NŌKU TE AO
LIKE MINDS

SERIES 1

MĀORI LIVED EXPERIENCES OF DISCRIMINATION

TE RAU ORA

TE KETE POUNAMU

SERIES ONE

When Māori have the opportunity to share their experiences in a world that is prejudiced against them, and others who have lived experience, there is real potential to reconstruct the impressions of lived experiences from a Māori perspective (Kovach, 2010).

As part of the discovery phase for Nōku te Ao Education for Social Change, Programme Leader Codey Bell invited Māori with lived experience to be part of a series of workshops for a kōrero. The purpose of the workshops were to engage with Māori to discuss wellbeing and ways to reduce judgement and discrimination for those with lived experience. The discussion ranged in topics such as facilitating a response to what wellbeing may mean to each person. This included asking the terms that were best used to describe their wellbeing and journeys. We then invited participants to share their experiences where they had felt judged, and to identify where the areas of focus should be to reduce discrimination.

Of the 16 Māori with lived experience who contributed to the workshops, were 10 Tane and six Wahine who had whakapapa connections to various Iwi from Te Tai Tokerau through to Te Waipounamu.

Wahine: Ngāti Mahanga	Wahine: Ngāpuhi	Wahine: Ngāti Raukawa	Wahine: Kāi Tahu
Tane: Te Rarawa, Ngāti Apakura, Ngāti Whatua	Wahine: Ngāi Tahu	Wahine: Ngāi Tahu	Tane: Ngāpuhi
Tane: Ngāti Kuia, Ngāti Apa, Rangitane, Te Arawa, Ngāpuhi , Waikato Tainui, Ngāti Paoa, Pare Hauraki	Tane: Pare Hauraki	Tane: Ngāti Kahungunu	Tane: Ngāti Hau
Tane: Ngāti Apakura	Tane: Ngāpuhi	Tane: Ngāti Kahungunu	Tane: Ngāti Kahungunu

Table 1. Workshop Participants & their Iwi

Personal stories about lived experience in Aotearoa are scarce (Nairn & Coverdale, 2005) and in particular Māori stories. The human experience of mental and emotional imbalance shared in stories can offer people insights into what life can be like with lived experience and to understand how people are coping (Liebrich, 1999). This Kōrero provides insights from the 16 Māori with Lived Experience about their insights about discrimination and provides an opportunity for outsiders to appreciate their worldviews.

WHAT WE SAY – WHAT WE MEAN

The Māori holistic approach to health, including mental health has been well written by Māori leaders for the last four decades (Durie, 1984). Māori have an appreciation of Māori perspectives and models of health such as Te Whare Tapa Whā, Te Wheke, Te Pae Mahutonga. Aspects of these approaches has included an understanding of Māori perceptions of mental and emotional health and well-being.

"We prefer to use Māori terms such as Mauri Ora, Pai, Hinengaro Mamae, Taimaha, Ngaro and other kupu Māori that are found in Te Reo Hāpai"

For the majority of mental health studies in Aotearoa the phrase 'mental illness' is used as a generic term or substitute for a 'mental health problem' or 'mental disorder' generally drawn from a western oriented foundation (Baxter et al.,2006).

When terms like 'mental distress' and 'mental illness' are publicly utilised in Aotearoa, it tends to imply there are problems with a person's mental health and wellbeing. Yet, blanket terms like this do little to resonate with the people it is referring to who have lived experiences (Liebrich, 1999; Mental Health Commission, 2004). For the 16 participants in Codey's workshops, none of them were keen on the terms mental illness or mental distress.

There is history and stigma with the term ' mental' with that of mental illness and psychiatric institutionalisation that conjures negative images and past experiences associated with mental health services. The purpose of the terms like mental illness and mental distress is to denote kinds of people and conditions, that once named has the ability to constrain the lives of those labelled, who must live intimately with their meanings (Karkazis & Feder, 2008, Barnett & Barnes, 2010).

"I don't like it, you've got the word mental coming in for a group of people that have been institutionalized and [put in] hospital and [placed] apart from others"

'Mental Distress' is a more contemporary term seemingly used in an attempt to reduce the harshness of the term 'mental illness' yet it does little but to describe someone based on their health status in an othering manner.

"I'm not a big fan of the term mental distress"

"Mental distress is just another negative label"

One of the reasons Māori prefer to reject the labelling from a diagnosis of mental illness or distress is embedded in their desire to develop their own sense of meaning and of their experiences, from their own worldviews in order to help with their recovery (Liebrich, 1999; Lapsley, Nikora, & Black, 2002). Often Māori will hold views that refer to ones wellbeing within a broader wellbeing frame that takes into account physical, emotional, social, and spiritual aspects of a person.

"Good exercise and sunlight and other things contribute to the energy you have,
I look at it this way to balance myself out and ensure I am retaining more than I'm letting out"

Some Māori will prefer to view their lived experiences within a Māori cultural context, and by doing so they may construct their experiences as being different from non-Māori and not a sign of distress (Lapsley et al, 2002).

"I think it should be more, especially for Māori whaiora, for us, it should be something like Hinengaro Mamae, or, you know, maybe some of the Kaumatua have got more of an idea, but I think that we could have our own Māori kupu, rather than [using]Pākehā words of' mental distress"'.

Māori possess their own psychology and will locate their experiences within Te Ao Māori constructs to privilege te reo Māori, that also profiles cultural and contemporary perspectives to describe a continuum of wellbeing that includes states of being, of balance and imbalance.

"I look at it as discerning the difference between being in a state of Tapu and being in a state of Noa. So if we look at it from there, any form of agitated state is usually considered the realm of two and the processes and rituals in place that we can counteract those particular states of being, whether it be from previously experiencing some form of trauma or something rather, or any other kind of experience which creates a feeling of agitation within ourselves"

"This is a Mate (un-wellness), things aren't balanced up here, this isn't me inventing the stuff. Once they got it, then I was able to get some real good support around it".

Māori are innately relational who appreciate connectedness to people and places in past, present, and future contexts. There are experiences described about being visionary, that is the ability to see (second sight), and about Makutu or Mate Māori that represent spiritual dimensions and perspectives about balance and imbalances which can be confused by non-Māori as a mental illness.

"It's about resonance and how we connect and how we resonate with other things… it's all about how we resonate within that space, and how we can connect and attune each other… that resonance of connection on the inside and how they're connected to the whenua the Atua and all there and bringing that one before them and that resonance to go to and how we navigate our wairua within those other spaces".

At times, there have been reasons for keeping silent, and why there may be so few Māori stories of lived experiences shared. There is some caution that exists in how much Māori may share about themselves with others, especially from their culturally informed perspectives, in case they're misconstrued for being mentally ill by non-Māori and mainstream mental health services (Lapsley et al, 2002).

"Using terminology like mental distress, I feel from a Māori perspective does not fully sum up what's going on inside us"

Māori lived experiences provide personal accounts, and important perspectives to varying aspects that have influenced the lives and recovery journeys amongst Māori. There are commonalities amongst the few published stories available that have included the enhancement to recovery from the exposure to Te Ao Māori, Māori healing techniques, and the support of whānau.

Conversely, there are as many negative experiences noted especially with mainstream mental health services, and government agencies; though there is an appreciation for cultural contributors toward holistic wellbeing in Māori centred services and by Māori mental health professionals (Fenton, 2000; Lapsley et al., 2002; Mental Health Commission, 2004; Pere, 2006; Barnett & Barnes, 2010; Procter et al., 2013).

Māori with lived experience indeed have benefited from Māori healing techniques such as karakia, whaikōrero, whakawātea, whanaungatanga, waiata, mirimiri and rongoa when it is easily available (Fenton, 2000; Lapsley et al., 2002; Semmons, 2006; Whareweka-Mika, 2012).

Certainly, there are some Māori who have had initial resistance to these (Lapsley et al, 2002), however most Māori have appreciated access to Māori healing approaches that in turn have contributed to their recovery. Māori have also benefitted from accessing Tohunga who incorporated traditional healing techniques (Fenton, 2000, Lapsley et al., 2002, Pere, 2006).

“Seeing a Tohunga and being blessed by him helped my recovery because it helped me to get back in touch with my Māori side. It gave me faith in spiritual things again like karakia, having water sprinkled over me when I was down, visiting my urupā where my old people are and returning to my turangawaewae when I needed to” (Sarah cited in Fenton, 2000).

There are various Māori realities, and for some, time and support are required to aid in the reclamation of ones Māori identity through knowledge of and connection to their cultural heritage. In these situations, whānau have played critical roles to make these connections as they aid in the understanding of the lived experience from a Māori cultural basis and provide access to spiritual guidance (Fenton, 2000). Whānau do hold cultural knowledge that can be passed on to whānau to aid with a person’s recovery, and often it is whānau who access Māori healers on their loved ones behalf. Whānau can provide practical supports such as caregiving, childcare, help in the home and a strong whānau base, with aroha and comfort (Lapsley et al., 2002).

“The way my experience was viewed by my whānau was very, very different from the way it was viewed by the psychiatrists and the nurses. What people call mental distress is what we call Wairangi or Pōrangi, which means existing in another worldly way. A psychiatrist from Switzerland will believe I’m hearing voices and have schizophrenic tendencies, but to a Māori I’m hearing my tupuna talk to me”. “The whānau better understood what was happening for me than I knew myself, and they guided me through a process of kaupapa Māori healing. Mostly reconnecting me with my whenua, my moana, my maunga and my Marae and guiding me through tikanga and matters of wairuatanga” (Tania cited in Fenton, 2000).

However, discrimination can exist within whānau, where there is limited knowledge of how best to support whānau; subsequently a lack of empathy or understanding of lived experience can be one of the most challenging for Māori with lived experience, especially if they are excluded or being constantly judged on past experiences of periods of their unwellness, when they are well in their recovery and thriving.

“ I’ve been socially excluded from my own whānau with family events that the rest of them get to go to… they just consider that I’m mad, crazy. The don’t see how I’ve rebuilt my life and grown on through the years, you know, with the skills that I’ve learned to manage my unwellness”.

“I am excluded by my whānau and communities [I don’t] allow myself to be afraid, upset, down, depressed, and [I don’t] conform to what society expects me to be inside their box of expectations”.

Being connected to one’s cultural heritage provides Māori with a depth of belonging, and this cultural enhancement has the ability to influence and enhance Māori in their recovery and can provide for a culturally safe environment (Tawhai cited in Liebrich, 1999; Semmons, 2006; Procter et al, 2013).

“I never grew up with an attachment to my Māori roots, yet when I become unwell there is a connection there. I seem to sense my grandmother around me. When I was back in the community after a particularly traumatizing seclusion when I was six and half months pregnant, I knew all I wanted to do was to get back up north to where my grandmother was buried. I felt if I did then everything would come right for me. The ward staff involved the Māori cultural team and I was given the most amazing support. They used to come and get me off the ward whenever I needed it and take me to the whare, which was a place of healing and sanctuary for me. More importantly they helped me make connections and links to the people back home in the north, so when my baby girl was born we were able to take a trip back up north to bury her placenta at my grandmother’s feet. There was a huge sense of belonging. To this day, during times of turbulence and extreme distress I want to link back to my turangawaewae. There’s a feeling and sense of safety in coming home” (Kerri cited in Procter et al 2013)

DISCRIMINATION

Pihama (2017) says discrimination is a defining characteristic of colonialism, institutional policies and practices, that have governed the access to resources and power. This forms part of the background for why Māori will experience multiple forms of discrimination over their lifetimes (Cormack, Harris & Stanley, 2020).

At the interpersonal level among Māori with lived experience, discrimination has meant being judged unfairly and treated differently from others, often causing an unnatural segregation from others.

"For me, discrimination [is] that I'm being judged. [I am being] judged by others who actually don't know where I've come from [or] what's happened, you know, all that are assuming that they know me. And they [think] they know, my background, assuming that I'm this way, or that way because (many reasons). So, you know, that for me, when I've been discriminated against, that's how I feel, I feel I've been judged unfairly".

"I think that discrimination is about being treated differently from others. It's us here vs those others over there. It's an unfair judgment, it's based on my unwellness it doesn't take into account my years of being well or the person that I am".

The intimate responses to discrimination has involved deep and painful emotional responses and trauma from the belittling behaviours and words of others toward Māori with lived experience. From a Māori perspective, this is a form of whakaiti or takahe te mana of the person which can have deep emotional and long term consequences.

"I consider discrimination a form of whakaiti (to belittle). It's a form of derogatory language used to belittle someone... I'm cautious that we don't let our people lose their autonomy., by allowing derogatory, diminishing, Mana munching behaviour and language to be accepted by us".

Māori with lived experience have a history of being disrespected, not listened to and in mental health services felt worse off because of the treatment provided (Liebrich, 1999; Fenton, 2000; Lapsley et al., 2002; Whareweka- Mika, 2012). It is even worse when there is a lack of recognition that Māori have a cultural heritage or background by health professionals and government agencies. Which inadvertedly discriminate Māori, who feel disregarded, and then alienated from their cultural identity (Lapsley et al., 2002, Semmons, 2006).

"What I found out in the mental health system is that they know everything about the tinana and the hinengaro but they don't acknowledge the wairua, which to Māori is a big thing" (Ataimihia cited in in Lapsley et al., 2002).

" You're [not] treating them with the same respect, or the same kindness, or the same whanaungatanga. [its] a point of treating them un-justifiably or whakaiti (belittling").

"These so called professionals had no idea of Māori anything. They treated me like some sort of interesting and unique opportunity to experiment with ....there wasn't even the remotest recognition of the fact that I was Māori from a tribal community" (Mako cited in in Lapsley et al., 2002)

Māori participants in Codey's workshops concurred with the history of being discriminated by health professionals and mental health services, and identified that the consequences were far reaching to them personally and collectively.

"We had a Community Services meeting, there was about 14 people around this table, you know, all from different services connected in with social services and mental health... the woman that was chairing the meeting, turned around and said, 'those people' she was referring to tangata whaiora"

Given the need for many Māori with lived experience to maintain contact with certain health and government agencies. There is a real need to have access to Māori professionals who can support Māori with lived experience from a holistic approach that privileges Māori cultural perspectives so that Māori are better supported and understood (Fenton, 2000, Semmons, 2006). For participants in Codey's workshop, they were mindful about how historically Māori were included in past times - not excluded for their imbalance and better understood for their lived experiences within a Māori worldview and response.

"When you had whatever form of Mate, you weren't excluded, you were actually looked at, like, oh this person has this attribute, let's nurture that, they see it that way they don't see it like Oh my god, that person's, hallucinating, our Tipuna didn't see it like that, they nurtured that person.

In this day and age we are shunned whereas previously, we had rongoa Māori take us to the river, or some awa and they would do a blessing over us, they would draw out our strengths, they would utilize the best that we had to offer for the benefit of the hapu or the iwi"

In mental health services, the discriminative approach to Māori has included the unnecessarily high doses of medication prescribed which then produces significant consequences, such as physical side effects (such as dribbling, dizziness, numbing, restlessness, inability to walk or talk, loss of short term memory), over sedation, extreme weight gain and an impaired ability to conduct normal activities in daily life (Liebrich, 1999; Fenton, 2000; Lapsley et al, 2002; Pere, 2006; Eade, 2007).

"What I remember was the lolly trolley, three times a day. Every day it seemed that my pills had changed colour or they'd added another one. No one told me what was going on. They never said anything about my condition. All they told me was I was going to get well. Again, I just [did] what they told me to do. One time I questioned the nurse when she gave me my pills and I asked, "What's this one?" because I knew it was a different colour. She said, "Just take it!" So, I took it, I got up and walked down the corridor and fell over flat on my face. The next time they gave me my pills that blue one wasn't there" (John cited in Fenton, 2000).

"I was on ....eight or nine pills three times a day.......there was a point where I couldn't stand up ...you know, that's how they wanted me to be.........." (Matua cited in Lapsley et al., 2002).

The experience of admission and treatment in acute mental health services is often unpleasant for Māori. Although, many acute mental health units may have updated their facilities in Aotearoa, their models of care are much the same as they were from their institutional pasts - with continual barriers such as exposure to high rates of restraint, seclusion, and high doses of medication (Fenton, 2000; Lapsley et al., 2002; Whareweka – Mika, 2012; Procter et al, 2013). With these constant high rates amongst Māori, this is evidence that discriminatory practice continues in mental health services.

The concerning issue among Māori, is the stereotypical view and impression of Māori men that exists within mental health services. That is, Māori males when seriously mentally unwell will be labeled violent, aggressive, or bad, which in turn perpetuates their being treated with high doses of medication, restraint, and long spells in seclusion (Lapsley et al., 2002, Eade, 2007, Matonga, 2010).

Moreover, as Māori males access mental health services via Police or compulsory committal processes, there is an expectation that physical restraint is used due to their intimidating physical presence (Eade, 2007). When Māori do have contact with the criminal justice system, it is considered a consequence of being unable to access the needed treatment for their mental health issues early (Barnett & Barnes, 2006).

There is no recognition by health professionals or others of the fear Māori experience of mental health services or Police, and the underlying lever for their fighting behaviours to being forcibly attained and treated in an alien environment (Adams cited in Liebrich,1999; Eade, 2007).

> *" it takes Māori twice, at least twice, three times four times as long to get out than it does Pākehā......Stuff like that just sucks....Because to me, we've just got too much spirit, which is not a bad thing, it's just that they don't acknowledge it" (Matua cited in Lapsley et al., 2002).*

> *"For Māori male's police are often called and there could be a standoff, there is a level of safety for all parties. When transferring to the [unit] you have five in the car, two people either side of the tangata whaiora who could be mechanically restrained and two in the front. Sometimes they are medicated but when they get to the [unit] this makes their symptoms lessen which could result in an early discharge. For first time presentations there are security issues if through the Police system. It's not a pleasant experience transferring to the [unit] when you've had to use an injection, sometimes the tangata whaiora is violent, can defecate and urinate during the trip. It doesn't happen often but can. For Māori they might and can over in the paddy wagon. This can be a long and drawn out process. If the tangata whaiora has had to wait for a slot to see a GP, some will make a space straight away and some won't but by the time its gets sorted it could be dark, you're in the back of a paddy wagon, restrained, cold, isolated, and noisy. Length of stay is also an issue especially in seclusion, and with the amount of antipsychotics to bring them down with the side effects of sedation, numbing, dribbling, then there is that fear. (Māori Mental Health clinician cited in Eade' (2007).*

Māori with lived experience have valued the access to Māori healing techniques, Māori health professionals and Kaupapa Māori mental health services. Māori welcome public services that have created various cultural settings and employed Māori professionals and traditional healers to provide for an appropriate cultural model to assist Māori with their recovery (Lapsley et al., 2002; Pere, 2006; Wharewera-Mika, 2012). Such as Māori units that were within mainstream services or standalone, where Māori mental health professionals provided karakia, waiata, a safe place to talk and share, with a range of cultural practices and activities to learn, to identify cultural supports and promote pride in ones Māori identity. Also, promoting and making stronger connections to whakapapa and whānau .

> *"We were able to do things in a Māori way, we had Kaumatua coming in, we had powhiri for people, we'd welcome other people in, you know, things like that...run like a Marae, I suppose"   (Matua cited in Lapsley et al.,2002).*

EMPLOYMENT SETTINGS

Evidence in Aotearoa has recognised that discrimination is commonly experienced by people with lived experience when it comes to employment, housing and in their interactions with public agencies (Peterson et al. 2007). The extent to which Māori experience discrimination is also associated with racism that is embedded in these same institutions, such as health care, the Police and in the education sector (Houkamau, Stronge & Sibley, 2017).

Participants in Codey's workshops shared of their discrimination in the interactions with Public Services such as Work and Income; Housing New Zealand; Police; Health Services and in their employment settings. Many participants held lived experience roles across a range of settings and identified various aspects of where stigma existed. The employment settings was one of the most common themes expressed by the workshop participants about discrimination and stigma in their employment.

"Sometimes it can be in my own mahi workspace and that comes from a lack of understanding on the other party's part, again, straightaway put into a box, you know, and 'Oh, she must be like this because, you know, because she has bipolar. So, she won't be able to cope with that', 'we have to walk on eggshells around her' and that's just not true".

"Clinicians often don't understand the value of lived experience. Peer Support workers refer people to clinicians but it's hardly ever the other way around".

I experience discrimination everyday here at mahi... we [get] new, GP registrar's, coming in from the medical schools [who] know nothing about lived experience. So ,they only know whatever they learnt in the books and with their Doctors... the workforce, and amongst my own family, and of course out in the community.

SUMMARY

Discrimination is about being judged unfairly by others. It is exclusion from the perceived negative differences placed on one group of people by another group of people. When there is judgement, there are assumptions made on people when in reality people may not know a person's experiences, capabilities, or journey. For the participants involved in Codey's workshops, discrimination infringed on their mana and belittled them. The most common observations amongst the participants involved other people's assumptions placed upon them, where they were excluded and treated differently by others.

Terms like mental illness and most recently mental distress were coined globally but do not represent the tangata whaiora of Aotearoa. The terms that focussed on 'mental' limited the comprehensive spectrum of aspects that make up a person's wellbeing. When connecting to Māori with lived experience, the terms mental illness and mental distress do not resonate and are part of a history of discrimination that carries judgement, labelling and stigma. There is a strong recommendation to move away from negative labels and to use more positive, strengths based, holistic, culturally affirming terms.

Māori with lived experience acknowledge the many factors that contribute to wellbeing and appreciate the journey of striving for, finding and maintaining balance between all the things that affect their wellbeing. Many Māori don't like to use clinical and westernised terms to describe their wellbeing and prefer Māori terms such as Mauri Ora, Pai, Hinengaro Mamae, Taimaha, Ngaro and other kupu Māori.

If Māori do use Pākehā Kōrero, they are usually utilising terms to reflect their own Māori perspectives and models of health (Te Whare Tapa Whā, Te Wheke, Te Pae Mahutonga) which go far beyond the westernised bio medical perspectives

Māori do consider the continuum of wellbeing, that takes into account energy, physical wellbeing, emotional wellbeing, environmental conditions, spirituality, and connection to self, others, wairua, and nature.

Māori want to shift away from words that have connotations with past stigma and judgment they have encountered as Māori with lived experience. However, there remains the constant compromise, when Māori have to conform with their language to westernised words and concepts to discuss their wellbeing in the clinical health setting where often there are restrictive, disconnecting, and inaccurate perspectives of the authentic Māori lived experience.

Participants in Codey's workshops identified that the most common environments where Māori with lived experience encountered discrimination and stigma included the health sector (mainstream, mental health services, General Practice, Forensic and Acute Services). They also identified discrimination in Government Agencies such as Work and Income; Housing New Zealand, Police and in their Employment Settings and by their own whānau

SUGGESTED SOLUTIONS

For those of us who have lived experience we have the ability to educate others on the value and importance of our lived experiences, whether this is within the workplace or other places where discrimination is often exhibited. It's important from a Aotearoa perspective, these experiences also include a focus on cultural and natural ways of wellbeing such as connecting with nature, mirimiri, waiata, kapa-haka, dancing and people.

To enable the opportunities for lived experience to have influence, we need to be present at all levels, and across all sectors and groups to ensure we are key to decision making and consulting hierarchy to advocate for Māori so that our voices are heard and valued.

We do need a dedicated focus on indigenous models of health and to stop the use of global westernised models that do not resonate with the people of Aotearoa. Participants from Codey's workshops recommended the following solutions:

EDUCATION

- Increases the knowledge about the levels of discrimination
- Improves the understanding about Diversity
- Improves the understanding of power in relationships, roles, and potential for power imbalance
- Introduces Equity and Māori Health Equity
- Reveals the impacts of discrimination on people with lived experience
- Increases the understanding of Māori perspectives and models of health (for example: Te Whare Tapa Whā, Te Wheke, Te Pae Mahutonga)
- In Health Professional Training and Professional Development: Introduction of the benefits and strengths of Lived Experience and Peer Support Workforces occurs early.

FOR MĀORI LIVED EXPERIENCE LED APPROACHES

- Terms and language that is utilised and promoted is more authentic to the experiences of those with lived experience.
- Pūrakau written and spoken by Māori with lived experience
- Ensure Māori lived experience leaders are in key decision making positions and to support others.
- Strategies and Safety plans established in Employment Settings that employed Māori lived experience workforces.
- More Lived Experience and Peer Support Workforce Opportunities.

Conclusion

The voice of Māori with lived experience offer insights to their worldviews and can increase a sense of understanding for others. The challenge currently with the dearth of stories of Māori lived experience is mixed, in that potentially there is a threat of being pathologised for a cultural perspective of one's lived experience. In contrast, the negative depictions of people with lived experience that exists, will continue to be fed by stereotyping, adding to the stigma of people with lived experience if we do not hear the stories of Māori (Coverdale, Nairn, & Claasen, 2002; Barnett & Barnes, 2010).

The sharing of stories and lived experiences needs to be enacted safely, that it will give voice to people and in doing so, the power of Māori to have the control over their narrative. This will be significant considering the marginalised position Māori have within mental health services, and to a point in Aotearoa. The important message here is there is a need to recognise the human experience and the understanding of Māori, in the search for better understanding, knowledge and with it the elimination of stigma and discrimination of Māori with lived experience.

INFORMATION SOURCES

Barnett, H., & Barnes, A. (2010). *Walk a Mile in Our Shoes: He Tuara, Ngā Tapuwae Tuku Iho Ō Ngā Mātua Tūpuna.* Mental Health Foundation of New Zealand.

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

Cormack, D., Harris, R., & Stanley, J. (2020). Māori experiences of multiple forms of discrimination: findings from Te Kupenga 2013. *Kōtuitui: New Zealand Journal of Social Sciences Online,* 15(1), 106-122.

Coverdale, J., Nairn, R., & Claasen, D. (2002). Depictions of mental distress in print media: a prospective national sample. *Australian and New Zealand Journal of Psychiatry*, 36(5), 697-700. DOI: 10.1046/j.1440-1614.2002.00998.

Durie, M. H. (1984). " Te taha hinengaro": An integrated approach to mental health. *Community Mental Health in New Zealand.*

Eade, L. (2007). *Marlborough Māori Experience in Accessing Mental Health Services Via Primary Health Care: An Exploratory Study: Te Kura Hinengaro Tangata, School of Psychology, Massey University, Turitea, Palmerston North, February 2007, Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of Master of Arts (Psychology),* Massey University, Palmerston North).

Fenton, L. (2000). *Four Māori Kōrero about Their Experience of Mental Distress.* Mental Health Commission.

Harris, R., Tobias, M., Jeffreys, M., Waldegrave, K., Karlsen, S., & Nazroo, J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social science & medicine,* 63(6), 1428-1441.

Houkamau, C. A., Stronge, S., & Sibley, C. G. (2017). The prevalence and impact of racism toward indigenous Māori in New Zealand. *International Perspectives in Psychology,* 6(2), 61-80.

Karkazis, K., & Feder, E. K. (2008). Naming the problem: Disorders and their meanings. *The Lancet,* 372(9655), 2016-2017.

Kovach, M. E. (2010). *Indigenous methodologies: Characteristics, conversations, and contexts.* University of Toronto Press.

Lapsley, H., Nikora, L. W., & Black, R. M. (2002). *" Kia Mauri Tau!" Narratives of recovery from disabling mental health problems*. Wellington: Mental Health Commission.

Leibrich, J. (1999). A gift of stories Discovering how to deal with mental distress: Toby Adams et al. Tell their stories. University of Otago Press. Mental Health Commission: Wellington.

Matonga, A. (2010). *An Examination of Mental Health Service Delivery Changes for Māori since the Mental Health Foundation Report in 2004: A Research Presented in Partial Fulfilment of the Requirements for the Degree of Master of Social Work (Applied) at Massey University, Albany, New Zealand.*

Mental Health Commission. (2004). Our lives in 2014: A recovery vision from people with experience of mental distress. *Mental Health Commission, Wellington, New Zealand.*

Nairn, R. G., & Coverdale, J. H. (2005). People never see us living well: an appraisal of the personal stories about mental distress in a prospective print media sample. *Australian and New Zealand Journal of Psychiatry,* 39(4), 281-287.

Pere, L. M. (2006). *Oho mauri: cultural identity, wellbeing, and tāngata whai ora/motuhake: a thesis presented in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Māori Studies at Massey University, Wellington, Aotearoa/New Zealand* (Doctoral dissertation, Massey University).

Peterson, D., Pere, L., Sheehan, N., & Surgenor, G. (2007). Experiences of mental health discrimination in New Zealand. *Health & social care in the community,* 15(1), 18-25.

Pihama L. (2017). Colonization and the importation of ideologies of race, gender, and class in Aotearoa. In: E McKinley, L Tuhiwai Smith, editors. Handbook of Indigenous education. Singapore: Springer Nature; p. 1–20

Procter, N., Hamer, H., McGarry, D., Wilson, R., & Froggatt, T. (2013). *Mental Health: A Person-centred Approach.* Cambridge University Press.

Semmons, W V (2006).Ko au te wahine Māori : a phenomenological study of Māori women diagnosed with a mental distress and their experiences of pregnancy and childbirth : a thesis submitted in partial fulfilment of the requirements for the degree of Master of Social Work, Massey University. Palmerston North.

Wharewera-Mika, J. (2012). Ahakoa te momo mate, whakanuia tāngata" Mental Health Inpatient Services: Māori needs when extremely distressed. *A thesis submitted in partial fulfillment of the requirements for the degree of Doctor of Clinical Psychology The University of Auckland, New Zealand.*

Bell, C & Maraku, L (2022). Noku Te Ao Education for Social Change Series 1. Māori Lived Experiences of Discrimination. Te Kete Pounamu & Te Rau Ora.

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