, justice, health and social sectors, and yet improvements to date have not yielded any substantial moves towards equity for Māori, signalling the continued dominance of Western institutional models. Positioning te ao Māori as the starting point upon which we understand Nōku te Ao is essential to addressing mental health and discrimination of Māori. The work of Mark and Di Kopua utilises the mahi-ā-atua approach whereby mental health services are positioned from and within a Māori world view (162, 163). Other mātauranga-led initiatives include Te Kuwatawata, Te Rau Ora (Te Rau Matatini) and Kaupapa Māori psychology that create space for te ao Māori approaches to mental wellbeing. Designing Nōku te Ao in line with these examples therefore aligns with recommended best practice for Māori. This is inclusive of Māori leadership, control, and decision-making and embedding of Kaupapa Māori principles within Nōku te Ao (21).

INEQUITIES IN MENTAL HEALTH AND DISCRIMINATION

This report has reiterated the extent of ethnic inequities in mental health and discrimination (114). Ethnic inequities provide evidence of discrimination, and inaction in the face of need constitutes a breach of human rights and the rights of Indigenous peoples (23, 80). The increasing rates and severity of psychological distress for all of New Zealand, and at higher rates for Māori indicate multiple intersectoral factors are at play that are placing unmanageable stress and pressure on whānau. Māori and rangatahi are particularly affected and higher Māori mental health needs are seen across the entire healthcare continuum (i.e., from no/low mental health need to severe need and suicide data).

Prescription data for antidepressants, antipsychotics and antianxiolytics reveals the extent of reliance on Western medicine symptom management, and less exploration of *the benefits of non-drug treatments or rongoā Māori health solutions.*

The plethora of recent strategic commitments and inquiries into Māori mental health is promising, and yet reiterate the recommendations of the Mason Inquiries some 30 years ago. Whilst commitments to Māori, Te Tiriti and equity are somewhat repeated, there has clearly been a lack of actioning of these commitments to date in robust and meaningful ways. The reaffirmed commitments now seek to 'reframe the problem' and hence locate Māori in critical shared decision-making, power, and control positions. Ideally, these new reforms will create meaningful change for Māori and move towards health equity.

RE-FRAMING DISTRESS

This report has affirmed that terms such as mental illness and psychological distress do not resonate with Māori and are located squarely within Western medical theories about the mind (37, 104, 137, 164).

These labels categorise Māori within Pākehā world views (84, 164). The idea that mental illness is a Western medical concept, created to identify behaviours and thoughts that do not align with European ideals is not new. In pre-colonial Māori society, the existence of peoples with mental illness was neither common nor framed in a negative light. Rather, extraordinary peoples were thought of in positive light and framed as 'gifted'. Hence, Māori require culturally informed perspectives, Māori concepts and te reo Māori kupu, "te reo Māori is the only language that can access, conceptualise and internalise mātauranga Māori" (p. 3) (165). We must move away from colonial systems that define us by 'illness' (e.g., those with mental distress), towards traditional methods of asserting Māori cultural identity (i.e., pepehā) (166). In short, we must focus on the person, not the diagnosis or the behaviour, and on the cultural alignment of the person, rather than on preconceived 'norms' that are dominant within the wider system.

The term 'mental distress' is not conducive to holistic Māori models of health (e.g., Te Whare Tapa Wha, Te Wheke). With this in mind, we might remove the term 'mental' all together, given that any type of distress is likely to impact on te taha tinana, wairua, whānau and hinengaro collectively (67, 68). To this end, symptoms of distress are normal physiological, emotional and wairua responses to stressors and allow us to recognise when our wellbeing is at risk or has been harmed. This is an important framing that Nōku te Ao must adopt. If distress is a normal human response, we cannot continue to frame those experiencing distress as ill or abnormal. Kreiger (2016) also identifies that Indigenous peoples have constantly elevated levels of stress and that this is linked directly to the embodiment of historical collective trauma, and personal experiences of trauma (167). For Māori, the combination of exposure to poverty, racism, oppression, and injustice increases acute and chronic distress on an ongoing basis. Western world views focus on distress as a problem to be managed, while Māori world views focus on preventing the cause of the distress, and acknowledging the outcome of the distress (i.e., mamae).

MINIMISING THE PROBLEM

Academic literature specific to Māori and Nōku te Ao is scarce. What information is available is largely based on studies carried out by, or about the Like Minds programme including surveys; however, detailed information about the Māori sub-groups is not routinely available. In much of the academic literature specific to this kaupapa, there remains a narrow focus on discrimination and prejudice related to mental distress, heavily noting its prevalence in employment and health settings. A focus on exclusion is also present and includes ideas about fear of participation in society, a move to withdraw from those environments, and resulting disengagement with determinants of wellbeing.

A critical Kaupapa Māori analysis of Like Minds specific literature reveals *how issues have traditionally been framed. First, use of the terms mental distress and discrimination affirm Western medical jargon and operate to exclude Māori engagement with the literature. Second, a focus on mental distress-related discrimination silences the other types of discrimination (i.e., racism) that dominate Māori experiences. Third, subsuming Māori-specific insights within an 'all of New Zealand' discussion minimises the unique experiences of Māori. Fourth, there is an absence of acknowledgement of the 'causes' of mental distress, and this positions mental distress as an inevitable experience rather than a preventable health outcome.*

We must therefore continue to locate Nōku te Ao within New Zealand's wider context and cannot keep minimising these issues.

As discussed later in this section, the narrow focus on prejudice and discrimination is related to 'interpersonal-level' discrimination and leaves out discrimination at internalised and institutional levels. When framed this way, the proposed solutions are also located at the interpersonal level. As such,

'The Power of Contact' is celebrated as the best practice approach to ending discrimination and prejudice against those with lived experience of mental distress. As far as we can comprehend, whilst celebrated as helpful to reducing discriminatory attitudes, it is unclear if this translates into reducing associated actions, and this approach is also likely to be retraumatising and at a minimum, harmful – to those who are already discriminated against (168).

In one critique, engagement with the Contact Method itself operates as a self-exclusion pathway from the discriminatory group. That is, if one can prescribe to have been liberated from their inherent discriminating activities through a deliberate engagement activity (contact), they then no longer see themselves as belonging to that group. Hence forth, the problem lies outside of their 'newly liberated' group, with others.

THE CHANGING FACES OF STIGMA AND DISCRIMINATION

A narrow focus on mental health-related discrimination, rather than addressing the fundamental cause of the notion of discrimination itself, is unlikely to create long-term change.

This is because stigma and discrimination are pervasive and historically have adapted to recreate disadvantage of the same groups in different, socially acceptable ways. In short, stigma and discrimination seem to evolve over time (i.e., as certain activities (e.g., racism) become socially unacceptable, discrimination reinvents itself in socially acceptable ways (e.g., exclusion of disobedient school children)). Hatzenbuehler et al., describe stigma as a fundamental cause of population health inequities that can find new mechanisms of production (120).

We have seen this in the United States where stigma and discrimination of Blacks (originally through slavery) was reinvented as was a subsequent war on drugs and then a war on crime; all three mimicking and perpetuating racial discrimination. In New Zealand, stigmatisation of unemployed, uneducated, homelessness, those with mental distress, the poor, and now the unvaccinated, overlaps with stigmatisation of Māori. Hatzenbuehler et al, therefore argue that interventions must address the social factor itself (i.e., racism), rather than the putative mechanisms that link this factor to health; “otherwise, fundamental social causes will continually produce health inequalities through the production of new mechanisms” (p. 813) (120).

FRAMING NŌKU TE AO USING A STRUCTURAL APPROACH

As this report has demonstrated, understanding mental health-related discrimination for Māori requires a significant ’undoing‘ of current understandings of Māori mental distress and discrimination. This ‘undoing’ critically includes locating the history and narrative of Māori mental distress and discrimination within the wider context of the fundamental/systemic and broader determinants of health; the inherent link between colonisation, racism, and Māori ill-health; and the continued systematic, institutional, interpersonal, and internalised contributors that continue. The TKHM structural approach model and the theory of fundamental causes align with the Kaupapa Māori principles of ‘kia piki ake ngā raruraru o te kainga’ and allow a critical analysis of structural power imbalances that cause unequal health outcomes. The structural approach identifies that the lens/gaze of previous approaches has focused on the surface level. At the surface level, there is a focus on prejudice and discrimination, and on broader determinants of health (employment, health services), and this level is reflective of personally mediated racism. That is, racism and discrimination that happens at the interpersonal interface. As the model notes, theories about causation and associated interventions that operate at the surface level, and interpersonal level are unlikely to create long-term population health change. Rather, factors located at the fundamental/structural level are likely to represent institutional racism. Institutional racism/discrimination is the most powerful and redistribution at this level is likely to create change in health outcomes, thereby supporting health equity.

A Nōku te Ao approach that adopts a systems approach and explains the problems using this ‘lens’ is subsequently more likely to achieve the programme’s equity goals.

> **the dominant approach to mental health in Aotearoa/New Zealand masks the ways in which colonisation, institutionalised racism, and interpersonal racism perpetuate Māori health inequities. Further, Eurocentric models of therapy exacerbate and entrench existing social and cultural inequities (p. 63) (169).**

RACISM

This report has clearly shown that Māori are discriminated against in nearly all settings and environments. Māori are clear that mental health-related discrimination for us is inseparable from, and overwhelmingly linked to other and all types of discrimination. Most predominantly, racial discrimination (racism) operates for Māori at macro and micro levels, in implicit and explicit ways, at fundamental, institutional, interpersonal, and internalised levels.

DISCRIMINATION, PRIVILEGING AND SOCIAL CONTROL

Unpacking notions of discrimination, prejudice and stigma reveal their direct link to systems of social control.

Systems of social control, otherwise referred to as imperialism and idealism are core components of colonial systems and involve creating an ‘ideal’ norm. These systems are designed to promote conformity to the ideal social norm, to reward (privilege) those who do conform and to discipline and punish those who do not (170).

What helps with identifying what is and is not ideal are differentiating between things, and labelling and categorising things. For example, male and female, being on time versus being late, and obeying teachers versus being disobedient. When people exhibit behaviours that do not fit the ideal, they become labelled as 'bad' (e.g., tobacco smoking, drug use). Good behaviours are rewarded with things like inclusion or access to determinants of wellbeing (e.g., employment of non-smokers).

Māori have been subject to Western European 'norms', stereotypes, labels, and categories; notably, stereotypes of Māori that undermine the Māori psyche and reinforce notions of 'hyperphysicality', or violence. As Hokowhitu (2007) describes, this 'dual approach' whereby Māori minds are questioned, and Māori physicality is emphasised, creates the 'silencing of Māori men' (171). We see this reflected in use of the Mental Health Act and prisons where Māori are chemically and physically restrained and silenced. The 'good/bad' Māori binary stereotypes the 'good' Māori as subservient, silent, and easily assimilated (e.g., obedient school children). The 'good' Māori is praised and rewarded by the colonial project agents. Conversely, the stereotypical 'bad' Māori speaks up (exercising their voice), questions and resists colonial project activities (e.g., protestors, critical thinkers). The 'bad Māori' is punished, excluded, and labelled rebellious, savage, violent and angry (171). Neither the good nor the bad Māori is permitted to express their voice, rather, this process of social control leaves Māori with the option of submission, or of becoming an outcast (e.g., gang members) (170). Moreover, Māori resistance to colonial subjugation is labelled as protesting, activism, violent, dangerous, and/or questionable sanity. A common example being the Māori male who asks a question in school being labelled as having 'behaviour problems'.

JUSTIFICATION OF RACISM BY MENTAL HEALTH SYSTEMS

As noted previously, racism has been defined as "the belief that some races or ethnic groups are superior to others, which is then extended to **justify** actions that create inequality" (p. 1503) (108). Williams (1997) reiterates that racism is "an ideology of superiority that **justifies** social avoidance and domination of groups" (p. 324) (109). The overview of Māori experiences of institutions in the above examples reveals the clear connection between racism (discrimination of Māori) and mental health systems. When investigating these examples two critical realities became apparent. The first is that Māori experience significant discrimination in almost all systemic and institutional environments in New Zealand such that Māori experience discrimination across the entire life course. Secondly, the mechanism of discrimination of Māori is justified and enforced by mental health systems.

We see this in schools where Māori students who do not obey are labelled as troublesome with behavioural problems. We see the removal of pēpi from their mothers justified by the presence of symptoms of trauma (mental illness, substance use), and expressions of injustice (e.g., lashing out, violence) as rationale for exclusion from society. Māori mental health patients are secluded and pacified, and those who resist (protestors) or choose to live outside the system are criminalised. This brings us to differentiating between a) those who exhibit symptoms of distress, in response to historical and personal 'stressors' and/or b) those whose resistance to oppression has been mis-labelled as problematic. Ironically, mental health systems seem to oppress the mentally healthy (i.e., critical thinkers, those who are liberated) and reward others. This requires further discussion in future research.

REAFFIRMATION OF MĀORI INTELLECTUAL SOVEREIGNTY

Even more concerning, was the core component of the colonial project that questioned, critiqued, and undermined the Māori mind. We have known for some time that the process of colonisation has included deliberate collusion against the minds of Māori; oppression of Māori intellectual sovereignty; and the use of assessment and labelling of psychological conditions for European colonial agendas. As noted previously, Māori descend from ancestries rich in philosophy, in research and development, in collective survival and in ecological conservation. In Aotearoa, a recent article in the

'Listener magazine', in which seven white 'academics' denied the existence and credibility of mātauranga Māori (172), provoked loud and clear reaffirmation of the place of mātauranga Māori within the realm of Indigenous knowledge (173). Mātauranga Māori has never required acceptance by Western European standards of knowledge validation (84). Māori, once were, and continue to be, gardeners, warriors, and philosophers. Deeply entrenched within Māori mōhiotanga, mātauranga and māramatanga is the ability to critically examine, to observe, and to assess complex whakapapa systems – including those of oppression, discrimination and marginalisation. As such, we can identify that discrimination is a tool of colonisation. More specifically,

discrimination against the Māori mind is a colonial tool that oppresses Māori emancipation.

Hokowhitu identifies that:

> **Pākehā men have maintained power by defining what they are not (and therefore what they are) through the constructions of "Others" such as Māori and women. For instance, constructions of Māori savagery inherently define Pākehā as civilised. (p. 64) *(171)***

An increasing mental health movement is gaining traction. This movement identifies what they term 'Mental health oppression'. 'Mental health oppression' has been defined by one group as:

> **The systematic suppression of discharge and the invalidation of people's minds. It is the attempt to control people by enforcing standards of conduct, invalidating the discharge/re-evaluation process, categorizing people into diagnoses, pressuring them to take drugs and other harmful treatments, and punishing attempts to stand up for their liberation. The point of mental health oppression seems to be to oppress mental patients. However, is it actually to maintain the status quo by reinforcing and obscuring the functioning of other oppressions and enforcing conformity. (para. 4) (174)**

EMANCIPATORY LITERACY AND CONSCIENTISATION

Literacy has been described as an instrument of oppression (175, 176). Conversely, evidence has shown that increasing health literacy can improve Māori engagement with and access to health services and thereby health outcomes (177). Similarly, improving racial literacy (reading, knowledge and skills) regarding topics such as racism, oppression, and colonisation can operate as a tool of emancipation and liberation from oppression. As noted within this report, terms such as mental distress, psychological distress and discrimination do not resonate with Māori. In the previously discussed study of New Zealand youth, it was affirmed that whilst they were not familiar with the terms, the experiences were a daily occurrence (104). Linked to this lack of resonance is a lack of conscientisation, literacy, and ability to identify and articulate the mechanisms of injustice and discrimination. That is, the inability to identify the injustice. Paulo Freire's discussion of the Pedagogy of the Oppressed talks about a critical awakening, or critical consciousness that can lead the way to freedom from oppressive situations (178). Graham Smith discusses 'political literacy' and proposes a shift from conscientisation to transformative praxis (179). With these discussions in mind, improving the ability of Māori to identify the mechanisms of discrimination is likely to improve participation in pathways to social justice and freedom from oppression.

VOICES OF FREEDOM

Although not the main focus of this report, several examples of alternative narratives about mental health and Māori/Indigenous or ethnic minority populations have been identified.

Accompanying these alternative narratives are groups, organisations, role models, institutions and social movements that promote, voice, and action the normalisation of diversity and upholding of human rights in mental health, and in society. Alongside the Like Minds campaign, other initiatives such as LGBTQI+ Pride/Gay Liberation, Black Lives Matter, Gumboot Fridays, and Pink Shirt Day call for an end to discrimination. The entertainment industry (e.g., movies, music, documentaries, memes, digital and Indigenous media} has been calling out oppressive and discriminatory systems, normalising mental health issues and operating as sites of resistance for decades. Notable mentions include Bob Marley, Eminem, Rhianna, Maimoa, and the Netflix series – 13 reasons why.

A recent study in the US found that college students were able to resonate with songs about depression, anxiety and mental health; were less likely to display mental health related stigma, and preferred music as a way to address their mental health needs (180).

> **“Emancipate yourselves from mental slavery, none but ourselves can free our minds”**

SEVEN LEVERS FOR CHANGE: ADDRESSING MENTAL DISTRESS

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The earlier sections in this report have highlighted the many examples associated with discrimination of Māori, and mental distress.

These examples paint an overwhelming picture that demonstrates the far reaching and multi-layered extent of this discrimination. Significantly, this report has shown that the multi-layered discrimination of Māori with mental distress originates across a range of broader avenues, not solely within mental health or even within a wider health silo.

These discriminatory issues span the sociocultural, sociohistorical, and socioeconomic realities of Māori; and as such, mental distress and discrimination must be viewed in light of these broader contexts. Accordingly, work needs to continue across Aotearoa, specifically in ways that resonate with te ao Māori.

Here we (the report co-authors) present seven **levers for change** in relation to the respective roles of whānau, Māori governance, Government responsibilities, health service reformation, community leadership, lived experience, and Nōku te Ao.

LEVER 1: WHANAUNGATANGA. THE ROLE OF WHĀNAU

Whānau are the ultimate kaitiaki for Māori health and wellbeing.

They guide their children and mokopuna throughout their lives and are first options for healthily living and ongoing connections. Whānau can provide the care and guidance necessary for the prevention of ill health and the promotion of wellbeing. Importantly whānau are the links to the past and provide foundations for the future.

For many reasons, not all whānau are in the position to promote good health or to generate confidence and certainty for the younger generations. But where there are problems that diminish standards of health and wellbeing, the aim should be to foster a spirit of whanaungatanga and to encourage whānau to assume the roles that will best serve their people. Inevitably it is whānau who will bear the brunt of misfortune, but it is also whānau who can regenerate lives that have been subject to discrimination and isolation.

The role of whānau as agents for good health goes beyond individual families to embrace a wider collective which, together, has the capacity to refocus lives that have become victims of social, political, and discriminatory forces.

LEVER 2: RANGATIRATANGA. THE ROLE OF MĀORI GOVERNANCE

Māori are best placed to identify and respond to discrimination and mental distress experienced by their own people. They share with them similar cultures, similar histories, similar experiences, and similar connections. In the past there has all too often been an expectation that professional help will be the best answer to Māori distress. Often it is and when needed, that help should be readily accessed. But more often than not, and for the reasons already mentioned in this report, Māori helping Māori is a preferred option.

Nor is help restricted to the provision of services. Marae, for example, are centres for wellbeing. They exemplify inclusion, they are conduits for te reo Māori, and for karakia, they stand on land that gives meaning to tūrangawaewae, they link the past with the present and are champions for whanaungatanga. They add a dimension to wellness that is beyond the reach of conventional services. Other Māori centred initiatives have similar attributes. Kōhanga reo, Whare Kura, wānanga, waka ama, and kapa haka provide opportunities for lifting the spirit and fostering greater self-confidence.

Over the past two or three decades the emergence of Māori capacity to address Māori health, education, business, and employment has shown how culturally aligned programmes can engage with Māori and foster changes that will reduce distress, generate enthusiasm, and change lifestyles. The emergence of Whānau Ora in 2010 demonstrated a new approach that focused on whānau rather than on individuals. It had two overlapping goals: whānau wellbeing and whānau empowerment. Whānau Ora is also distinctive because it is not accountable to a government department but reports directly to the Minister of Whānau Ora.

At a national level various groups have advocated on behalf of Māori – the Māori Women's Welfare League, the NZ Māori Council, the National Māori Congress, the Iwi Chairs Forum, Te ORA the Māori Medical Association, the National Council of Māori Nurses - Te Kaunihera o Nga Neehi Māori – and many others, including the recently established Māori Health Authority -Te Aka Whai Ora. They share a common philosophy driven by a 'by Māori for Māori' commitment. While they are often funded by Government and as a consequence are accountable to State agencies, their longer-term goals are to be more independent and to be more closely linked to Māori self-determination.

A challenge for te ao Māori in the future would be to establish a capacity for self-determination and self-governance that embraces the several dimensions of wellbeing especially health, education, housing, and employment. Self-determination is addressed in article 2 of Te Tiriti, but, despite the establishment of Māori-specific services, has yet to be fully realised. If it were to become a reality, Te Aka Whai Ora for example, would be part of a wider Māori governance system, operating alongside the government system but accountable to Māori and funded by multiple funders. In that Māori governance system, health would be closely linked to a range of accelerants that lead to Māori wellbeing and would be governed and managed by Māori.

LEVER 3: KĀWANATANGA. THE ROLE OF GOVERNMENT

The Government is responsible for ensuring that legislation and policies improve the health, social, and economic circumstances of tangata whaiora. Under articles 1 and 3 of Te Tiriti o Waitangi, Government has a role to ensure service availability but also to establish equity between Māori and others, and to generate policies and legislation that address prejudice and discrimination against tangata whaiora.

Several policies for health and wellbeing have emerged over the past 50 years. The repeal of the Tohunga Suppression Act in 1962 legalised Māori approaches to health, including tohunga and the use of rongoā. A notable Government policy was the closure of mental hospitals in 1972 and the subsequent establishment of community health services. Te Reo Māori was made an official language in the Māori Language Act of 1987. The Pae Ora Act 2022 saw a major shift in policy and planning. Like arrangements for the Whānau Ora Commissioning Agencies, Te Whatu Ora and Te Aka Whai Ora do not report to a government department but report directly to a cabinet minister – in this case the Minister of Health. Although Te Aka Whai Ora is a government agency (insofar as it reports to the Minister of Health and is funded by the Crown) it has established a Treaty-like partnership with Te Whatu Ora and has its own governance structure.

Increasingly, Government agencies, including the Ministry of Health have been urged to adopt a cross sectoral strategy. Whānau Ora was intended to have input from the ministries of health, education, housing, and social development. But in the first two years, and for a number of reasons, that proved difficult. Instead, Whānau Ora commissioning entities were formed with accountability to a newly appointed Whānau Ora Minister. Intersectoral collaboration will be critical in the years ahead as evidence mounts to confirm that health is as much a product of socioeconomic factors as it is of personal susceptibility.

A future role for the Government might well be to partner with a Māori health leadership group that enables Māori to be self-determining.

Among other things the partnership would agree on the broad goals for Māori health, enter into a collaborative arrangement, and enjoy a two-way sharing of resources. But the Māori health leadership group would carry responsibility for delivery, quality control, and governance of the wider Māori health system.

LEVER 4: ORANGA TANGATA. THE ROLE OF MĀORI HEALTH SERVICES

The establishment of Kaupapa Māori health organisations (KMOs) dates back to 1983 and the launching of Raukura Hauora o Tainui. In the following decade more than 20 Māori health services were established, some associated with Iwi, others linked to specific communities. Since then, they have continued to grow in number and in capability with an increasing range of priorities. But underlying them all has been distinctive modes of practice which draw heavily on mātauranga Māori, a whānau orientation, and close associations with respective Māori communities.

KMOs generally consider health problems in relationship to whānau, to Māori communities, and to co-existing socioeconomic pressures. As well as conventional standards of healthcare they have also adopted standards of practice based on tikanga and kawa. A kawa for engagement, for whānau involvement, for care and treatment, and for the development of a strategy for health gains. Kawa will guide the adoption of a two-way process that involves tangata whaiora as much as Māori health workers. The overall aim is to enable whānau to assume responsibility for addressing their own health and wellbeing.

Kaupapa Māori services have distinctive priorities that include shifting the focus from treating sickness to generating wellness, from a focus on the patient to involvement with the whānau, and from making a diagnosis to respecting the integrity of the person. Moreover, KMOs have working relationships with Māori providers of education, social services, corrections, and hospital-based services.

A complication for most KMOs has been a requirement for multiple contracts to fund different aspects of care. Even within a single discipline such as health, there are likely to be multiple requirements for a wide range of services, e.g., spanning wellbeing checks, immunisation, arthritis, loss of weight, weight gains, pregnancy, abdominal pain, depression, and hospital follow-up. While most contracts have been with DHBs, and will now be with Te Whatu Ora, additional contracts with the Ministry of Social Development, or other Government agencies tend to create a fragmentation that goes against the overall mission of integration. The Whānau Ora approach provides a model that could lead to KMOs signing a single contract with funding from a single government agency to provide a wide range of services.

LEVER 5: ORANGA KAINGA. THE ROLE OF MĀORI COMMUNITY LEADERS

Along with increased urbanisation Māori influence in communities has grown with the formation of Māori ‘hubs‘ in towns and cities. The establishment of a range of organisations gives voice to Māori living in urban situations. They include Iwi agencies, Māori health and social organisations, branches of the Māori Women’s Welfare League, Te Kohanga Reo and Kura Kaupapa Māori, NZ Māori Council district committees, and sporting and cultural clubs. In many respects they have a guardianship role, to ensure that Māori interests are supported and can thrive so that Māori living away from ‘home’ are able to actively participate in work, education, and in te ao Māori.

Although they are not always afforded recognition by local authorities, their capacity to protect and promote Māori interests is nonetheless significant. They can be champions for Māori with zero tolerance for racism, bigotry, prejudice, and discrimination in the streets, in the workplace, in schools, in detention, in the media, or online. They can contribute to the establishment of a community where Māori can enjoy whanaungatanga with access to marae, recreation, socialisation, employment, learning, housing, accommodation, and inclusion within a Māori network.

The appointment of Iwi Māori Partnership Boards has been integral to the 2022 health reforms. Each Board has a mandate to keep Te Aka Whai Ora connected with the experiences of their community, and to ensure local perspectives, knowledge, and strength go into the development of plans so they are fit for purpose at the local level. Timely Māori access to appropriate mental health services and the abolition of discriminatory practices will be on the Boards’ agendas. The Iwi Māori Partnership Boards will ensure Te Aka Whai Ora has a direct understanding of the inequities and barriers experienced by specific communities and local providers and will be taking action to address them.

The role of Māori community leaders will have greater impact when the several ‘hubs’ can be better aligned with each other, creating a stronger voice within towns and cities.

LEVER 6: WHAKAORANGA. THE ROLE OF PEOPLE WITH LIVED EXPERIENCE

The day-to-day effects of mental distress, including associated discriminatory practices, are more readily understood by people who have themselves experienced those impacts. Mā Purapura Mai and Te Kete Pounamu have undertaken nation-wide campaigns to help reduce negative impacts associated with mental distress. They have also continued to advocate for Māori to receive high-quality care and support, while also supporting the development of services that are ‘by whaiora Māori, and for whaiora Māori’.

Lived experience adds to knowledge derived from personal experiences and brings messages of recovery and hope to people in distress.

From an era when discussing mental ill-health experiences was avoided, out of shame and fear of further isolation, Lived Experience voices have encouraged people to speak out, to share their stories and to take a more optimistic view for their futures. They position themselves as evidence that recovery is not only possible but can lead to greater life-fulfilment than previously imagined.

The inclusion of people with lived experience in mental health services has added an element of collegiality and humane understanding but has also encouraged services to focus on the person more than the diagnosis, to avoid discriminatory case notes, and to respect cultural difference. Greater involvement of whānau has been advocated for Māori along with confident participation in te ao Māori.

While the focus has been on people with mental distress, Te Kete Pounamu has also embarked on educational programmes to change popular assumptions and to counter negative attitudes so that participation with whānau on marae, in wānanga, and in whānau celebrations can become the norm.

Te Kete Pounamu and other related groups, use their own experiences to help reshape environments where mental distress and discrimination are rampant. Their focus is on alleviating distress and refreshing conventional practices in services and wider environments.

LEVER 7: TE AO MARAMA. THE ROLE OF NŌKU TE AO

It concludes that all people, especially those funding and delivering health services, have a duty to uphold the mana and human rights of tangata whaiora. Simply treating an illness or making a diagnosis is insufficient.

Nōku te Ao has launched a mission to end prejudice and discrimination of tangata whaiora. The focus is not only on those most affected, or on health services, but also on the wider political and historical contexts that lead to marginalisation and diminished outcomes. Emphasis on Te Tiriti o Waitangi and the promise of article 2, highlights the case for Māori decision-making and Māori governance especially where Māori health and wellbeing are compromised. Similarly, the article 3 emphasis on equity expects that Māori health standards will be at similar levels to non-Māori.

Nōku te Ao has the important role of monitoring progress and continuing to champion the cause for Māori self-determination especially as it relates to Māori health and wellbeing. The aims are that Māori will have greater influence on the health system at both policy and service levels and will experience more positive and relevant outcomes. Making changes and reconfiguring the current system to incorporate Māori self-determination will not be easy or swift. But the groundwork has been laid over the past 50 or so years and a progressive step towards rangatiratanga has been taken. Nōku te Ao will be a central focal point for us as we move towards a reconfigured Aotearoa health system guided by the articles of Te Tiriti o Waitangi, the principles underlining Kaupapa Māori, and an ongoing commitment to equity.

CONCLUDING COMMENTS

CONCLUDING COMMENTS

This report has discussed the wide range of factors that contribute to the discrimination of Māori with lived experience of mental distress. This kaupapa is inseparably linked to and located within wider historical, social, political, and cultural issues. Some of the core issues include: the causes of Māori mental ill-health; differential explanations of health and mental health; the discrimination of Māori; and the discrimination of those with mental distress.

Māori health and wellbeing has been heavily determined by historical trauma, colonisation, and the multiple forms of oppression of Māori world views, mātauranga Māori, and Māori ways of knowing, being and doing.

Colonisation simultaneously forced Māori to assimilate to Pākehā idealised social, political, and institutional systems; the result of which has been disconnection from te ao Māori, and overrepresentation amongst most negative health indicators, socioeconomic status, housing, poverty, and financial security. The impact of these factors on Māori wellbeing and Māori mental health has been significantly detrimental, and Māori mental health needs continue to rise. Māori mental health problems such as depression, anxiety, distress, and suicide are the result of multiple intersectional layers of direct and indirect intergenerational harm. As well as systemic determinants of Māori wellbeing, a core tool of colonisation has been the representation of Māori as the savage, uncivilised native; and through this, the devaluing of the credibility of the Māori mind.

From a te ao Māori wellbeing perspective, the discussions within this document are not new. For example, we have known for a long time that the process of colonisation has included deliberate collusion against the minds of Māori; oppression of Māori intellectual sovereignty; and the use of assessment and labelling of psychological conditions for European colonial agendas. The idea that mental illness is a Western medical concept, created to label behaviours, thoughts and symptoms that were not understood by Western medical doctors is also not new. Our intrinsic, and critical knowing as Māori tells us that in pre-colonial Māori society (and Indigenous societies worldwide), the existence of peoples with mental illness was neither common nor framed in a negative light. Rather, extraordinary peoples were thought of in positive light, framed as ‘gifted’, and valued.

Whilst these ideas are not new to Māori, bringing these concepts together, within the context of Nōku te Ao is critical to advancing the work in this area. Somewhat overdue, the re-launch, re-branding and re-locating of Like Minds to Nōku te Ao is a great step forward to designing and delivering a programme that is conducive to Māori wellbeing and reducing inequity.

As with the newly reformed health system, for too long, Like Minds has operated on models that are neither Māori specific nor effective for Māori. As stated above, strategic and governance commitments, and structural changes have been made that are necessary Kaupapa Māori building blocks. What the current document provides is a collation of Kaupapa Māori thinking (theory) that aims to support and enable Nōku te Ao partners to shift mindsets, and thereby approaches and actions. It is hoped that understanding Kaupapa Māori thinking will support the shifting of mindsets to a Māori world view, and thereby inform the new direction of Nōku te Ao.

For many Māori working in this space, this report may offer an overdue affirmation of their ongoing whakaaro and insights. This is not to say that the kōrero here is not useful, innovative, or meaningful; rather, returning to our whakapapa kōrero, to te reo Māori, Te Ao Māori, and tikanga reaffirms the notion that Māori wellbeing systems are and always have been fit for purpose, flexible and adaptable to changing landscapes.

Hence, it is hoped that this report can support kaimahi by providing some words, explanations, and descriptions for the things they already know. For others, the kōrero here may seem hopeful and yet foreign, simple and yet uneasy, and innovative and yet potentially threatening. Indeed, when you have been operating within environments that are conducive to your own world view, stepping out into the margins, and relocating yourself as the 'learner', ally and supporter can seem daunting. The challenge, for non-Māori is likely to be, being comfortable with relinquishing control and power; with not fully understanding and not expecting to; with trusting in others to lead the way; and at times, putting the money on the table and taking your hand away.

This report is written with optimism, which hopes that Nōku te Ao can and will achieve the promises it has made to te ao Māori. The challenge, for Nōku te Ao partners, and others, particularly senior managers working within Te Whatu Ora, Te Manatū Hauora (Ministry of Health) and other organisations, is to back up those promises with actions, accountability, and affirmation.

Nōku te Ao – This is my world

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