Haere mai ki te kapu tī: Come have a cup of tea.

Developing therapeutic relationships

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A research report submitted in partial fulfilment of the degree of

Master of Arts, psychology

at Massey University, Albany, Aotearoa

2022

Abstract

As New Zealander's, when people come to visit, we often welcome them into our homes and offer them a cup of tea. This provides an opportunity to sit together and converse over a cup of tea and generally engage in an enjoyable experience of hospitality and friendship. However, within mental health and addiction clinical environments, this simple act of hospitality can be overlooked due to our clinical Western ideology which inadvertently deems acts of hospitality as unnecessary. This qualitative rangahau (research) explored the blended rivers approach (MacFarlane, Blampied, & MacFarlane, 2011) that suggests that Western and te ao Maori worldviews can be incorporated together like the flow of two merging streams. A narrative inquiry was used to investigate tea ceremonies (the offer of a cup of tea to service users and their whānau) within clinical environments and a thematic analysis was then applied to interpret the six practitioner and ten whānau narratives. The results suggest that introducing tea ceremonies into clinical practice provides a safe space for meaningful engagement. Tea ceremonies provide an opportunity to allow for quiet pauses and reduce anxiety in new, unfamiliar or often sterile clinical environments. When this practise is integrated with pōwhiri tikanga, manaakitanga (the care and protection of people, hospitality) and whakawhanaungatanga (the sharing of genealogy to create connections with others), practitioners are then able to prioritise the development of the therapeutic relationship instead of focusing on assessment, treatment and recovery plans. By engaging authentically with service users and their whānau, practitioners create an mutually supporting and trusting therapeutic relationship which could lead to better outcomes for service users and their whānau.

Acknowledgements

Nāku te rourou, nāu te rourou ka ora ai te iwi.
With your food basket and my food basket, the people will thrive.

This whakataukī has provided the guiding principle for this thesis. With your basket and my basket, the people will thrive: pooling our resources and knowledge can develop interventions that are tangible and can be useful in life. The journey of rangahau is rarely a road that is predetermined. Narrative rangahau proposes a pathway but just as you think you have reached your destination, there is a twist in the road or a detour to be taken. Some lead to dead ends and others to new areas. This has definitely been my experience of this rangahau. Initially practitioner's voices were captured however their narratives produced more questions than answers. So service users and/or their whānau were invited to share their stories. The participant's voice as a collective, produces some hard truths but also offer achievable and practical interventions. This thesis is filled with the participant's personal experiences of mental health services in the Far North District. It is a raw and at times brutal recounting of the difficult environments whānau and practitioners can find themselves in when trying to keep service users safe. I would like to express my sincere gratitude to the practitioners, the services users and the whānau participants who have allowed me to capture their stories, their thoughts, their beliefs and their aspirations for the improvement in mental health services for Māori.

I would like to acknowledge Dr Pikihuia Pomare for supporting my development in becoming a Māori psychologist and sharing your passion and commitment to improving outcomes for Māori. I would like to acknowledge my rangahau whānau (research advisory group): Stephen Allen, Esther Bates, Jaqi Brown, Joan Norman, Shirley Neho, Rangimarie Peterson and Neta Smith for your cultural advice, critical reflection, editing and belief in my chosen area of speciality. Thank you to Te Rau

Puawai for your scholarship, leadership, advice and tautoko of my academic studies. Navigating university, being dyslexic, Māori and an adult student creates many moments of awkwardness in a strange environment. Byron Perkins thank you for always listening and helping me find some sort of balance between work commitments, home responsibilities and my studies. I have really appreciated your honesty throughout the years and your impeccable timing in knowing just when to call me, ngā mihi nui ki a koe.

I would like to acknowledge my kuia, Hokimate Dixon and my matua, Ron Dixon for always picking me up when I have fallen, dusting me off and setting me back on the right path. I would like to acknowledge my children Natalie Allen, Manurereau Allen, Reuben Allen and Maggie Allen who have always been my whānau champions, my cheerleaders and the reason I continue to push myself to step outside my comfort zone. Every one of you are my motivation to learn new skills, techniques and culturally responsive approaches so that I can continue to develop as a mother, wife, daughter, aunty, sister, cousin, friend, colleague and psychologist for the betterment of our whānau, hapū and iwi.

Finally I would like to acknowledge my husband Dave Jenkins who throughout my thesis has kept our home fires burning and consoled me on many occasions when it felt like it was all too impossible and overwhelming. My desire is that this thesis supports the development of authentic and meaningful therapeutic relationships with service users, their whānau and practitioners.

After all of that, surely it's time for a cup of tea.
Grab yourself a cuppa and come along with me.

Glossary

Āhurutanga	Warmth, comfort, creating a safe space
Aki	Denotes a reciprocal action
Aroha	Compassion, love, empathy
Awhi	To support, to surround, to embrace
Hapū	Subtribe
Hui	Meeting or gathering
Iwi	Tribe
Iwitanga	Iwi specific principles, customs and practices
Kaitiakitanga	Guardianship
Kanohi ki te kanohi	Face to face
Karakia	Prayer
Kaumātua	Elder(s)
Kaupapa	Topic
Kaupapa Māori	An approach that privileges the perspectives, beliefs and values of Māori
Koha	Contribution, gift, donation or offering
Koha kete	A bag of supplies for a cup of tea
Kōrero	Conversation, dialog, speech, discourse
Kuia	Wāhine elder(s)
Mahi	Work
Mana	Power, strength
Manaaki	To share, care and protect
Manaakitanga	Sacred obligation to care and protect people

Mākutu	Supernatural, to inflict physical or psychological harm through spiritual powers
Māoritanga / Māoridom	Māori culture, values, practices, beliefs and a Māori way of life
Manuhiri	Guest or visitor
Meihana Model	Māori clinical assessment model
Moana	The sea or ocean
Ngahere	Bush or forest
Noa	Peace
O rātou heahea	Their difficulties
Pā	Māori village
Papatūānuku	Earth, Earth mother and wife of Ranginui – all living things originate from them
Paru	To be dirty, soiled or unclean
Pīnono	Like to beg or elicit an offer in a cunning way
Pōhara	Poverty stricken
Pōuri	Sad
Pōwhiri	Invitation, beckoning, welcoming ceremony and ritual
Rangahau	Research
Rangatira	Leader
Taiao	The environment and natural world
Tātai	The ability to recite genealogy
Tāngata whenua	Local people, indigenous people – people born of the land
Tanga	Used to designate the quality of a base noun

Taonga	Treasure or prized object of social and or cultural significance
Tapu	Sacred, restricted, or prohibited for safety and well-being
Taumata kōrero	Distinguished orators, speaking bench
Te ao Māori	Māori worldview
Te reo Māori	Māori language
Te Whare Tapa Whā	Māori model of health, holistic well-being
Tika	Correct, right or appropriate
Tikanga	Māori principles, lore, protocols, rituals, customs and practice
Tino rangatiratanga	Self-determination
Tohunga	Chosen expert, specialist, skilled person, priest, healer
Tūpuna	Ancestor
Tūrangawaewae	A place where one has the right to stand and belong due to kinship and whakapapa
Whaea	Woman in a respectful way
Whaikōrero	To make a formal speech and the practice of oratory
Whakamā	Being shy or ashamed
Whakanoa	To remove tapu
Whakapapa	Genealogy, descent, kinship, linage
Whakataukī	Māori proverb
Whakawhanaungatanga	The process of establishing relationship
Whānau	Family, kin, can be blood related or not
Whare	House, home

Whenua	Land, country, ground and can also denote placenta / afterbirth

Pepeha

Ko Kirioke te maunga

Ko Punakitere te awa

Ko Te Iringa te marae

Ko Ngāti Tautahi te hapū

Ko Ngāpuhi te Iwi

Ko Agnes Allen ahau

Tihei mauri ora!

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Introduction

The aim of this rangahau is to: 1) describe the practice of tea ceremonies (the offer of a cup of tea at every interview) within mental health and addictions clinical environments; 2) explore how tikanga (Māori principles, customs, lore) concepts of manaakitanga (the care and protection of people and hospitality) and whakawhanaungatanga (the sharing of genealogy so that connections can be made) are implemented; and 3) to explore the potential impact of tea ceremonies and tikanga based engagement strategies for service users and their whānau.

Offering guests a cup of tea upon arrival is common practice in many countries and within many cultures around the world. The sharing a cup of tea is a universal expression of hospitality and respect. However, within psychological clinical environments, a tea ceremony is not common practice. This may be due in part to time poor working environments. It is hypothesised that when engaging with service users and their whānau, the tea ceremony helps to improve rapport and trust as it generates a safe space for meaningful engagement. This safe space is likened to the social work theory of āhurutanga (safe space) when establishing a relationship. The safe space is created by offering an environment that is free from judgement that supports a whānau centred approach to aspirational change and is accepting of all cultural views (Coley, Hona, Tutaki, & Amderson, 2019; Phillips, 2014). The cup of tea is an action of manaakitanga and slows down the clinical interview by creating an environment conducive to pōwhiri tikanga (greeting ceremony), karakia (prayers), whakawhanaungatanga and the sharing of relevant life experiences. The more we share of ourselves, the more relatable we become to service users and their whānau. Therefore, the more connections we make, the better the therapeutic relationship as our

commonalities help to build rapport and develop trust. The role of manaakitanga and whakawhanaungatanga is to develop mana (power, strength) enhancing relationships (Waitoki & Levy, 2016). The simple act of offering and making a cup of tea for service users and their whānau is a powerful engagement strategy that is underutilised and undervalued in clinical environments.

In Japan, the traditional practice of Omotenashi is a formal tea ceremony where one whole-heartedly cares for one's guest (Takeda et al., 2016). It is more than the expectation of being hospitable, it is a sign of utmost respect. Informal tea ceremonies are enacted with the same intent as the Omotenashi practice, to show respect and care for one's guests. In the author's extensive search for tea ceremonies within clinical environments, Hunter's et al. (2008) was the only researcher who specifically investigated tea ceremonies. Hunter identified the importance of offering peppermint tea to Aboriginal/Indigenous Australian service users at the beginning of every clinical interview. Hunter expressed that tea ceremonies signal that usual time has been suspended. This sentiment of suspended time is a similar view to the practice of Omotenashi. Time is positioned within the concept of how long it takes to consume the tea. Hunter puts forward that engaging at this level, has the ability to reduce power inequality as the process is 'humanised' i.e. just people having a cup of tea together rather than the practitioner positioned as the expert. The tea ceremony within a clinical environment challenges the traditional Westernised clinical practice that prioritises the practitioner's time by positioning the practitioner in the role of host rather than expert. Hunter expresses that humbling yourself as the practitioner by making the service user a cup of tea you demonstrate humility, courtesy and respect. Making a cup of tea for service users has the added benefit of providing the practitioner with a momentary gap between clinical interviews and an opportunity to safely transition from one interview to the next.

Taking mirco-breaks between appointments provides mutual benefit. Time to reset and time for the service user to collect themselves.

The current state of mental health in Aotearoa/New Zealand

The New Zealand Health survey (NZHS) is an annual collection of data from a large proportion of New Zealanders which explores the health and well-being of its participants. It provides a general idea of health and well-being experiences for New Zealanders as they report it. Mental health is one of the key issues investigated in this survey. One indicator used to explore participants mental well-being is 'psychological distress' (Ministry of Health, 2020/2021). Psychological distress is defined as psychological or mental distress due to symptoms of depression, anxiety or psychological fatigue in the four weeks prior to completing the survey. The NZHS reported that there was an increase in the prevalence of 'psychological distress' amongst adults in Aotearoa from 4.6% in 2011/12 to 9.6% in 2020/21. The prevalence of this mental health indicator is worse for Māori than non-Māori, as Māori are 1.6 times more likely to have experienced psychological distress than non-Māori. A more specific indicator was depression. Depression is defined in the study as, "having depression if they had ever been told by a doctor that they have depression". The prevalence of self-reported depression amongst New Zealanders has increased from 14.2% in 2011/12 to 17% 2020/21. Yet again, for Māori this difference is even more substantial increasing from 14.9% to 20.6% in the same time frame. These increased rates suggest that New Zealand's current health system is failing to address, support or maintain the mental well-being of its citizens. The failure of our health system is furthermore evident due to the persisting and increasing mental health outcome disparities between Māori and non-

Māori in Aotearoa. Wilson and Barton (2012) put forward that hospital environments are not as healing for Māori in comparison to Pākeha, as Māori cultural and spiritual beliefs are often dismissed in favour of the dominant Western culture. This suggests that processes and practices within clinical environments need to be responsive to Māori needs to reduce the disparities and improve health outcomes for Māori.

Tikanga Māori

Tikanga can be defined as Māori law, cultural and social practices, the principles and protocols of a Māori way of being and/or Māoritanga. Tikanga focuses on the "correct way of doing something" (Mead, 2016, p.7) with **tika** meaning "to be right". Tikanga is performed in a certain way and provides guidance on expected behaviours within earthly environments: whenua (land), ngahere (bush) and moana (sea); social environments; and wairuatanga (the spiritual realm). Tikanga in this rangahau was gathered from academic sources within Aotearoa and collated to aid understanding of how tikanga can be implemented into clinical environments. Tikanga is often adhered to due to the fear that failure to execute rituals in the right way could result in a breach of tikanga. In the past, a breach may have resulted in reprimand, redistribution of resources (food, tools or stock), mākutu (physical or psychological harm through spiritual powers), isolation or death (Mead, 2016). However, with the erosion of some tikanga due to the process of colonisation, Māori customary lore is no longer practiced to the extent it was in the past. Nonetheless, breaches of tikanga can still result in whānau members becoming mentally or physically ill with whānau requiring assistance from health services, kaumātua (Māori elder) and tohunga (expert, specialist or priest) (Durie, 1998; Walker, 2004).

Māoritanga is a collaborative, interdependent philosophy that has a culture, value and belief system grounded upon a holistic and ecological epistemology (Levy, 2007). This produces principles and practices that overlap and are often intertwined, generating multiple layers of tikanga with several levels of actions, understanding and comprehension. The two fundamental tikanga of Māoritanga are manaakitanga and kaitiakitanga (S. Allen, Ngāphui, personal communication, August 27, 2019) and together they underpin all other Māori principles, values and beliefs (Mead, 2016). Manaakitanga is the sacred obligation to care for and protect people and it embraces the concept of hospitality. Kaitiakitanga is the sacred obligation to care and protect Papatūānuku/whenua/taiao - the land and the physical environment. Kaitiakitanga is outside the scope of this rangahau however, it is imperative to acknowledge the importance of kaitiakitanga as Durie (2011b) posits that "the essence of being Māori is to be found in nature or relationships with the environment" (p. 255-256). Thus, the interrelationship between kaitiakitanga and manaakitanga suggests that caring for and protecting whenua is as vitally important, as the care and protection of people. It is difficult to condense all of these terms into a simple definition that serves Western paradigms without diminishing the mana of tikanga due to their multiple and interdependent layers.

Moving towards a bicultural approach

It is in the action of participating in tikanga that the principles and practices develop their meaning, because without the experience, we lack the level of understanding and comprehension of how these values and practices impact upon ourselves and the whānau we work with. This transition from clinical to tikanga

experiential learning can initially be a difficult conversion for practitioners as they are required to possess the relevant training and practicing certificates affiliated to associations that set standards based within a Western-centric epistemology. Clinical training favours the Western individualistically focused reductionist approach to illness and categorises illness as a disease or abnormality, prioritising a psychopathology approach to illness and a preference for pharmacological interventions (MacFarlane et al., 2011). In contrast, indigenous perspectives view illness as an imbalance or absence of well-being due to factors such as environmental deprivation or spiritual, social, emotional and/or mental disconnectedness (Durie, 1998).

In a health context, Te Tiriti o Waitangi, 1840 was forged between Māori and the Crown offering a partnership which involves working collaboratively with Māori to develop strategies for Māori progress; Māori participation at all levels of health planning, development and implementation; and protection so that Māori will have the same level of health as non-Māori while also safe guarding tikanga (Ministry of Health, 2014). Indigenous psychologies have become more widely accepted and legitimised as Western approaches have moved towards incorporating environmental, social, historical and biological factors into psychopathology (Chidarikire, 2012; Pitman et al., 2017).

The Ministry of Health states that it priorities reducing the disparity of Māori mental health outcomes and identified that there needs to be a 'people-powered' health system that moves towards an integrated and 'one team' approach for the health and disability system (Ministry of Health, 2018). Sir Mason Durie developed Te Whare Tapa Wha in 1984 as a way to understand a Māori perspective in health (Durie, 1985). The hui process (Lacey, Huria, Beckert, Gilles, & Pitama, 2011) and the Meihana model (Pitman et al., 2017) have been developed to improve engagement and assessment with/for Māori

service users and their whānau. These Māori models offer practical applications of engagement and assessment tikanga incorporating a holistic Māori view on health. However the transition from Western to Indigenous Māori approaches remains underutilised or disregarded in the current mental health environments in NZ. Haitana, Pitama, Cormack, Clark, and Lacey (2021) strongly recommended the need for systemic change and a reposition of responsibility on to providers to have to deliver culturally safe, competent and equitable health care (p. 8).

MacFarlane et al. (2011) formulated "The Braided Rivers" approach that recognises the ability of Western and te ao Māori knowledge to be blended together in a conducive manner. The braided rivers approach acknowledges biculturalism in research conducted in Aotearoa and does not diminish the mana of either of these knowledge paradigms. Instead, the braided rivers approach advocates for an interconnected approach where the two streams (of knowledge) can merge, overlap or separate without conflict and without the suggestion that one stream is better than the other. Macfarlane et al. suggest that practitioners are therefore ethically and legally required to be bicultural and go even further to offer a self-appraisal format 'Tō Tātau Waka' to support cultural competency. However, what does clinical biculturalism look like in Aotearoa? The ideal is that practitioners utilise their Western training and infuse that knowledge with tikanga engagement strategies such as pōwhiri (formal greeting ritual) tikanga, the hui process and the Meihana model. Accepting Western and te ao Māori worldviews is not about suggesting one is better than the other. Rather it is accepting that there may be situations better positioned within a te ao Maori worldview. If practitioners exercise biculturalism in clinical practice, practitioners honour their ethical obligation of cultural responsiveness which enables culturally appropriate services to emerge (Elder, 2008).

Pōwhiri

Pōwhiri tikanga can be used to guide engagement with Māori. When attending pōwhiri the manuhiri (guests) or "waewae tapu (strangers with sacred feet)" are welcomed on to the marae by way of a karanga (welcome call). The tāngata whenua (people of the land/hosts) engage in the ritual of whaikōrero, offering words of welcome and entering into a process of whakawhanaungatanga, the sharing of genealogy and history of their tupuna (ancestor), their whenua (land) and their whānau (family). This process aims to elicit a reciprocal response from manuhiri (Walker, 2004, p. 73) and creates engagement in a respectful and acceptable manner. Gilgen (2016) refers to "whakawhanaungatanga as the creator of relationships" and the connecting principle that requires the sharing of whakapapa, whānau and career experiences (p. 72). Sharing your hapū and iwi affiliation, your whakapapa and relevant experiences creates a story. This conversation can create a bond between people as it cultivates connection, relevance and sameness between individuals. The way in which whakawhanaungatanga is shared and how much to share, depends very much on the whānau present and the purpose for the gathering.

Once the formalities of the pōwhiri have been concluded, manuhiri are invited to share kai (food, refreshments), an action of manaakitanga and transition from a state of tapu (sacred) to noa (free from tapu). The tikanga around consuming kai works to shift manuhiri (guests) to a position likened to tāngata whenua after the pōwhiri process and is used in many Māori social interactions (Mead, 2016). This transitioning process does not mean that all of the same rights as tāngata whenua are now held to be true for the people who were manuhiri. For example, merely partaking in the pōwhiri process and kai does not automatically give you the right to sit on the taumata kōrero (distinguished

orators, speaking bench) as tāngata whenua to then welcome on manuhiri. This privilege is negotiated and is often based upon one's whakapapa and connections to the people and marae. Manaakitanga is another important practise in the pōwhiri process and is actioned by providing kai. Mead states that manaakitanga is one of the final acts in pōwhiri tikanga. The researcher goes on to suggest that manaakitanga reflects the ideal that the tāngata whenua are now "honour bound" to care for their guests to the best of their ability (Mead, 2016, p. 104). Manaakitanga also supports pōwhiri tikanga as it helps to whakanoa (to remove tapu) waewae tapu. It is a Māori belief that visitors arrive with the spirits of their tupuna (ancestors) alongside them and a process of whakanoa is necessary so there is no conflict with tāngata whenua and their own tūpuna (Walker, 2004). Manaakitanga and pōwhiri tikanga is practised in home environments or when whānau come to visit when we offer them a warm welcome, a cup of tea and a kai. This starts any interaction in a trusting and comfortable setting.

Manaakitanga

"He tangata takahi manuhiri, he marae puehu"

"A person who mistreats his guest has a dusty Marae (Meeting house)"

(Woodward Ltda, 2019).

Whakataukī (Māori proverbs) provide guidance and help with understanding and comprehension of tikanga (Waitoki & Levy, 2016). The whakataukī above reminds us of the importance of exercising manaakitanga, the principle of hospitality, and suggests those who deny hospitality and care to manuhiri willfind themselves alone in their dwelling. In Māori culture, it was seen as a sign of great disrespect when a travelling party passed by a pā (Māori village) without calling in to visit the Rangatira (leader/chief)

(National Library New Zealand, 1879). This action denied the reciprocity of manaakitanga and would have a mana diminishing effect. Hence why when the whakataukī expresses the phrase ‘he marae puehu’ you have a dusty marae as no one comes to visit due to past infringements of manaaki. Your marae becomes dusty and the stigma attached to being unwelcoming is mana diminishing (Mead, 2016).

Barlow (1991) refers to manaakitanga as the most important attribute that a host can possess. The word ‘manaaki’ means to take care of, to protect and can be related to the English term, hospitality. ‘Mana’ is expressed as spiritual power; ‘aki’ denotes a reciprocal action. Therefore, manaakitanga can be defined as a holistic and obligatory principle to exercise care, show respect and kindness towards others and to protect people (Benton, Frame, & Meredith, 2013; H. M. Mead, 2016). Consequently, manaakitanga in a generalised term has been expressed in the English language as hospitality. By applying a more in depth exploration of the term manaakitanga and to ensure the expression of the true depth of the word in te ao Māori one must consider the holistic perspective of the term. In te ao Māori the term is not limited to only those who are physically in your presence, but also to those whom you serve. This includes consideration for the generations yet to come. Protecting people can include exercising care for your colleagues; developing policies and procedures that demonstrate care for service users; advocating for service users in multi-disciplinary meetings or accessing resources for others. This suggests that our role within manaakitanga is also to protect people from those who wish to cause harm to others. In addition, the act of exercising manaakitanga upholds your mana whilst also bestowing mana upon your guest and those you serve. This generates a mana enhancing relationship beneficial to both individuals (Benton et al., 2013). Furthermore, manaakitanga is about being mindful of peoples needs and if you’re able, supporting them to meet those needs through actions of manaaki and aroha

(compassion or social protection). As we have discovered, manaakitanga is an obligation and being hospitable and caring for someone's well-being is mana enhancing. Similarly, making a cup of tea comes from a place of aroha, not from a feeling of obligation or resentment. This conveys that it is a privilege to serve others.

The social aspect of sharing a cup of tea is similar to sharing a meal with others, expressed better through the term 'breaking bread together'. The term breaking bread together in a literal sense was when a loaf of bread was broken into pieces to be shared and eaten with guests. The act of sharing a meal together creates a comfortable and friendly interaction that creates a positive space for social interaction (Seymour, 1983). The cup of tea (ceremony) demonstrates hospitality and when it is used in the clinical environment the practitioner can be likened to tāngata whenua and the service user as manuhiri. Offering a cup of tea and a biscuit is a simple, yet effective way to reach a state of whakanoa. The tea ceremony acts as a cleansing ritual indicating that a balance has been reached (Mead, 2016) and creating āhurutanga (a safe space where spiritual beliefs and cultural values are respected) (Coley et al., 2019; Phillips, 2014). As aforementioned, tikanga is poorly defined using one English word due to the complex and holistic considerations that are implied within Māori culture. Due to this, while there are many definitions referring to hospitality as an English interpretation of the value/term manaakitanga, this is an oversimplification of the meaning behind this word. Manaakitanga is showing respect and caring for others; it is an obligation to protect people; it is a privilege to serve others and be hospitable; there is an expectation that resources will be provided to accommodate people comfortably in any social setting; it is a process of giving and receiving; and a process that is mana enhancing.

Tapu and Noa

Tapu can be explained in different ways and has been expressed as meaning 'forbidden or set apart' (Anderson, 1940), sacred (Walker, 2004),dangerous, privilege or restraint (Tawhai, 1990 as cited in Durie 1998). In a health context, the consideration of tapu is as a protective practice and noa is represented as being safe. Together tapu and noa form a dynamic balancing act (Durie, 1998). It can be likened to a health and safety manual. For instance, Māori do not sit on tables or sit on pillows as this is tapu. With logical interpretation this practise could have become tapu due to the potential health risks and contamination associated with such behaviours. Often tikanga provides a practical knowledge base and guidance system to keep those in the living world safe and well. However, tikanga like tapu, may have been misconstrued due to the influence of Western ideologies and values.

Durie (1998) suggests that early missionaries may have imbued the term tapu with their own "preconceptions, emphasizing superstition, retribution and punishment from the gods" (p. 8). Therefore, this brings us back to the process of breaking bread together, which is used to reduce or remove tapu to achieve a state of noa (Mead, 2016). Smith (1976) identifies that cooked food is associated with the human world, as the gods only ate raw kai. The process of cooking kai, physical contact with cooked kai and eating cooked kai, is the most common way in which to remove tapu in social engagements and has the effect of "reducing the social distance between people" because you are sharing a positive experience together (Durie 1998, p. 9). Applying manaakitanga by implementing a tea ceremony into clinical environments and serving biscuits (cooked kai) offers a simple way in which to achieve whakanoa while also supporting Māori ways of engaging. The tea ceremony creates an environment that is less formal and humanised

(Hunter, 2008) and provides an opportunity to implement the practice of whakawhanaungatanga, a strength based approach that elicits a reciprocal sharing and discovery process between the practitioner, the service user and others present (Elder, 2008). Exercising whakawhanaungatanga creates a space for meaningful engagement that is tika and responsive to the needs of Māori.

A practical example of a Māori engagement model is the hui process, which was developed to support psychologists to improve their clinical practice and improve their responsiveness to Māori service users and their whānau. The hui process identifies four components of a hui: mihimihi in the initial greeting; whakawhanaungatanga – making a connection and building the relationship; kaupapa – identifying the purpose for the hui; and poroaki/whakamutunga – closing the hui (Pitman et al., 2017, p. 8). The hui process has received a high level of satisfaction from practitioners and whānau and is able to be applied to all mental health practitioners. Pitman et al. (2017) identifies that organisations need to take a leading role in providing bicultural professional development training for their employees including cultural supervision to enable practitioners to be culturally responsive.

In summary, the tea ceremony can be used to help create safe spaces to increase whānau engagement whilst also aligning with the weaving of Māori practises such as tikanga, manaakitanga and whakawhanaungatanga into our everyday mental health clinical interactions. Taking the time to make service users and their whānau a cup of tea is mana enhancing and achieves a state of whakanoa that could reduce the power inequality between practitioner and service user. Often English translations and descriptions of tikanga are unable to capture the true essence of the singular word. This is because Western translations or descriptors especially using singular term definitions

lack of depth needed to understand the true meaning or values set by tikanga. This rangahau aims to explore how tikanga concepts of manaakitanga and whakawhanaungatanga are implemented in the mental health services in the Far North, Aotearoa and the potential impact of tea ceremonies and tikanga based engagement strategies, or lack thereof, have had with whānau and service users. In the interest of cultural responsiveness and in order to get the true essence of tikanga, one needs to actively participate in pōwhiri and Māori ways of engaging. Experience it, practice it and live it. This is how practitioners can not only understand Māori terminologies, values and belief systems but also feel the emotional impact and connection that can be achieved through manaakitanga and whakawhanaungatanga. Manaakitanga and kaitiakitanga are the two fundamental tikanga. They are sacred obligations to care and protect the environment, whenua, resources and those gone, those now and those people in the future. How practitioners choose to engage in tikanga within clinical environments is only limited by their own level of understanding, comprehension and competency. Aotearoa practitioners have an ethical and legal obligation to be bicultural. Māori scholars have provided Māori models to support practitioners to be responsive. Organisations now need to accept responsibility for bicultural professional development and allocate appropriate resources ensuring practitioners have access to effective cultural supervision and are competent in using tikanga engagement processes. Research has shown that pōwhiri tikanga and Māori models are an acceptable and effective way to engage with Māori. As a result these initiatives must become a required expectation for all health practitioners working alongside Māori service users and their whānau in order to start addressing the massing inequities in mental health outcomes for Māori.

Methodology

This rangahau is grounded in social constructionism whereby meaning is constructed through an individual's perception of their social experiences (Crotty, 1998; Jonassen, 1991; Lyons & Chamberlain, 2005; Tuffin, 2005). This qualitative study used a phenomenological braided rivers approach to achieve a bicultural methodology which accepts Western and te ao Maori worldviews to flow together into a "workable whole" (MacFarlane et al., 2011; Martel, Shepherd, & Goodyear-Smith, 2022, p. 18). Each stream of knowledge is accepted and has the ability to cross, intersect and separate without conflict or one being more dominant than the other. Narrative inquiry was used to explore if tea ceremonies are used in clinical practice and if so, why were they implemented and how does this effect service users and their whānau. Phenomenology investigates phenomenon through human experiences and focuses on how one constructs their social life (Denscombe, 2010). A thematic analysis was applied to the community voices to identify common intersecting themes and provided a way of understanding Māori experiences and managing the mass amount of data collected (Moyle, 2014; Ware, Breheny, & Forster, 2018). This qualitative data collection is aimed at providing insight into how practitioners contextualise and practice tea ceremonies and pōwhiri tikanga within clinical practice (Bell, 2010; Lyons & Chamberlain, 2005).

There was two target group in this rangahau. The first group was mental health and addiction practitioners within the Far North District, Aotearoa New Zealand, working with Māori service users. The second target group was service users and/or whānau members of service users who had experiences with mental health services in the Far North District. Initially the rangahau was targeted at mental health practitioners, however it was evident from the initial narratives that the voices of service users and their whānau

were needed to give a full and complete picture. Therefore this rangahau was extended to capture both perspectives. The target populations were selected due to the author's location and personal interest in the implementation of pōwhiri tikanga within mental health service. Due to the possibility that Māori may form part of the participant group, it was important to position understanding phenomenon within a transactional and relational ontology as this is shown to be appropriate when engaging with Māori (Clandinin, 2013; Durie, 2011a; Smith, 1999). Kaupapa Māori theory was applied to centralise indigenous values, attitudes and practices to assist in bridging the gap between Westernised clinical practices and culturally responsive and appropriate ways of engagement with Māori (Elder et al., 2009; Moyle, 2014; Simmonds, 2011; Smith, 1996).

Recruitment

The Northland District Health Board (NDHB) Clinical Director was approached to seek permission to conduct this rangahau with current employees (practitioners) working in mental health. Upon approval, an email was sent through the internal email system to perspective participants with an advertising flyer (Appendix 6) and additional flyers were placed on mental health staff notice boards within the Far North NDHB.

It was identified that there was a significant gap in rangahau that explores service users or their whānau perspectives on mental health engagement services. The researcher canvased the Far North District and invited community voices to participate in this rangahau. Advertisements were placed on the Far North social media pages through Facebook and hardcopy advertisements were posted on local community notice boards and placed in doctors' surgeries around the Far North District (Appendix 7). Participants

contacted the researcher and an electronic or hardcopy of the Participant Information Sheet outlining: purpose, aim, objectives, scope, ethics; timeline of the rangahau; contact details for the author, the author's supervisor and the Psychology Department at Massey University (Practitioners Participants Appendix 3; Whanau Participants Appendix 4) was sent out to the perspective participants.

All participants responded by telephone or return email and were screened for eligibility:

1. Over 18 years old
2. Working within the mental health and addiction services or a service user or whānau of someone who has accessed mental health
3. Working/living within the Far North District.

All participants interviewed met eligibility criteria and were sent a voluntary informed consent (VIC) form outlining their voluntary participation (Appendix 5); informing them they could withdraw from the rangahau at any time and confidentiality requirements. The VIC form was reviewed and signed at the face-to-face pre-interview with the author at a safe location of the participants choosing.

In order to practice in this field of work, all six of the practitioner participants have completed relevant university qualifications and affiliated to their respective associations at the time of writing and are therefore bound by their own specialisations code of ethics, confidentiality and professional standards.

17 whānau participants volunteered to participate in the rangahau resulting in ten whānau being interviewed. The researcher interviewed all ten whānau participants as they were determined to have their experiences recorded. Due to the vulnerable population of this group - whānau participants were able to stop the interview at any time and withdraw

from the rangahau at any stage to help maintain their safety and well-being. All participants received contact details for local support services at the end of the VIC form and will receive an executive summary of the thesis findings at the end of the rangahau.

Procedural and Data Analysis Considerations

Interviews

One-to-one interviews using semi-structured questions was selected to uncover participant's experiences of tea ceremonies. The benefit of face-to-face interviews is that they provide an environment that is adaptive and supportive. The author was able to observe verbal and non-verbal interactions and offer support, pause or choose to exit the interview if the participant's emotional state was being compromised. Interviewing has shown to be culturally appropriate for Māori engagement (Oetzel et al., 2015) and it was important that the author honour the lived experiences (Clandinin, 2013) and committed to ensuring that the participants truth was maintained. In order to be culturally responsive, Māori practices of manaakitanga, karakia and whakawhanaungatanga were implemented prior to interview questions. At the end of every interview a koha of $30 gift card was given to each participant and the conclusion of the interview. Whānau participants who were interviewed in their homes, received a koha kete: tea, coffee, milk, biscuits and fruit for the whare and all interviews were closed with a karaka.

Video conferencing applications such as Zoom and Skype or telephone interviews were excluded to ensure the safety of the participants well-being throughout the interview (Massey University, 2015).

Demographic Data

Voluntary demographic information was considered as data for analysis including: age group, gender and ethnicity collected at the pre-interview for the purpose of identifying any differences between participants in regards of their mental health experiences and only used if confidentiality of the participants was maintained.

Narratives

Interviews were recorded for the purpose of accurate transcription. The narratives were transcribed and returned to participants to view, edit and approve before a thematic analysis was applied. All participants chose to accept their transcripts as the researcher had transcribed. Participants were reassured that their stories will be handled with respect, compassion and cultural sensitivity (Massey University, 2015). Practitioner participants were given a first name pseudonym. The whānau participants were allocated a New Zealand native tree pseudonym to associate the participant as a representative of their whānau experience. Pseudonyms were used to protect their identity, their whānau and those whom they support.

A thematic analysis was applied to identify common themes to develop generalisations (Clandinin, 2013) and provided a process to manage the mass amount of text transcribed. The author was the only person involved in gathering, recording and transcribing of the data. The thematic analysis was conducted by the author and guidance was provided by Dr Pikihuia Pomare from the Psychology Department, Massey University and cultural safety was provided by the author's Kuia (female elder) Hokimate Dixon. At the end of this rangahau, an executive summary will be provided to all participants and the Clinical Director of the NDHB. In addition, the findings of this

rangahau will be presented to the Far North Community Mental Health Team later once the rangahau has been finalised.

Ethics

Voluntary Informed Consent and Confidentiality Considerations

The Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants (Massey University, 2015) requires participants to be able to make a voluntary informed decision in which to participate in rangahau. The VIC form was provided at the pre-interview and any concerns were discussed with participants prior to signing the form. Information gathered from participants is held by the author in a safe and secure location. No personally identifying information was used within the rangahau or shared to a secondary source.

Audio files will be destroyed at the end of the rangahau. Transcribed narratives are saved in electronic form on an external drive for the possibility of further rangahau and was communicated to all participants at the pre-interview. All information for the rangahau is stored in a secure environment.

Consideration of Researcher Bias and Cultural Competency

The author is Māori, living in the Far North district and is employed within mental health and addiction services with the NDHB. The potential for researcher bias is present due to the author's cultural beliefs, lived experiences and clinical training (Bell, 2010). To reduce researcher bias, Frewin (1997) seven metaphoric discourses were used

throughout the rangahau to reflect and consciously look further than the differences or similarities; to understand where and how personal epistemological, political and social systems are formed and from what source. The author accepts that as we get more involved and entrenched in rangahau, our perspectives may change as we accept the participants as the experts of their knowledge and experience. Therefore, the author applied a constant critical cycle of contemplative and reflexive thought throughout the rangahau.

The author applied Ethical Guidelines for Observational Studies: Observational rangahau, audits and related activities: the National Ethical Standards (National Ethics Advisory Committee, 2019) and the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants (Massey University, 2017) and the Code of Ethics for Psychologists working in Aotearoa/New Zealand (Code of Ethics Group, 2002). All three documents posit that rangahau conducted in Aotearoa, accepts the principals of Te Tiriti o Waitangi and Māori as tāngata whenua. As such a kaupapa Māori research approach as applied: Māori researcher and advisory group, capturing Māori experiences for the benefit of Maori. As the Far North District is highly populated by Māori, it is inevitable that this rangahau involve Māori participation and therefore requires the rangahau to include te ao Māori to ensure the principals of protection, participation and partnership of Te Tiriti o Waitangi are included in all ethical considerations. In particular, consultation with Māori is required throughout the rangahau to ensure that Māori cultural interests are protected, and their well-being promoted to ensure Māori participation is within ethically sound perimeters. The author's rangahau whānau (research advisory group) consisting of academic and clinical supervisors, kuia, team leader, colleagues and whānau provided cultural guidance and support throughout this rangahau.

Practitioner's Results

This rangahau explored the evolution, practice and purpose of tea ceremonies within clinical practice. Table 1 presents the themes and sub-themes identified by practitioners.

Table 1.

Themes and sub-themes

Themes	Sub-themes
1. Engagement tikanga within clinical environments	• Manaakitanga • Whakawhanaungatanga
2. The psychology behind: 'Can I make you a cup of tea?'	• Establishing rapport • Developing the therapeutic relationship
3. The origins of: 'Can I make you a cup of tea'	• Cultural influences
4. Barriers impeding a reciprocal exchange of manaakitanga	• Manaakitanga in action
5. Clinical Development	• Being authentic • Resources

Six participants volunteered to participate in this rangahau: Maree, Moana, Peppa and Pita are of Māori descent and all whakapapa to one or more of the five Iwi of Muriwhenua (Far North): Te Aupouri, Ngāti Kuri, Ngāi Takoto, Te Rarawa or Ngāti Kahu. Lizzy and Sarah are non-Māori and hail from the United Kingdom. Pita is recognised as a Kaumātua (elder) in the community and the only male participant. All participants were in the age group of 41-60 years old and have been working in mental

health for more than five years. All six participants implemented a tea ceremony into their daily practice when engaging with service users and their whānau within their workplace regardless of nationality.

Theme 1: Engagement tikanga within clinical environments

Manaakitanga

All participants expressed that the act of making a cup of tea was completed from the position of being hospitable and showing courtesy and respect to others. The Māori participants acknowledged that making a cup of tea for service users is just part of exercising manaakitanga.

> *"It's hospitable. It's manaakitanga in practice and just part of my upbringing as Māori that you take the responsibility for hospitality . . . and trying to replicate that in the workplace . . . it's just what we do." Moana*

Maree points out that making a cup of tea for service users:

> *"Establishes a really good relationship, it lets* the[ir] *guards down. . . it might be really simple and basic."*

Peppa suggests that manaakitanga is more than the expression of hospitality:

> *"I ask the community for blankets, sheets, clothing, anything you don't want or fit…and I'll drop it off to certain whaiora (service users) whom I know, will distribute it to other whaiora. I have been known to raid my cupboards and bring in kai (and) when I think a family is suffering and I think they need something. I've paid for doctors' appointments, I've paid for medicines, anything to help them get well."*

Moana cautions us that *"we are judged on the quality of our hospitality . . . (such as) don't go to that place, they don't clean their toilets very well."*

The participants acknowledge that actions of manaakitanga is the main motivator for offering a cup of tea. Be it in their homes or on the marae, it is a cultural obligation of being welcoming and is not limited to whether you were Māori or non-Māori. Manaakitanga was not just about being hospitable but also being able to support service users in tangible ways such as access to clothes, furniture or medicine. Moana infers to the unwritten expectation of manaakitanga that results in judgement from your guests when we do not fulfil their expectation of manaakitanga. This includes not just the refreshments we offer and how we behave, but also the environment we provide as Mead (2016) points out, manaakitanga demands of the marae that the facilities are adequate, well-presented and clean. Our demeanour, facilities and level of cleanliness can encourage or discourage further visits.

Peppa works in an environment where she needs to carry the cup of tea from the staff kitchen down a long corridor and through heavy security doors, balancing the cups of tea while trying to swipe her security card and push through heavy doors results in a very precarious situation and provides some light entertainment for her service users as she struggles to navigate the obstacles of making and delivering their cup of tea:

"It's just taking a little bit of time to show them you care by just making it, balancing it up the hallway, get it to them, you know, they appreciate that and its cracks the eggshell."

This gesture speaks volumes in respect and manaakitanga and is appreciated by her service users and their whānau. All participants describe different acts of kindness and different levels of hospitality representative of manaakitanga that starts with a humble

offer of a cup of tea and creates a space to kōrero, building and developing the relationship as people first and then slowly ease into the concerns that brought the service user in.

Whakawhanaungatanga

All six participants identified a process of engagement representative of whakawhanaungatanga, introducing yourself, ko wai au? Who am I? The way in which practitioners position themselves when engaging with service users and whānau, sets the scene for how whānau engage with practitioners. All participants acknowledged using a process of whakawhanaungatanga to improve rapport and build trust with service users and their whānau.

Pita acknowledges that when meeting service users and the whānau for the first time, the majority of the hui (meeting) is:

> *"Spent developing connections and commonalities so as to build trust…we would go to these home visits and the home visit would take you know, it may take up to an hour and honestly, the first 40 minutes would be like a cup of tea that's the biggest part…where we have got this relationship going and trust is going and everything just slots into place…You know, that first part of engagement, sitting down, getting them to relax a little bit more. Showing them that actually, this isn't so stressful, let's start with a cup of tea and let's not talk about why you're here. Let's just talk about whanaungatanga, connection. I think half the battle is over when you make a connection such as ahh 'I know your aunty' or 'I know your whānau' and that's always beautiful over a cup of tea."*

Maree's role requires a very delicate and strategic approach to engaging service users and their whānau. Maree clearly explains to service users and their whānau:

> *"Who I am, where I am from, so we can start connecting…and then they start, you can see them you know, going wow, oh okay, I know somebody from there…The offer of a cup of tea allows you to get your foot in the door…*[and when] *you've got the connection, you got them and that's when I start talking about other than the resources that we can support them with and that's when we start getting a little bit deeper on how else we can support them, with some of the therapy, treatment or programmes that we can assist them with, but that's a little bit down the track. I think it's (about) establishing the rapport, that whakawhanaungatanga."*

Moana is passionate about developing meaningful relationships with service users and their extended whānau:

> *"It is really important to me to develop a relationship with the whānau as well and that might seem like a give-in but actually a real relationship and that is very significant to me and effects my engagements with them…*[for example] *as I approach the whare or come into the entry way, (I) knock obviously, 'Kia Ora Te Whare!' which is pretty standard, it's what I do with all my whānau, greet the house, and then greet the people. Kia ora whare, and again, if I think about when we are on our marae, you see that, 'Te whare e tū nei, te Papa, e takoto nei', so I greet the house and this lets people know, oh somebody's here. When I come in, I will go around everybody there and give kisses. 'Kia ora, Moana tēnei mwah mwah…so I will act really relaxed and at ease and try* [to] *replicate my experience of what it is like to engage with my whānau, which is hopefully not uncommon amongst our whānau within the community, so again, trying to elicit, a different rhythm or dynamic in how they relate with me."*

Sarah speaks about and an energy source and spiritual connection when there has been an exchange of, ko wai au? For Sarah it is:

> *"Journeying together…energy that floats out, it wants to connect with people and when I have managed to connect with* [people] *and they know that I've connected with them, they know I care, and they know I'm there."*

This is true of all participants' comments, when a connection is made through the sharing of whakapapa or experiences, the therapeutic relationship deepens, and the result is service users and their whānau become more comfortable with the practitioner. Furthermore, Moana pointed out that when:

> *"We act comfortable…and make a point to greet everyone and the whare* [home]*."*

It demonstrates care and respect on multiple levels. It signals to the whānau that we aim to be inclusive and respect that nature of whānau in the care and protection of the service user. The process of whakawhanaungatanga helps to identify those significant whānau members that need to be included in treatment and recovery plans. This is important as whānau offer 24 hours and seven days a week support and insight. One of the benefits to identifying the wider support network of the service user is being able to seek their support in monitoring well-being, safety, and care.

Theme 2. The psychology behind "Can I make you a cup of tea?"

Establishing rapport

What is it about a cup of tea? Sitting and sharing a pot of tea with others is a tradition of many cultures around world. The practice invokes feelings of familiarity,

family and friendship, connection, caring for others, love and generally a time to converse with others about the worries of the day or the concerns of the world. Yet in our clinical environments, we seem to have stepped away from this basic human interaction.

Pita expresses that:

"A cup of tea . . . that's the first thing because I always believe that those first few minutes. That interaction there, is the most important one. 'Would you like a cup of tea' are very simple words, you can see a person relax straight away, sort of like, *'man I'm at home'. Boom and that's where our interaction starts…So for me, the cup of tea would initiate the relaxing…* [and creates a] *nice kōrero environment…I think that a cup of tea just breaks a lot of barriers down and opens up gateways for us or doors…service users are able to verbalise, slow down, think about what they've got to say and that's cool. Because it does, the cup of tea gives them space (to take a breath and) they are a lot more relaxed, and they don't have to speak with pressured vocab and they are able to think about what they want to get across. Which is great, I think it's cool, it's perfect…It's like shaking hands. It's that greeting. Like when you've been karanga on to the marae, had a feed, then that cup of tea, that HAA moment."*

Pita's metaphor of a HAA moment is a deep inhaling breath followed by a deep exhale with a sound added haaaa. This sound and expression creates a sense of relaxation and comfort is a shared experience and understanding throughout participants. That by sharing a cup of tea with service users, creates just enough space to re-centre oneself and talk freely and openly.

Peppa expresses a cup of tea:

"De-escalates them, builds trust and provides a space and time to kōrero about what's going on for them."

Lizzy expresses that:

"Coming into [the clinical] *building is an anxiety provoking experience. So, you want to put them at their ease cause you are going to* [be] *discussing information like anxiety, so you want them to feel at ease with you as a practitioner."*

All participants expressed that the offer of a cup of tea creates a space in which to start a casual conversation before delving deep into the psychosocial issues that may have brought them to seek support. Lizzy, Maree and Sarah all identified that tea ceremonies have a way of putting people at ease and reducing anxiety because it allows time to take a moment, to gather their thoughts.

Developing the therapeutic relationship

Pita states that he offers a cup of tea to:

"Start a conversation mainly…to relax them a bit more to make it feel more homely and to show them that we are not this clinical [sterile environment]*, you're in a clinical setting so everything here should be clinical. So, I think that the cup of tea actually breaks that clinical setting. Keeps it more whanaungatanga, you know whānaunga-ish you know that sort of thing…offering a cup of tea, has the ability to make the transition into people's lives easier."*

Moana puts forward that:

"We have a degree of power to affect people's lives and therefore we need, as practitioners, to use that judiciously."

Peppa expresses:

"You know, our goal, well my goal specifically is to build that therapeutic relationship to a point where, even if my whaiora are telling me something that goes against all [the] *mental health regulations and procedures, I need to have that trust with them and if I don't have that trust, it doesn't work, so…a cup of tea is where it starts."*

While the cup of tea offers an informal setting, Pita reminds us:

"We're human beings, we are always assessing each other, and I think a cup of tea is a really cool way to see where this person is, in regards to being introduced to our facility, our staff, into a new environment."

Maree points out:

"Okay so, at that time, I'm not doing an assessment by my piece of paper, it's all up here (pointing to her forehead, implying mental assessment) so it's just knowing those appropriate questions to ask and depends on who's there [who is present at the time of the interview/interview] *and depends on how relaxed they are. So, for me it would be asking 'talk to me a little bit about what's going on' and I think it just comes naturally even though you don't mean to, you're watching, I hate the word assessing, but you are, you are assessing throughout that whole time."*

The tea ceremony acts like a temporary distraction from the reason for the visit and creates a neutral space between the service user and the practitioner. Moana is supposing that as practitioners, we have a responsibility to realise how our perceived position of status impacts upon the therapeutic relationship. As Pita expressed tea ceremonies are not normally associated with clinical environments, yet implementing a tea ceremony has the ability to reduce power inequalities, as it positions the practitioners as the host, like a servant to the people (Hunter, 2008). This practice paves the way for more informal

conversations that are akin to whanaungatanga and therefore reduce barriers to engagement as we as practitioners disentangle ourselves from sterile clinical practices.

Tea ceremonies offer practitioners an opportunity to observe service users and their whānau without the need for a clipboard and piece of paper and, position ourselves as host and engage authentically. Peppa concludes that without trust in the therapeutic relationship, she is unable to get her service users to be honest about what's going on for them. Which could include social stressors such as homelessness or alcohol or drug use. If practitioners are able to gain the trust of service users, practitioners become privy to all the information and stressors legal or illegal that may be contributing to the recent relapse. Only then can we make treatment and recovery plans that will be effective for service users and their whānau.

Theme 3: The origins of the 'cup of tea' practice

Cultural influences

Peppa recalls her experiences with her Nanny (Grandmother):

"If offered a cuppa tea, you always, you know, I can hear my nanny saying 'now don't be rude, say yes, thank you and you drink it all'. Even if it's in a cup that chipped and hako [not the best looking]*."*

Sarah states:

"It's the first thing Mum says 'do you want a cup of tea love? Sit down. It's welcoming. Just a nice thing to do, I mean I'm English. Everything is a cup of tea. It takes me back to sitting there with Mum. So, it may take you back to (a) nice, comfortable, familiar place, something familiar, its common ground."

It's about developing a connection with someone, in that moment, an expression of kindness and attention and the meaningful engagement with another person. Sarah's Mum wants to make a connection with her daughter.

So where did the practice originate from? Pita expresses:

"Ahh, like the saying, 'all the tea is in China' isn't it. You know, back in the day, it might [not] *have been* [a cup of tea, but] *food,* [the practice of manaakitanga] *it's evolved. I come from a family where all this different kōrero and stuff was handed down to us."*

Maree puts forward that the practice originated:

"With my whānau, my grandparents, my mum and dad…We always had a big pot, not one of those little ones, a marae size one…So that's where it started from."

Peppa acknowledges her new colleagues and praises their training programmes:

"I noticed that our new and up and coming nurses [psychiatric nurses]*, it's ingrained in them already…For me it's the way my family raised me. You know, I don't know whether it's a Māori thing or, or it's an indigenous thing, but when you go to someone's house, my mother wants to feed you, she wants to give you fluids, she wants (you) to have a bed, she doesn't want you drinking and driving, and that's just ingrained in me and I don't know if that's just part of my, because of my mother's kaupapa or my mothers, mothers, mothers, mothers kaupapa, you know. It's just how I was raised, being polite."*

All participants have implemented tea ceremonies as it helps to reduce anxiety and put people at ease within the clinical environment. All participants acknowledge that the practice of offering a cup of tea was culturally ingrained in them through their upbringing,

to always be hospitable when people come to visit which has been adopted into their clinical practice.

Theme 4: Barriers that obstruct the reciprocal exchange of manaakitanga

Manaakitanga in action

When attending home visits, the practitioner switches from the host to the guest. When Moana's is cold calling, she carries with her a koha kete (a bag filled with hospitability items such as tea, coffee, sugar and biscuits):

> *"I will try and use an element, I guess of human (nature). 'I've brought the biscuits whaea (woman in a respectful way), hope you feel like a pīnono (like to beg or elicit an offer in a cunning way) cuppa tea? You know and again that seems to work. So, it is slightly different, because my goal at this point, is to elicit the offer, of some form of refreshment from them. I got my sachets, sweetener - stevia, because some of our whānau are that pōhara* [poverty stricken], *so I take my biscuits, I might need to add tea bags, 'got water? You got running water, a pot or a jug?"*

Pita expresses:

> *"The good thing about* [being] *out there in their environment is that you're being welcomed. I take tea, coffee sachets and biscuits…I would make sure there was fruit or biscuits in our (work) vehicle or drink. So* [when] *we would go to home visits…the first 40 minutes would be a cup of tea."*

Maree states:

> *"I usually take some chocolate biscuits…with me and that works wonders, it really does…even if they don't offer me cup of tea, then that's ka pai* [good]."

These statements are not to embarrass whānau, instead offer a koha or contribution so that whānau can exercise manaakitanga in their home. Lizzy mentioned that she also carries her own cup for hygiene reasons. The belief here is that regardless of the environment, boiled water here is as safe as boiled water anywhere. These practices demonstrate that exercising manaakitanga can be in the form of a koha kete and regardless of whether you are guest or host, by humbling yourself in these situations and being receptive to the offer and acceptance of manaakitanga, you are showing respect towards the service user and their whānau and engaging in a mana enhancing process. However, the transition from the clinical environment to home visits is not without its difficulties.

Sarah identifies:

"I generally don't have a cup of tea when I do home visits, ever. I generally have my water and I say no that's okay, I'll have water. Oh, you're making me think, I should have one and maybe their wanting to have familiar, familiar ground yeah and their introducing it. I kind of made it a habit not too. One, for bladder - where are you going to next and two, I just tend to drink water myself and it didn't occur to me until now really, that's, that's the same kind of ritual. But I don't think my bladder could cope with it, to be honest, tea after tea after tea yeah."

This concern is also expressed by Lizzy. When Lizzy was working back in the United Kingdom, she would express to her service users:

"If you don't mind, it's because I've got an hour ahead and I'm gonna be here for an hour and I know I'd get caught short somewhere and there just weren't enough toilets around along the way."

However, Lizzy also identified:

"But I don't know how that would go here? In this culture, because I know if I refused, that would be classed as rude."

When making home visits, five of the six participants took along some sort of koha kite to service user's homes with the hope if eliciting an offer of a cup of tea. Sarah declined the offer of a cup of tea due to physical and geographical needs. However, during the interview, she made the realisation that declining may have unknowingly reduced the level of interaction. Lizzy acknowledged that it could be culturally inappropriate to refuse a cup of tea because she is denying the whānau the opportunity to exercise their manaakitanga.

All six participants mentioned that the only time that a cup of tea is not offered in clinical environments, is when the service user's current mental state is compromised and could possibly cause an increase in at risk behaviour. For example when the service user presents in a state of crisis,with high levels of paranoia or in an agitated state which may increase the risk of spilling hot drinks.

Peppa explains:

"An example: a client comes in, he won't let me do a baseline OBS [medical observations such as blood pressure and temperature], *he wants the injection, he doesn't want me to talk to him, he just wants me to jab him and get out* [and] *they don't want to be your friend. You just learn who you can and can't go down that road with."*

Sarah states:

"I probably wouldn't offer a cup of tea or coffee if someone is really angry or floridly psychotic, initially and the reasons for that probably would be for risks

really. What if it got thrown? I was just thinking, maybe a cup of tea might help calm things down?"

Sarah was the only participant who identified that maybe offering a cup of tea at this time could help to deescalate the situation.

Moana provides another example when offering a cup of tea is not appropriate:

"When they are nil by mouth for a period because we have to do bloods. I've messed that up once before and have learnt. Well, no bloody body told me…it's like put a sticker on it, so I know."

Moana experience was that she had exercised her manaakitanga and fed one of her service users who was due for fasting bloods, and when it came to her attention, she felt a little bit embarrassed, but was a good learning curve as this would require the service user and their whānau to come back into town another day to complete the fasting bloods requirement. The possible consequences of this mistake by the practitioner could cost the whānau more financial resources in an already restricted budget and extra time from employment to attend during working hours.

Theme 5: Clinical Development

Being Authentic

The Collins Dictionary (2020) defines authentic as being genuine and as an accurate presentation of the facts. Being authentic means you are being honest and forthcoming with information. In the context of this rangahau, being authentic means engaging with people holistically, honestly and with good intentions and being true to who you are and the services you support.

Moana expresses:

"I personally find that being my most authentic self, real me, enables whānau to be [our] *most authentic selves also. I will signpost when I'm switching hats, you know when I want to communicate with them, 'okay so I'm going to put my psych hat on now, okay now I'm going to take it off now' and signposting that to whānau so they know the different perspectives that I am offering and they can make an informed choice."*

As practitioners, expressing which perspective or which hat we are positioning our point of view from can provide more information so that the whānau and service users to make better informed decisions. By providing different perspectives on issues relevant to the whānau, we can initiate relatability between the practitioner and the service user through shared experiences.

For Sarah:

"I think being really honest. I say, I am really honest, really straight up… [and do] *not bring my own stuff to any interview, this is their time, just be present, not thinking about what I'm going to cook for tea…otherwise I don't feel like I am doing a good job because you can feel it, you can feel it if you've lost them."*

Moana shares her experience of attending a professional development workshop run by the NDHB 'Engaging with Māori' the facilitator expressed:

"If whānau are not engaging, then you need to ask yourself, what am I not doing? Not, what's wrong with them…Māori whaiora are overrepresented in DNA [did not attend] *and then stereotyped as unresponsive."*

Moana's statement reminds us, if we are having DNA's then maybe the way we are engaging is not at the right pitch. Being our authentic selves as practitioner's means that

all of our experiences and training are actively present in our engagement with service users. Being present and authentic produces responsive and empathic approaches that increase relatability, understanding and comprehension. The level of information shared is very much dependant on the needs of the service user and the environment one is positioned in. It does not mean practitioners share everything about themselves, just the information that may be relevant and helpful in building rapport, reducing barriers, creating connection and helping to increase understanding and comprehension of the service user's needs.

An interesting observation throughout the rangahau was that none of the participants mentioned that the NDHB was restrictive in their clinical practice nor did any of the participants mention any negative comments about their organisation. Demonstrating that the NDHB is actively engaged and supportive of kaupapa Māori being implemented into clinical services.

Resources

All participants suggested improvements to their clinical environments that would produce spaces that were more conducive for enacting manaakitanga. Two of the participants identified that they did not have the physical space in which to host whānau members while another mentioned that there wasn't a space available in which to hold whānau hui or provide refreshments without navigating heavy security doors.

Pita suggested that what would improve engagement in the clinical environment for the initial meet and greet would be *"a proper tea set, with a tea pot with matching cups."* Pita feels this would signal to whānau that this tea ceremony is just for them (excluding all other service users in the building at the same time) and that time is

suspended until all the issues and concerns have been heard. The intention here is that as the tea pot becomes empty, the kōrero comes to natural full stop, as all the words that needed to be spoken have been shared.

This is reinforced by Sarah:

"It's a privilege to be in a position whereby you hear someone's life story when they walk in and never to minimise that. Never to rush it and I think in my experience when I've honoured that, truly honoured that, and it doesn't matter if the assessment takes two and a half hours, that the quality that I get at that level of engagement and connection is so much deeper and better than ticking boxes and filling in assessments and it's a reminder, you know every time, it's a privilege. No one's going to open up to you if you're rushing things. So, I try and remember that…because it's that one time you have a window, and if you lose that window, your basically saying 'I don't care, I don't care enough about you to sit there and listen to you, I don't care' you know and I do care."

Peppa suggests that whānau friendly spaces that are confidential and safe are needed:

"The DHB put so much emphasis on dollars and times and appointments and boxes, there's no real whānau room where we can sit round a table and…share a cup of tea or share kai. Sometimes Mum's just need to have a vent and we've got no real spaces for them to do that, there's nowhere we can do that, unless I go to their house and then they can do that. And sometimes they're really ugly (loud and aggressive behaviour) but by the time I have left, their happy, they feel like they've been heard."

Lizzy expresses that:

"I need to find the right room, cause I have argued in the past that…one of the rooms is too narrow (and) he needed space…and I knew that room just wasn't right for them [and she suggested going to the local café]…*but it's not always good sometimes* [as] *it can be a little bit too open and they feel self-conscious so they don't always want to open up…I'm also conscious that in the past clients have put complaints in, when they have been interviewed like at certain café, cause other people can hear, so you have to be very careful where you sit."*

Moana shares that in her past clinical environment there was:

"A budget…and we had a hospitality table set up there. It included not only drinks, beverages, but a bit of kai…I did put through a suggestion ([o the NDHB through] *that thing of continuous improvements…I did mention that there should be a budget for biscuits when we do home visits."*

The lack of dedicated space for whānau engagement is limited in all clinical environments due to the small spaces provided in clinical interview rooms. One space has the ability to offer a whānau friendly room size and has a small kitchenette, however the kitchenette is not available all of the time due to staff meetings that consume the space and there are no hospitality resources to stock it. The results show that all services have the capacity to make tea and offer biscuits however, the clinical environments do not have many, if any, whānau friendly spaces. Additionally, the NDHB do not have allocated hospitality budgets and adequate resources to restock hospitality spaces within mental health and addiction clinical environments.

Whānau Results

This rangahau explored whanau experiences of engaging with mental health services in the Far North District. Table 2 presents the themes and sub-themes identified by whānau participants.

Table 2.

Themes and sub-themes

Themes	Sub-themes
6. Therapeutic relationships	• Cultural responsiveness • Environments and approaches to consultation and intervention implementation
7. The effect of mental illness on the whānau	• Communication with mental health services • Drug addiction or mental health? • Whānau burnout • Whānau rights
8. Whānau recommendations	• Whānau request for early intervention services • Service collaboration • Collective responsibility

Ten whānau participants were interviewed and allocated a whānau pseudonym represented by native tree names: Tōtara, Rimu, Pōhutukawa, Kowhai, Pūriri, Tī Kōuka, Kawakawa, Mānuka, Kahikatea and Nīkau. Five whānau participants whakapapa to one or more of the five Iwi of Muriwhenua: Ngāti Kahu, Ngāi Takoto, Te Rarawa and Te Aupōuri; one participant married into Muriwhenua; four participants were Pākeha (those who do not whakapapa Māori) with one being an immigrant to Aotearoa; three participants were service users; one participant was male, all whānau participants resided

within the Far North District. Their narratives were collated into three key themes as identified in table 2.

Theme 6. Therapeutic relationships

Cultural responsiveness

Having culturally responsive practitioners or lack thereof, was a theme highlighted by whānau that was pivotal to the effectiveness of the care they received from the mental health (mental health) services. Pitman et al. (2017) advocate for cultural responsiveness especially when working with Māori and translated cultural competency principles into practical applications initially for medical environments and was adapted to include all clinical environments and psychotherapy spaces. "The hui process" developed by Lacey et al. (2011) guides practitioners through a pōwhiri process and combined with the "Meihana model" aids in clinical assessment. These models identify how components of the practitioner's approach inter-relate for the service user and their whānau. This culturally responsive approach was not the experience of many of the whānau interviewed. Most of the whānau expressed that they felt their cultural values were ignored or disregarded by practitioners.

> *"This young* [Pākeha] *doctor...and so culturally, it was a really bad fit straight away and just had that attitude and* [our son] *was just um, you know, it just didn't fit with him…you've got someone that doesn't even speak the way we speak, you know, doesn't see the way that we see our world." Kawakawa*

> *"I feel, you know, we really need to train like more Māori people into* [these] *positions. You know…there* [was] *no one I could relate to, you know, culturally,*

you know, from the Māori way or in my culture, the Indian way or Pacifica way...they couldn't relate in any of those ways. Just regimental - yeah, basically, this is how it is. So, it's made me feel a bit uncomfortable." Tī kōuka

"There wasn't a lot of whanaungatanga that was shown, just straight into the, it was the doctor, the clinical sort of stuff...Sometimes, I just think from a 20-minute interview, you're giving someone a diagnosis. I was like aye! And there was no cup of tea. He was Pākeha [the practitioner]*…he didn't understand my culture and couldn't speak English properly you know, and it was it was just, it was just weird to be in that space...Most of the people I've dealt with have been Māori or people whom I've formed a relationship with but he was a completely new stranger and no whanaungatanga, no building the rapport, which I thought was weird…And straightaway into a diagnosis. And that was that." Kahikatea*

An emergent value whānau described throughout their kōrero (speak/conversation/lived experience) was the tikanga Māori practice of whakawhanaungatanga. Whānau expressed that whakawhanaungatanga and manaakitanga can produce positive outcomes. Kahikatea recommended that practitioners make time to build the relationship through the practice of whakawhanaungatanga and manaakitanga before leaping into assessment and diagnosis.

"I found going to the sub-acute very welcoming…my sister has been there and that's always been, there's always an offer of a cup of tea…let's got meet outside or meet wherever you need to meet them, and the staff have…been chatty and friendly. And so that's a lot more relaxed than going up to the ward who seem to be very busy." Kahikatea

(The sub-acute unit is a Northland DHB, short term, six bed residential unit with 24/7 care for mental health service users that supports them with their recovery and independence back into the community.)

Nīkau also highlighted the importance of whakapapa in developing the therapeutic relationship. One of the practitioners embodied the practise of whakawhanaungatanga and identified a whakapapa connection which helped to solidify the therapeutic relationship.

> *"I only remember her because we ended up having a* [whakapapa] *connection, which is why I remember her and to this day, as whānau...I'm sure she came around to check on me every day…she even went as far as. I was having an operation down in Whangarei and I had no way of getting home and my partner at the time didn't feel it necessary for him to drive down and pick me up and take me home. So, she actually offered. She drove from Kaitaia to Whangarei, I think she knew that I was still quite fragile. So, she drove down from Kaitaia to Whangarei to pick me up and so yeah, she went above and beyond her service I'd say." Nīkau*

Te ao Māori uses a holistic approach that encompasses the physical, social, environmental and spiritual dimensions of an individual as vital components of their well-being (M Durie, 2011a). The practitioner identified that completing the 5 hour round trip to escort the service user home was part of their mahi (work). In a Western reductionist paradigm, one could suggest that the practitioner operated outside of their professional boundary as this was not directly related to mental health. Whānau and service users are looking for inclusive interventions that acknowledge and accept cultural diversity and that promotes culturally responsive practices and support services. The

practitioner's holistic approach to the service users mental health was highly valued as the service user was unable to manage her grief, physical health and fractured whānau dynamics at the time.

Another common cultural belief highlighted by several whānau was that being Māori included a spiritual connection to the whenua/taiao (land and environment) and all of its inhabitants. Practitioners who possess the ability to actively listen to the concerns of whānau and who support whānau to uphold these values are able to establish good rapport with service users and their whānau. Whānau connections, stories/histories, challenges and experiences can help the practitioner to identify what may be influencing the well-being of their service user. If this relationship is not developed from the beginning, whānau whom experience a loss of trust and connection with their mental health services, will no longer feel like it is helping them. This also makes it difficult for the practitioner to elicit further helpful information from the whānau because of this disconnect.

> *"I remember the first time I went to sub-acute and someone said to me 'oh yeah they start hearing things from birds'. Well, that was* [my girl], *talking to birds and everything and I actually felt really stink because I always brought my kids up that they're getting messages from birds. I always bought my kids up with all that stuff in so I'm glad that it's getting recognized as just a normal thing because I think yeah, that's, that's good you know. You can't say they're getting crazy because they're talking to birds, or they're getting messages like that, because that's part of being Māori... And I think that Māori are, you know, they're connected to their environment they're connected to everything." Pūriri*

"I spoke about the spiritual aspects with them and they just thought I was mad. You know, maybe he got a ghost in there? Maybe he's got some spirits in there causing the voices? The boys used to pick up bones all the time when they were little, you know. Maybe?... I said that aye...You never know!" Kawakawa

Kawakawa was expressing his cultural belief in the spiritual realm and referring to the idea that maybe his son had picked up some negative energy in the past that is affecting his behaviour and making him unwell. However, when whānau expressed this belief, the practitioners ignored them and did not respect that this could be an important part of their son's mental health experience. Kawakawa spoke about having access to tohunga (healer) in the past however the tohunga had since passed away and he had no other way of finding another healer nor did mental health offer a referral or possible contact. This may have been a valuable and effective intervention pathway for this whānau. This information was discounted by the practitioner which continues to create unrest within the whānau today. When practitioners connect with whānau and service users in a culturally responsive and holistic way, whānau feel listened to and valued for their insights and respected for their role of caregivers (who are often caring for their adult children/service users). Nīkau expresses that knowing what she does now of mental health services, she would prefer a Māori practitioner.

"If I had of known that I would have had the choice of a Māori lady first, I probably would have tried the Māori lady...I didn't know I had that choice." Nīkau

It is not always possible to refer service users to Māori practitioners due the shortage of Māori practitioners available locally here in the Far North and even Aotearoa wide. For this reason practitioners within Aotearoa need to be mindful that a Māori way

of being is important to some whānau and how their cultural beliefs may provide an alternative view to westernised clinical knowledge (M Durie, 2011a). "The Braided Rivers" approach accepts the blending of Western and te ao Māori knowledge to promote better outcomes for whānau and service users (MacFarlane et al., 2011). It does not diminish the mana of either of these knowledge paradigms. Instead, the braided rivers approach advocates for an interconnected approach where the two streams (of knowledge) can merge, overlap or separate without conflict and without the suggestion that one stream is better than the other. Practitioners who are open to learning about te ao Māori and how tikanga may be implemented into service delivery, intervention and recovery plans will have better outcomes with their service user's well-being. In addition, having this form of therapeutic relationship could also enhance the well-being of wider whānau of the service user.

Environments and approaches to consultation and intervention implementation

All of the whānau shared kōrero about environments, approaches and interventions that were not seen as effective or acceptable in their experiences with mental health services.

> *"...not very welcoming at all...there was no invitation even to sit down... You know... I travelled like an hour and 15 minutes from here…and with my injuries in my leg…there was nowhere to sit, no comfortable chair, no nothing. So, I actually had to ask for somewhere to sit... It just felt like that she didn't really want to work with me. I felt a little bit uncomfortable about it. But I had, really had no choice. She was the only (one) available and I knew that I needed help and so I persevered. And just stay strong...it's a bit sad because, you know, I'm a*

really friendly sociable person, and you would think a psychologist would be just you know, friendly, welcoming, making you comfortable." Tī kōuka

"So, we walked over to [the locked inpatient unit] *which is the most horrible experience that we've had as a parent, my wife, wouldn't go over. And you know that whole thing of taking someone over there and then you're locked the door and it's like being in a prison that shit. So like, we were like, what have we done?...that place is so cold, it's like going to prison." Kawakawa*

On another occasion, Kawakawa was in telephone communication with the practitioner while their son was in the inpatient unit:

"*So* [our son's] *diagnosis changed a couple of times that week and I rang* [the practitioner] *back and* [shared his thoughts on the proposed diagnosis]… *and I remember at one stage. She said, "Do you think you're Dr. Google?"*

Kawakawa already felt pōuri (sad) for placing their son in such a facility and they were actively trying to understand the needs of their son and work with mental health services to provide the best possible care. This negative experience resulted in the whānau becoming frustrated with the practitioner. They felt undervalued and disrespected. This destroyed any possibility of developing a whānau therapeutic relationship with the mental health team and resulted in the whānau being excluded from the treatment and recovery planning.

First impressions impact greatly on one's ability to connect and relate to another human being and in a mental health context, developing this connection is crucial if service users are to be open and honest with their practitioner. This extends to the working environment in which service users and their whānau are greeted. Inadequate seating or

cramped workspaces can create environments that are unwelcoming. Add to that, practitioners who cannot relate to service users and their whānau and this creates awkward and unsafe spaces.

> *"I saw* [practitioner] *at mental health, I didn't like him. He was an old man. And he just had a cold approach as well... I found him hard to understand because I think he's got an accent. But I just didn't feel, I didn't feel the connection… I felt like he was quite pushy with his answers, with his questions. He was probably being straight up. But I couldn't take that at that time. Yeah, so maybe if he was a bit more soft…I just found him blunt! Full stop… I didn't want to talk because he annoyed me." Kōwhai*

Rimu identified that sometimes practitioners had an approach that appeared to be quite distracted and disengaged. This can leave whānau feeling unworthy or not taken seriously which could negatively impact the therapeutic relationship.

> *"…you'd get maybe one or two that were really good at it. Yeah, then you'll get five or six that were absolutely terrible at it. And they would sit there and express how much their job means* [so much] *to them. And to be honest, they didn't care because as soon as their phone rang, they were on it, then when they finished, they had forgot about what we were doing again. So, I knew straight away that their mind was not on the job…" Rimu*

Whānau reported that they struggled to find practitioners who understood them or who could develop interventions that were personalised rather than a predetermined treatment programme that wouldn't work for them. This led to moments of awkwardness,

disengagement or left the service user in a position where they felt like they had to lie to the practitioner just to get through the session.

> *"… I felt uncomfortable there...And I felt like I was just given worksheets all the time to go and do it at home. And* [it was] *not actually fixing my problems. I felt it was a generic response…I didn't like her approach… She's suggested things like dancing or gardening, which I had no interest in. And I told her that, but she kept pushing for those kinds of things rather than deeper mental, like thinking processes and things like that. I remember just saying 'yeah, I want to do gardening in the end', and you're saying, 'yep, I'm going to do that'. So, she would stop talking about it because she didn't listen the first time. And yeah, I just ended up lying pretty much saying I was... I think if she listened to what I was trying to say. I think she had her set ways, I don't know if it worked for other people. But it wasn't working for me. And she wasn't listening to that." Kōwhai*

Access to interventions such as counselling in the Far North District is limited and waiting times can be up to six months. With the current mental health system that is already constrained by lack of access to human resources such as psychotherapists, engagements like this that are not benefiting the service user and is a waste of precious consultation time for the practitioner and the service user.

> *"…I went into hospital for trying to commit suicide and they said, we're going to get you someone, straightaway a psychologist because that's what you need...and they didn't get me someone for five months, because there was no one else, no other psychologist available... I just felt like pushed to the side...I know, my parents were very upset...I don't know what the word is, but just didn't feel like* [it was important] *that I saw someone. And for me, I thought, if I had seen someone*

straight away, I could have come out of the hole that I was in much earlier." Kōwhai

"I don't think that we would have needed mental health in my family...if there had not been this abuse at different points on my family, on [my] *sisters. They've all experienced* [some] *sort of abuse and I don't think there's enough work done in that space to help them understand what's happened and how to move on from it. And that proper, good proper counselling. I don't think people who enter the mental health system get counselling...I don't think there's any counselling available. I don't know...but no one's ever really sort of helped to deal with it and we didn't know how to deal with it." Kahikatea*

Kahikatea expresses that long term trauma has never been addressed for their whānau over nearly 30 years of being involved with mental health services. They also highlight that access to counselling could have reduced the impact of mental illness for their whānau. A common element in these whānau experiences was that practitioners failed to listen or make a connection and consequently failed to recommend appropriate services.

Another difficulty with building therapeutic relationships that whānau described was that they never got to see the same practitioner for any length of time. Whānau felt they were trapped in a cycle of constantly repeating themselves. This resulted in many disengaging because they were fed up.

"It's really hard because it was already heart-breaking seeing our daughter go through all of that and not being able to, because every psychology or

appointment with the psychiatrist, each month was different. There was never ever any two that were the same they always changed." Pūriri

"… that was just a nightmare because every time they came to see our son it was a new person. Like he'd get one person for like two or three visits, and then there'd be a new person and he just ended up shutting down and saying, "I'm not telling anyone else, anything!"…And then he went to the psychiatrist and he just said, "I'm not talking". And they said, "why?" And he said, "I've always had a different person every time and I'm just not doing this anymore. And I'm not talking to you. And I don't want to be here." Nīkau

"The problem is that the doctors are changing. You know, like every time you, you think you're making headway. And then you go back and then they go "hello, my name is so and so. I'm your doctor now…So we['re] *back to this again, I have to explain myself once again, that needs to stop...I've been repeating myself for 15 years. "Do you people read the paper* [clinical notes] *and see what the problem is?" Because every time I come back here, I get a new face. And I tell the same story." Mānuka*

There are many factors that may influence the changing of practitioners such as availability of human resources; changing employment contracts; a world pandemic; or shortage of trained practitioners. The point extracted from the kōrero is that they would like to have their concerns recorded so that new practitioners are able to see what interventions and support services have been provided already. Therefore, even if there are unavoidable changes to practitioners, effective clinical note taking, and improved handover processes could reduce the need for whānau and service users to constantly repeat themselves and thus provide positive first impressions.

Whānau identified several ways in which the therapeutic relationship could be improved between the practitioner, the service user and their whānau. One way was for practitioners to be forthcoming in sharing their specific roles and responsibilities and why they were important in the treatment planning for their whānau member.

> *"So, I'll get a hold of* [my son's practitioner] *if we've got issues, which is really awesome. ...we had this big conversation with him* [my son's practitioner] *over what his actual role was I think both of us got along a 100 times better…I got the emails and I needed to know what each person did and that's when I found out what each person* [person's roles were] *and then this is after a couple of years of the stuff going on. And once I actually felt that this isn't just their fault, it was my fault too because I kind of thought that they'd all be able to fix the problem. You guys will sort it out, but it didn't work like that. Like I definitely had to know. I had to be involved otherwise it wasn't going to work at my end." Pūriri*

It was often assumed that whānau understood the process of mental health treatment/interventions and whānau lacked the confidence to ask for information when they were unsure. This predicament suggests that there is a power of authority in play. Practitioners who are transparent, authentic and place themselves within a supportive role rather than expert, are rewarded with a therapeutic space that is safe and effective. As Pūriri highlighted when whānau were fully informed and educated about the treatment plan/team they were able to be sure about the importance of everybody's role including their own.

This enabled whānau to explore interventions that were supportive of their way of life and enhanced the relationship they had with their service user. Practitioners who

are authentic and provide environments that are inviting, help make service user and their whānau feel welcome and cared for.

> *"It was just us two in a cosy room with a heater and things like that. And yeah, and they will offer drinks…But she was very, very helpful. I saw her last year… it was more about the thinking like trying to find things I would enjoy...she would read, she'd ask me about how I was since I saw her and actually listen and give advice...not just* [the feeling of] *'hurry up, stop talking, so we can move on to the workbooks'. And then we would go on to workbooks. And she'd do it with me and that was helpful." Kōwhai*

> *"All I know is that it worked for me...because she was just there like she was just straight up... and you know she wasn't like, wasn't in your face too, like not lovey dovey and all of that. She was just like, firm, but you know, that if you needed to cry in* [her] *presence, she was gonna let you do that too, you know, she's not going to shut you off." Nīkau*

Approaches and actions taken by practitioners working alongside whānau to maintain whānau well-being resulted in a collaborated response which improved the therapeutic relationship for the service user and their whānau.

> [Our dad] *has his episodes way more often.* [Our practitioner] *she'll just come out and she just talks him through... Like he doesn't like to not do what she wants him to do. And it's magic. Because you know, when he's not well he gets all bossy with all of us, but not* [the practitioner] *…it just slows his, you know, he starts sleeping again and she might check his medication out and he doesn't get to that really bad place* [full relapse of Bi-polar manic episode]*." Pūriri*

"Well, I did I have one psychiatrist that actually came around to the home and we sat down, and I think we hashed it out for about two hours. And she clearly understood what was going on by the time she left...That was the only time there was the only time that I felt like there was a doctor that actually heard what I was saying. So, I think they psychiatrists need to actually listen to the people, you know, and not just to the patient." Mānuka

Whānau are looking for whānau inclusive approaches when supporting their service user. They are looking for strategies and coping mechanisms that supports their collective way of life and supports them as a whānau to experience whānau well-being.

Theme 7. The effect of mental illness on whānau

Communicating with mental health services

Whānau found it difficult to communicate with mental health services and often felt they were blocked by gatekeepers within mental health. Whānau tried to contact mental health for extra support when early warning signs to relapse were evident and asked mental health for early intervention to reduce the risk of full relapse. However, the response from mental health was not always favourable.

"So, getting in contact with them [mental health] *is a nightmare, they just don't want to know about you unless you say he's going to die… I keep ringing them* (mental health) *could you come and see* (our son)? *'No, no, no'...So in the end, I went in and said I wasn't leaving the office until somebody talked to me." Kawakawa*

"I wanted to make a complaint. So, I went online to search for whoever was in charge of mental health. The closest I got was mental health in government was the highest that I could go to. However, they referred you back to my area. And my area would turn me around and say 'sorry, there's nothing we can do. "Maybe if you're an Auckland, you'd get better service, they get more money." Rimu

Whānau felt frustrated when trying to communicate their needs, they felt shut down and ignored and often retaliated by taking out their frustration on mental health practitioners because there seemed to be no other way to get support for their service user.

"We've got to the point now, with my sister, we can see her unravelling and we want earlier intervention. And they're like "oh, she's not that unwell" I went well, no, no, no, we don't want it to get to the point where she's completely unravelled. And we've got you handcuffing her and taking her." Kahikatea

Kahikatea found that they were had to push mental health firmly for early admission to the Inpatient Unit.

"Take her now and I think that was the difference with the last visit. The police were good. She was on the cusp of, of really unwellness and because this is 30 years of it! I mean, we know, we've dealt with the same spiral, she goes along for so long and then she stops taking her [medication] a*nd we know it's coming...have some faith that the whānau might actually know what they're talking about. That will be the one thing, listen to the whānau...in a real way, you know, also listen to the whaiora* [service user]*. You know, listen to the patient as well." Kahikatea*

The majority of the whānau identified that successful practitioners were those who are actively engaged with the whānau, expressed manaakitanga, listened to their

concerns, answered their questions and took the time to deescalate situations before a Police intervention was necessary.

A whānau centred approach is what whānau are pushing for in these experiences they shared. A whānau centred approach is when the service user is positioned within their wider social network i.e. their whānau. Both play integral parts of each other's well-being. A whānau centred approach acknowledges the importance of the emotional, physical, spiritual and social connection between service user and whānau. This holistic awareness between service user and whānau means that when whānau ask for early intervention this is because they are fully aware of the early warning signs their whānau member is displaying and this is based upon close connection and observation of their service user over their whole life regardless of their mental state. Applying a whānau centered approach means acknowledging the importance of the whānau structure and trusting whānau observations and kōrero when they contact mental health with concerns.

Drug addiction or mental health?

The whānau suggested that mental illness may be hidden and labelled as a drug induced psychosis. Whānau want practitioners to delve deeper into what may be causing the drug use. Pōhutukawa shares how they had been requesting mental health support for their daughter who was afflicted by drug addiction since she was 14 years old. It took an overdose and suicide attempt before mental health engaged with the whānau. The triage doctor at the hospital had requested an urgent assessment from the mental health crisis team. Unfortunately, their intervention was not helpful to the whānau:

> "*...I had already been talking to them* [crisis team] *and they had been saying to me, 'you know, we can't do anything until she gets to this point.' So, I was like.*

Okay, here we are. Now, can you help me?...so they did the assessment. "Well, she's okay. So, we're going to discharge [her] *home". I walked out of the room, and the woman came with me and she's like, "what's going on?" I was like, I've been struggling with this for four years. Everyone's says until she's a threat to herself and someone else or someone else. There's nothing I can do. She's a threat to herself. I can't control her! I can't contain her and I don't have the space. I don't have the skills or, or whatever it is that she needs…"We don't have somewhere to put her...she's actually okay. It was drug induced". And I was just a mess." Pōhutukawa*

"We had some awful experiences with one of my sisters who was an addict and dual diagnosis, the only place for her, who was in the mental health ward, which eventually [she] *escaped from and shot up and died. And was just like, fuck! We tried to get her into a drug rehab thing through that. But there's a real disconnect between those services that needs to be tidied up, it's hard to tell, what is it? Is it a true mental illness? Or is it just the drugs or their lack of access to the drugs?" Kahikatea*

"So, it doesn't matter, if we took meth on Tuesday, Wednesday or a year ago? It's kind of irrelevant...we need to sort out what's making him unwell...so that's the first thing we deal with not... I think for some of the nurses if they think that unwell people using drugs. It changes how they see the patient…" Kawakawa

Whānau are suggesting that drug use is a result of something causing distress, and practitioners should be looking deeper into what is causing the distress and not keep blaming drug use for psychosis or relapse. The implication is that drug use should not change the way in which we see a person or treat a person in mental health. An inability

to effectively provide secure and safe environments has resulted in loss of life and suicide attempts that have increased the demands and stress on whānau. Whānau are left feeling like there is no hope for a better life for their service user.

> *"It's really hard to really save yourself as a mum, but also someone who has an understanding of mental illness and the effects of drugs and alcohol to step back and say, ah, "I'm here if you want me, but I can't be there with you* [in the] *state that you're in". So, I do understand that's heart wrenching. It's more than heart wrenching, it is soul-destroying! ...It's physical, there's been times where I'm like, "Oh, my heart is actually breaking. This is pain." Pōhutukawa*

> *"I have a nephew, had a nephew! Who was with mental health...they say that he took his own life, but I believe it was a few things that happened before that actual incident. I believe that he was pushed from the lack of service, from the lack of accommodation, food, he had not enough money to live off. And to him, I guess it was better to take your own life. But I didn't feel like he just took his own life. I believe he was bullied." Rimu*

Suicide creates uncertainty and the loss of life can be difficult for whānau to find closure always asking, "what if?" and "how could this have been avoided?" mental health in its current state has whānau anxious about who will care for their services user when their parents die, who then will ensure the service user is safe and who will advocate for services for them?

> *"I'm running out of a time, I'm bloody 64 this year and I'm still hoping and praying. You know, my family by saying you should just give up on her* [tearful] *and I say nope, I'm not gonna give up on her. Someone will hear us. But I certainly*

hope it's in my lifetime that those changes happen, you know? Because, boy, I'm really concerned about what's going to happen to my girl when I'm gone." Mānuka

One could suggest that whānau are creating a type of co-dependency between parents and their adult child in a Western context however in te ao Māori, whānau are interdependent of each other. When one member is unwell, the collective wraps around to provide awhi (support) to nurture them back to well-being. However, when whānau aren't around, whānau look to practitioners to help rule out medical conditions or underlying factors such as illicit drug/alcohol abuse that could be masking a mental illness. Whānau look to practitioners to provide information, guidance and support to manage the mental illness and provide strategies for helping the whānau care for service users. Whānau want practitioners to walk alongside them and their service user so that there is more cohesion between services.

Whānau burnout

All whānau spoke about being overwhelmed by the effects of mental illness. They feel frustrated by the constant battle for appropriate support services for the service user and for them as whānau. Whānau sometimes felt defeated in trying to keep their service user safe and burnt out from the constant demands from their service user.

"As hard as you want to be you know, sometimes it's just easier to go and buy a packet of smokes for him because I just need a break. Yeah, and that's like chucking a kid in front of the TV or something." Kawakawa

"She was pushing me away, so I couldn't help her, which I really struggled with…but she wouldn't let me help her." Pōhutukawa

The impact of mental illness causes instability within the whānau unit. Kawakawa and Pūriri had to resign from fulltime employment to be able to better care for their adult children. The added financial burden only increased the demands on the whānau. Whānau became exhausted and burnt out by the constant demands and ever-changing home dynamics.

> *"…it's hard, it's really hard for us. So, the other thing they don't take into account is, with families, is the impact on the family. I whack back heaps of clonazepam, I can get really anxious about it, you know, as well as trying to live…I've got a job, but I've got to pack it in'…I've just resigned...I kind of resigned because not just because of* [our son] *but largely because of* [him] b*ecause I just can't deal with their shit as well as my shit. It's just too much...which means I can't pay my rates, which means we could be put out on the street' I'm doing that because* [our son] *can't be here by himself. And I can't leave his brother here by himself* [to care for his older brother] *...So they don't, they don't really take into* [consideration]*...the impact that it has on the rest of the family." Kawakawa*

> *"…which meant me quitting my job and, you know, going from two paid house to one paid so that my son could come and live with us and that kind of thing." Pūriri*

> "[Our son] *he had some good moments of insight last year, for about two months. And got him to build a cabin with a mate...and then he came home...he still had $12,000 worth of debt that we couldn't get him out of, so I rang the bank. And we talked about ditching...all the interest and everything and I'd pay the principal…It really pissed me off when I was in the mental health place and they said to me, "think of all the other people that can't do this". I thought, fuck, I've got a nice*

view, but I've got no money, you know...I've got no whānau land, I've no one that's going to back me." Kawakawa

Practitioners need to be wary of the way in which they communicate with whānau. Whānau make daily sacrifices for their service user and often there is no regard for the impact of these sacrifices on the whānau unit. Burnout can develop feelings of powerlessness.

The amount of times I've planned a funeral, right down to what she's wearing...[I] *put myself into these states because all I can feel is that, it's death... I'm screaming at every person who's sitting there, because you've been mean to my daughter...That's actually a thing that you do when you're in the state of powerlessness…" Pōhutukawa*

You know, they can be as clinical as they like, it doesn't really matter because they go home aye. They go home every night. We've still got to live with it every day. I've never lived with something so destructive in my life. I mean, really, if he'd thrown himself off the road years ago, that would have been, you know, would have been sad for 10 minutes, you know, a year, or every year on the day he did it, or his birthday or whatever it was before, you'd be a bit sad, but it's gone. It's over. It's finished. It's done. We rock on with their lives. But with this, you see them die every day. You know you have to watch them implode everyday and then, and then the wreckage of that, is on the rest of the family, if you're dealing with it, or we just kick them out." Kawakawa

The thought of planning your child's funeral or suggesting that a child dying is less painful than watching them die a little more every day speaks volumes of the

devastating effect mental illness has on the whānau unit. No parent wants to bury their child before themselves. Practitioners need to be aware of how whānau are managing at home and support whānau to develop coping strategies, provide psychoeducation on mental health and support respite care solutions so that whānau can receive support that maintains whānau well-being.

Whānau identified that when practitioners fail to gather the whānau perspective, they miss the opportunity to include whānau in their clinical discussions and this can result in clinical decisions that are in conflict with whānau values.

> *No one else would take him and my parents are in the 70s, they ended up taking him. And yeah, no one wanted* [to help]*...So if you make those people like my parents…if you make them feel like they're the problem. What is that? How is that going to help? Because there's nowhere else for him to go anyway...But, telling them that they are the problem or telling other people they're the problem. What is that going to do except upset and hurt their feelings and possibly make the ill person, have nowhere to live!" Pūriri*

> *They* [mental health] *always felt like,* [we, her parents] *were the problem, even though she, she didn't live with us* [in the beginning]*... The nurses and all that that were coming up here to see us. They just really felt that* [our daughter] *was just locked in her bedroom, that we wouldn't allow her to see anybody. This was from day one, when they first came up here! We were these really mean parents who, who wouldn't let her go out and wouldn't let her do anything. I just didn't understand. I couldn't understand why they were talking like that, because* [our daughter] *was in the room...like I couldn't believe it. I kind of thought. "Can't you tell she's having you on" You know, should we say stuff? Surely, they know that*

she's having them on?... but no, they didn't. They believed everything she was saying." Pūriri

There is nothing to be gained for blaming whānau for the service user's unwellness or implying that whānau are the reason their service user is acting up. Blaming whānau can create irreversible relationship breakdowns not just between the whānau and the practitioner, but also between the whānau and the service user, leaving the service user homeless, abandoned and/or isolated from their home and whānau.

The majority of the whānau voiced that there is a disconnection between them and their wider whānau due to their lack of understanding of mental health. This can present as whānau not feeling comfortable in sharing their concerns or in the wider whānau pulling away and choosing to have no association with the whānau.

"I think as a single parent, you don't get everything out very often…Because there's some things I'll tell my mum, but she's so judgy…So I just don't talk to my mum about stuff that is bothering me…and you don't want to tell your friends…". Tōtara

"[My son's] *information stays for a little bit but then it's gone. So you have to keep reminding him. He rings me constantly every day. He's like, my teenager that hasn't grown up even though he's in his 20s and he just constantly rings me, he's quite annoying...his siblings say 'naahhh I don't want to talk to him because he just says the same thing over and over again and repeats everything' And I said it's because he's got nothing else to think of. He's got nothing else but the only thing he thinks of is his family. And I said 'I know if it was you in there or me in there, how can I communicate to my family that not listening is just as bad*

[as the way he is excluded from conversations with mental health]… *Because if your own family's not gonna listen to him, mental health isn't gonna listen to him either." Rimu*

"When you're dealing with people who've got mental health issues, you do get…cut out of the family…they're just trying to protect themselves. 'Oh well, we'll just protect our children, we'll protect this and that' and you, you just [get] *cut, they just* [throw] *you out really, you're on your own…My whānau are big, but no one would look after him. I couldn't because I was working…no one else would take him and my parents are in the 70s, they ended up taking him. And yeah, no one wanted* [to help]. *Even my sister who does all the spiritual work, she didn't want anything to do with him either." Pūriri*

Feeling pushed aside or abandoned by your own whānau can be devastating. No longer can they go visit an aunty, cousin, or sister or mum for a cup of tea and friendly and safe place to talk about life's trials and tribulations. When these support networks are no longer available, whānau take on the daunting task of managing alone. This can lead to burnout from the constant demands of their service user. Whānau expressed that more mental health awareness is needed in the community and on the marae to help whānau and hapū reconnect and support each other. Whānau felt that if others could understand the impact that mental illness has on whānau unit and how mental illness effects behaviour, may help the wider whānau to be more accepting and reconnect.

The majority of the whānau interviewed expressed long-term involvement with mental health services with an ongoing lack of resources to support them in their roles as caregivers. Whānau identified that there is not a caregiver benefit available like the elder or intellectually disabled peoples; there is no financial support for housing solutions;

there is no counselling available for whānau; and sometimes mental health services blame whānau for their predicament; add to that the abandonment from wider whānau. It is not surprising that whānau are burnout and do whatever they can to find a moments peace from their service user. Practitioners need to be compassionate when working with whānau as for them, there is no one else for them to turn to turn to be heard or validated. As the practitioner of the service user, you're it, you're their everything, you are the only person who can advocate for services for the whānau. They are looking to you to help them.

Whānau rights

Several of the whānau identified that there needs to be consideration to allow whānau rights in relation to the care and protection of their adult service user under mental health.

> "*I found out that she had more rights, than what I have as a parent and she could refuse, you know, to have me there if she wanted to...I was really sluttered…here am I trying to help this girl and "oh, no, you can't do that. It's against the law"...I'm still having problems trying to get in there to help her because she has rights...I feel so badly that I feel like I've failed her. Because I just can't help her. They won't let me do anything. You know, I have to go see a lawyer, get some sort of a bloody order…I'm just interested in her well-being. It's very hard for me. I feel like I'm just up the creek without a paddle all the time. So yeah, it's very emotional journey. It has been for the last 15 years...Yes. It's very, disheartening when you are trying to help someone you love...I think we as whānau need more rights, if we feel that our children aren't in control of the minds or their lives that we should be able to step in and say no, that's it's enough...So I think that parents*

should have more rights, to say something instead of just being shut out. You know I feel like I've been left out in the cold." Mānuka

"Yeah that the biggest thing aye. Talking with whānau, "what does it mean to be family" and they don't get it [the clinical services). *So you want them to come home. But you don't want us to be involved. Then when he comes home, you don't want to be involved either because you're too busy. Just go to the next case. So you leave them, so they get well, like* [my son] *was really good last year for a while. So why don't you engage with them …instead of waiting until he is unwell again." Kawakawa*

Whānau are advocating for inclusion and rights to:

1. have active involvement in the service user's recovery and treatment plans;
2. be informed of their service users treatment options and progress when hospitalised;
3. be actively involved in discharge planning;
4. be able to take a leading role of care and protection when their service user is in a mentally compromised state.

Whānau are asking practitioners to consult with whānau and use a whānau centred approach to their service users care because they know this going to give them the best chance at recovery.

Theme 8. Whānau recommendations

The aim of this rangahau was to investigate tea ceremonies and tikanga practices of engagement. Whanau participants revealed many concerns and gaps in the mental

health service and were quick to come forward with solutions. Often whānau have been the only ones supporting with service users outside of the clinical environments. This would suggest that their experiences make them the experts and this may suggest that mental health services need to listen to their proposed solutions and early intervention strategies. Whanau are looking for a partnership and want mental health services to work collaboratively with them to improve outcomes for them and their service user.

Whānau request for early intervention services.

Whānau report that the lack of early intervention services in mental health means that they are often left in a position of trying to support their service user with inadequate resources and skills. Whānau often feel let down by mental health and can be overwhelmed by their service user's needs leading to burnout.

> *"He was really bad. I think he'd had enough, he was driving back from a job about the 20th job* [he'd been] *fired from. He said," I just can't do it anymore dad". He was up the top* [of a hill known for suicide] *…and I was thinking. 'Oh just wait there a minute mate and we'll come up, you need to come and talk to the doctor'. Which I thought would have been a pleasant experience. So, we got to the hospital and we got put into the waiting room in the emergency department. And* [we waited at] *ED for ages, hours...and* [my son] *was really losing it. But he had wanted to engage...and I don't know how I managed to keep him there. But every time he told me he was gonna leave. I'd say, 'hang on mate, I've just got to go down to the toilet and then we'll go', you know. I don't know I just found a million excuses." Kawakawa*

In this critical situation the whānau feared for their son's safety. The lack of urgency and response from ED increased the whānau anxiety in an already highly distressing crisis. This was not an isolated incident as the whānau expressed on several occasions the hospital would suggest the service user self-present to mental health.

> *While in Auckland* [our son] *rang the hospital to say that his head was splitting open, and yeah, and he had a big hole in it... I encouraged him to go to the hospital…maybe there's something, who knows to this day…get rid of all those fears…they…referred him to...mental health services. I mean that's just as stupid as you can get. If there's somebody presenting them like that, why would you give them the opportunity to present themselves? Why don't you just take them there! It's so obvious he's not well". Kawakawa*

Whānau need mental health services to provide early intervention process by increasing the level of support that is provided to service users. When service users spiral and become unmanageable, whānau are left no alternative but to contact mental health and the Police for help. By the time the Police and the crisis team arrive there is no time for niceties or whakawhanaungatanga or manaakitanga. The presence of Police and the crisis team can invoke retaliation, aggressive language or violence as the service user often misinterprets their presence. It is in this moment that service users may turn on their own whānau for dobbing them in. This places whānau in the role of a 'nark' and whānau expressed that trying to rebuild a relationship with their service users becomes almost impossible when mental health constantly places whānau in this position. Whānau want more home visits, access to support services such as budgeting, counselling, employment and housing solutions so that relapse can be avoided. Whānau believe that effective early

interventions can reduce the need for hospitalisation and reduce the stress and impact of mental illness on the service user and their whānau.

Service collaboration

Mental health like other government organisations continue to operate within their own organisational bubbles which can disadvantage whānau when they try to seek support for their service user. Sometimes this can create unfair and unjust environments where whānau feel they are constantly battling Government systems. Oranga Tamariki, Ministry of Justice, MSD, Housing New Zealand and the Police are organisations that could benefit from forming a collaborative approach with mental health. Even when whānau propose a solution, if it does not fit with the service guidelines, it's dismissed

> *"When we went to the court case, to ask the court for the drunk driving charge to put him* [under] *the mental health system* [to ask for consideration of his compromised mental state]. *Our community care* [practitioner] *from Whangarei came down with us with all his notes and they just said 'no, he's able to instruct a lawyer so there's nothing wrong with him'. So you just like fighting all the time!" Kawakawa*

In this example, the justice system does not allow for different levels of compromised mental capacity. Kawakawa son may have been able to direct the lawyer based on conversations he'd had prior with his whānau. However, the ability to understand consequences at the time of the incident was due to a compromised mental state.

Rimu puts forward that if mental health and Housing New Zealand worked together, they could develop better housing solutions for service users.

"[My son] *needs a proper place and yet he wants his family and he wants to live on his family land and that sort of thing...it would be good if, if we could count on mental health providing things for him…My brother has mental illness...He has a home which is great. Housing New Zealand has put him in a home, but they put him in a danger zone...my brother's been stood over. He's been bashed, he's been attacked, he's been hurt and they've come into his house, taken over everything and stolen things…he's been asking for years. "move me, can you move me because I don't like this area" and they don't."*

Whānau were quick to offer positive solutions to their concerns. They suggested that the main deficit in current services was accommodation for their service user. Whānau have suggested that HNZ and mental health provide a way for whānau to access cabins to be placed on whānau land or develop villages that offered independent units/cabins for service users, access to places of supported employment, access to gardens, arts and crafts, shared facilities and access to an onsite manager that can provide early intervention support if needed.

"Maybe it's actually about what can they do, instead of just treating it with drugs…I think we need [to] *invest more money in healing places, places...where she could do her art and you know, and allowed to express herself in a in a safe way with whatever that was...like having a cafe, one of those whaiora cafes where they can they go, in Auckland on K road, they offer cheap kai. And it's all, the whole thing is run by whaiora, and they get they get a minimum of pocket money, that type thing or whatever it is, they get free food and they get to think, but it means that they can participate in a normal activity. And if they are unwell than the person who's running it isn't going "oh, bloody hell", you know, the person*

there's going hey bro you might need to sit this one out. And you know, and then come back when you have, you know awhi and it's given him that confidence again...It will be the thing about manaakitanga that we manaaki and create good spaces where our whaiora can just express themselves and participate in a normal way. But in a supported way." Kahikatea

"…instead of ditching Carrington and Oakley and all those horrible places, maybe they just need to change the model. I think it's quite good that there's somewhere for people to stay. You know, maybe they need farms and gardens. You know somewhere [service users] *can go... Put him on a benefit, but don't cut it because he's done some work, you know. He needs a place where he can stay, he can work, where he can actually* [make a contribution to society], *grow veggies for the place, make some money himself, pay off his debt, buy him a new car without the hassle of taking $50 off his benefit and all that shit, you know.* [Our son] *just needs to be on a permanent disabilities benefit forever. You know, whether you're working or not, because they're incapable of working. People like* [our son], t*hey can work a little bit, but they can't function like we do…I think that would be helpful…So I think...that would help, having a place like subacute. But in a nice place not...in town on a farm." Kawakawa*

"A lot of Northland people have been sent to Auckland because there is nowhere to go. And there was a question when my son came out...would I be okay with him going to live in a facility there? And I said, I am. I'm happy for him to do that. But he's not. And he will tell you that. "I don't want to be locked up for the rest of my life". Because that's how he sees it. Yet, if there was a facility where they can be normal, even though it's a struggle. And they count on other people to help them,

you know, through their week that maybe things might change. May be people being on top of things can help them before they even get to the part where they lose it. He needs a proper place." Rimu

Whānau want mental health to work more closely with other organisations so that collectively they could provide services that would make real differences to service users. For example, Housing New Zealand or a housing body provides affordable housing options for service users who have access to land and need capital input to secure a cabin on whānau land. Building homes on whānau land creates a sense of belonging and connection to the land, their people and their identity (Boulton, Allport, Kaiwai, Harker, & Potaka-Osborne, 2022). This same principle could be applied to collaboration with mental health and the justice system that offers advocacy and support and consideration of impaired judgement due to mental illness.

Whānau advocate for social environments where service users feel accepted and where they feel they belong. They support efforts to find a way for service users to contribute to society without losing benefit entitlements. Whānau want their service users to be able to learn from skilled people about the basics needed for daily living such as car maintenance, computer skills, cooking, and budgeting. An environment where they could learn skills useful for employment like hospitality or customer service. Whānau suggest that providing these things in a village type environment could create a safe space for service users to build their capacity to function and contribute positively within society and increase their self-worth.

Collective responsibility

Whānau wanted mental health to provide more practical support to whānau and their service users such as informing whānau of the practitioner's role and responsibilities and what services they can provide. Whānau wanted consistency with practitioners. If practitioners needed to change, that they take the time to read up on their clinical notes, interventions and whānau history prior to working with the service user and their whānau. Whānau wanted access to social workers to provide support for service users when they are being hospitalised so they can maintain their financial responsibility. Whānau wanted a truly whānau centred approach to the discharge planning, recovery plans and transition to home plans so that everyone involved understands the process and responsibilities they have to support the well-being of the service user from a holistic/te ao Māori point of view. Whānau recommended more readily accessible counselling for their service users and more support given to the whānau unit as a whole, so they are better able to cope and manage things at home.

> *"I think that they need to talk about the role that they play* [practitioners], *just explain exactly what they do. You know, if they know about the medications, if they know about you and everything. If* (they are the) *person that you can contact to get a hold of the doctor to make a doctor's appointment. If they're the person that can help you with WINZ...I think it would be really helpful if they were able to share that." Pūriri*

> *"Everything stops while they're being treated and everything just goes on hold and you've still got to deal with this stuff at home as well, their bills to pay, but* [there] *doesn't seem to be any support, there's no one to help them and that's like, gosh it causes double stress...There needs to be a social worker that goes along*

with mental health to make sure that when they come home, they're coming back into a better environment...because quite often they've burnt bridges and people are like, "oh", you know and "they're hoha" and they've got to go back [into possibly hostile environments]*...possibly with anxiety, anxious, stressed way but no one checks on the whānau and say " are you fullers okay?" Nobody does that ever!" Kahikatea*

Whānau challenge practitioners to have courage and stand up for the injustices within mental health so that the problems within the system can be fixed. Whānau want to participate in voicing their concerns so that as collective we can stand together to demand change in the mental health system.

"So, we need doctors that stay for sure. And nurses we need, I think, to make the immediate change, I think they need to have courage in there [inside themselves] *and just be, you know, really voiceful, and open up the problems. And let the parents do... something to help change and we're a whole group of people." Kawakawa*

Whānau advocated for local drug and alcohol rehabilitation centres that incorporate alternative practices to well-being and whānau support groups.

"A Support group...just people coming together and maybe having someone there to guide it...So I have this kind of picture in my mind of what rehab should look like and that there's this detox and it's really intense of physical support. So, whether it's exercise or it's yoga or it's running or it's dance or whatever, but there's this physical support. There's really specific high nutrient food and all the things whether it's just the things to bring the body and the mind to just get some

healing happening on a biological level. Then there's the next phase which is behavioural, mental, emotional rehabilitation and what are your traumas and doing the different work that way. But bodywork and then also having creative outlets. So, there's art, there's sports, there's music, there's dance, there's all these things...Someone with mental health problems needs double the amount of physical activity, like you've got to move that stuff. And it doesn't just have to be you know, Star jumps and boxing like dance, swim, you know, just something being in nature, connect and grounding." Pōhutukawa

Whānau are calling for holistic approaches to mental health services and call for organisations/services work collaboratively to provide effective services. Whānau are the key element to the service user's well-being. The practice of whānau exclusion must stop.

Discussion

Whakataukī: He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata.
What is the most important thing in the world? It is people, it is people, it is people

This whakataukī is from the waiata (song) 'Hutia' composed by Hirini Melbourne and reminds us of what is the most important thing in this world, it is people and includes the connections we make and the relationships we develop (Mead, 2001).

Therapeutic relationships

> "As psychologists you frequently have as your clients, Māori people. The challenge I put to you is: Do you seriously believe that you with the training you get, are able to nurture the Māori psyche?" (Turia, 2001, p. 27).

Turia's comments published 21 years ago, are still relevant today and remind us that professional training in psychology remains positioned from a Western worldview producing clinical environments that are not always culturally responsive to the needs of Māori. Our working environments are considered to be a place of gathering and social interaction and as such the practitioner becomes the host. This can challenge our Western clinical ideology of supposed elitism, whereby the practitioner is placed in the position of expert and position Māori from a perspective of deficiency rather than the perspective of potential and possibility (Waitoki & Levy, 2016). Tikanga based models such as Te Whare Tapa Whā (Durie 1985) are based within a holistic view to health and well-being embodying taha hinengaro – the mind, taha tinana – the body, taha wairua – spirituality and taha whānau – family. The model posits that when all four elements are in balance,

well-ness is achieved. The Meihana model (Pitman et al., 2017) is a multidimensional clinical assessment tool adapted from Te Whare Tapa Whā and considers the diverse and holistic needs of service user and their whānau. The hui process (Lacey et al., 2011) provides a practical engagement strategy process for engaging with Māori. These tikanga based models aim to reduce the misdiagnosis or mistreatment of Māori (Ardila, 2005). Regrettably, the uptake of these tikanga based models remain secondary to our Western training (Levy, 2007). Bennet, Fleet, and Babbage (2014) posit that Māoritanga and Western clinical psychology diverge on many levels. This convergence can be better articulated through the braided rivers approach (MacFarlane et al., 2011) which posits a shift away from the dominant mainstream paradigm towards a place of learning how Western and te ao Māori worldviews and can merge, overlap, interconnect, separate and reconnect at different times and for different purposes for the 'goal of learning rather than assimilating' (Arago-Kemp & Hong, 2018, p. 8). The intention here is not to shun our Western training, as there are many benefits to be had from those teachings, but to acknowledge that Māori models of health, engagement and assessment already exist for use within clinical environments.

Practitioners are legally and ethically bound to be responsive to Māori needs however, their stance is of a passive and stagnant nature resulting in failure to practise a bicultural approach due to a lack of training and opportunities to apply Māori models of care (Pitman et al., 2017). By viewing well-being from a te ao Māori/holistic perspective, taha whānau is an element that needs to be nurtured and supported alongside taha wairua, taha hinengaro and taha tinana to achieve complete well-being. This rangahau identified that whānau often felt excluded from mental health services and assessments due to differing worldviews on well-being. Whānau are requesting mental health interventions that acknowledge and accept cultural diversity and promote culturally responsive

practices. Whānau are advocating for a whānau centred approach that accepts and respects the role of whānau and positions the service user as part of a collaborative and interdependent whānau unit. A whānau centred approach acknowledges the importance of the emotional, physical, spiritual and social connection between service user and whānau. Each member of the whānau unit may move independently but ultimately they move, develop and work as a collective for the benefit of the whole whānau and hence create whānau responsibility for achieving well-being at an individual and at a whānau level. This suggests that practitioners must prioritise the inclusion of whānau when engaging with service users and spend time developing a collaborative therapeutic relationship that works towards achieving whānau well-being. Tea ceremonies are well placed in providing opportunities for practitioners to engage in tikanga practices of pōwhiri in any clinical setting with ease.

Tea ceremonies help to develop connections, rapport and trust with service users and/or their whānau and concentrates on building the therapeutic relationship before attempting to complete assessments, clinical analysis, treatment or irrelevant and unacceptable recovery plans. The only time that tea ceremonies may not be suitable is when the service user is in a crisis situation and the cup of tea becomes a safety hazard. During these stressful environments there is generally no capacity for pleasantries as the whānau is operating in crisis mode and trying to keep their service user safe. These moments call for practitioners to be compassionate towards the whānau and acknowledge the difficult and dual position they are placed in. The way in which you approach the service user and their whanau, directly effects their response. Consequently, whānau advocated for practitioners to slow down and stop rushing into clinical assessments as assessments without whānau input can lead to a misdiagnosis and therefore disagreement about the proposed treatment (Pitama et al., 2007). Practitioners who are open to learning

about te ao Māori and how tikanga may be implemented into service delivery will develop trusting therapeutic relationships with service users and their whānau which will lead to better engagement and outcomes. This suggests that practitioners need to take personal responsibility to position themselves alongside culturally responsive practitioners/supervisors to learn how to implement Māori models of health and tikanga practices of engagement into daily practice just the same as they learn assessment and psychotherapy techniques (Fernandez, 2015; Manna, 2002).

Manaakitanga

Tikanga Māori is underpinned by the fundamental principle of manaakitanga, the nurturing of relationships and care and protection of people. Manaakitanga is commonly expressed as hospitality. However, manaakitanga is much more than being hospitable. The principle includes the expectation that you will care for others through offering hospitality; it requires a reciprocal notion of humility and respect; it is the offer to exercise manaakitanga and the acceptance to allow manaakitanga to be executed; it is consideration of intergenerational, historical, current and future concerns of people; including accessing and the redistribution of resources to those in need; it can also encompass developing whānau inclusive policies and procedures; advocating for the service user; and being authentic in exercising manaakitanga. As a result, through the actions of manaaki, aroha and social protection, manaakitanga bestows mana upon people and therefore creates mana enhancing relationships. It is important to point out that offering hospitability from a position of resentment is mana diminishing, insulting and disrespectful. Manaakitanga has no limits and no restrictions per se other than to manaaki

people and be a genuine expression of care and protection, as the whakataukī proposes. What matters most in this world? It is people.

How does this relate to sharing a cup of tea? Making a cup of tea for others is manaakitanga in action. Offering a cup of tea at the beginning of all clinical interviews is the first step. Actually, making the tea for service users and their whānau is part two and making yourself a cup of tea could be suggestive of part three of the process of a tea ceremony. Sitting and conversing while having a cup of tea together develops a neutral environment. The action of drinking tea together creates a safe space in which to start a conversation and it is representative of how we engage with guests in our homes or on the marae. We come together as people first rather than the clinical titles that can cause a hierarchical segregation and power inequalities. During the tea ceremony, time seems irrelevant as the conversation is more akin to that of friends and family discussing issues and concerns together. In this space, the cup itself offers a temporary distraction as we lift the cup to our mouths and drink the tea, this creates a natural quiet moment and a pause in the conversation. This natural pause allows for the practitioner to contemplate how the interview may be best facilitated or consider the meaning of the service user's kōrero and then which models or theories may be more suitable. While the service user gathers their thoughts before moving into the next topic of discussion.

Hunter (2008) suggests that when working with indigenous people, we need to become comfortable in the these quiet pauses. He suggests that practitioners need to develop skills in unspoken communication so as not to fill this space with words, but instead to allow the pause to happen and acknowledge the communication with body language. Hunter refers to this process as time-independent attentiveness. Simply put, the practitioner uses the cup as an instrument that supports moments of quiet pauses that

also conveys attentiveness. The cup becomes the focus in these silent moments, allowing for the HAA moment, as expressed by Pita, is a moment of exhale and relaxation, and produces a conscious approach to engagement. In this way, quiet pauses become meaningful. However, long quiet pauses can also imply other things so and this is where your clinical knowledge and experience should help to interpret the difference between meaningful pauses and awkward silences.

Tea ceremonies have an informal nature that creates a sense of safety and comfort in an often sterile clinical environment and enact practices of normal human hospitality and promote engagement relative to those in pōwhiri tikanga. By taking the time to engage at this level the practitioner can create a safe space likened to the concept of āhurutanga in social work environments, where cultural beliefs are valued and respected (Coley et al., 2019). As expressed by the participants in this rangahau, service users and their whānau have experienced many negative outcomes when engaging with mental health services in the past. Whānau identified that they are wanting whānau inclusive approaches to their mental health care that acknowledges and appreciates their cultural way of life and promotes a collective/whānau well-being. Approaching consultation with whānau and Māori service users in a non-judgemental manner and in a culturally responsive way allows whānau to feel comfortable and encourages them to open up to clinical practitioners. This environment promotes the sharing of experiences and expectations for their mental health care, which enables the practitioner and service user to develop a treatment plan that works and that the service user is willing to adopt and put into action due to good therapeutic relationship that has been established.

Moana expresses:

"I could also justify this from a cultural perspective, that food we know, we use food to make tapu thing whakanoa and so often when we are engaging with whānau. Especially where there are challenges and difficulties and problems, things have been made tapu. We don't' talk about this, we don't disclose about this as its discomforting and embarrassing and all of those things, and the breaking of bread together can engender I guess, elicit a more relaxed kind of relationship…when you're…sharing food with somebody, it is somebody you have a good relationship with and culturally I can say 'there is stuff here that has been made tapu, and we want to try and make this whakanoa, so that it can be brought out into the open and we can address it transparently."

Moana refers to cultural tapu in regard to being able to talk about things that may have been taboo in the past. The act of a cup of tea, biscuit or kai and pōwhiri tikanga such as practices within the hui process of karakia and whakawhanaungatanga transitions us to a place of whakanoa. In doing so, tikanga practices ensures the safety of you as the practitioner and the safety of the whānau and in this way respects the tapu nature of some kōrero. It creates a safe space to hear whanau histories, concerns and issues that may be creating problems for the service user and their whānau. Tea ceremonies allow time and space to develop rapport and trust and provide the safety mechanism to ensure practices are tika and authentic.

Whakawhanaungatanga

Gilgen (as cited in Waitoki & Levy, 2016) suggests that whakawhanaungatanga is more than merely saying where you are from. What we are trying to achieve in sharing whakapapa and experiences is to develop commonality between the practitioner, the service user and their whānau that elicits a reciprocal response. When we listen to service user's story, practitioners can gain insight into their life events, connections, similarities and possible trauma to help us understand their journey and factors that may have contributed to their recent relapse or reasons for their need in accessing support services. Another benefit of hearing people's stories helps to identify their support network and develop effective safety and recovery plans that are inclusive of whānau.

Pita refers to this process:

> *I guess one of the biggest things for me is whakapapa, through doing whanaungatanga, through doing tātai (to be able to recite genealogies), doing things that we like…*[you are] *trying to find things that their interested in and pairing them to yourself of others who have an interest in that* [area]*…trying to find a way in where, where we can help the best… without compromising I guess, their trust, our trust, the honesty in between us…Taking them to their Papakainga* [ancestral home/land]*, taking them to their marae, into their rohe. Identifying whānau from their rohe, you know, and if our whaiora* [service user] *don't know who they are. Introducing them to them (their whānau) so they have got that tie…you can't know where you're going, until you know where you've come from."*

It is important to note that service users who identify as Māori may not know their whakapapa and the role of the practitioner is not to determine 'how Māori' the service

user is, instead the practitioner needs to ascertain how the service user defines Māori concepts, beliefs and values within their everyday lives (Gilchrist, 2017; Pitama et al., 2007). As being born Māori does not mean one was raised knowing about Māori ideals or values and may not even identify as Māori. Therefore, when engaging in kōrero whakapapa, asking who their parents and grandparents are can be a helpful starting place. Implementing whakawhanaungatanga into daily clinical practice can lead to the identification of links for service users and their whānau as you engage in a reciprocal process of kōrero whakapapa. Whanau spoke of practitioners who embodied the practise of whakawhanaungatanga and were able to identify a whakapapa connection helped to solidify the therapeutic relationship. Overtime your knowledge of local whakapapa increases and you start to learn the whānau connections within the area you live and work. These connections can help you to understand whānau dynamics and to connect with them or to connect them with their own whānau. Mead (2016) points out that "understanding your culture and reviving lost customs can inspire confidence and spiritual satisfaction that can transform the lives of people" (p. 25). The transformation of knowing who you are, gives you pride and confidence to stand proud in your skin, knowing where you belong to, your tūrangawaewae and whom you belong to is part of the holistic view to well-ness for Māori (Boulton et al., 2022). As Pita pointed out, being able to link people with activities they enjoy and teach them to fish, hunt or gather kai and them becoming providers for their whānau, alongside being able to unite service users with their whānau or tūrangawaewae, is important in supporting service users to understand who they are and where they come from and therefore where in society they fit (Gilchrist, 2017; Waitoki & Levy, 2016).

Suspension of time

Is there a difference between a 'cup of tea' and a 'pot of tea' one may ask? Pita suggested that: "*Sometimes, a tea pot or a coffee pot can sort of instigate how long a hui would go for."*

Pita's kōrero is indicative that a cup of tea may take less than an hour, however a pot of tea may signal a longer time. In the author's personal experience, when my children or whānau needed to talk to me, they would ask if I wanted a cup of tea. This would signal to me they needed my attention for a short period of time. When my children or whānau suggested a pot of tea, I predetermined this to mean they needed an extended period of time to talk. "The tea ceremony invites the practitioner and the patient to abandon the physical structuring of the interview" (Hunter, 2008, p. 131). The longer it took to finish the cup of tea, including offering a refill, the longer the interview continued. This suggests that the practitioner be aware of the volume remaining in the cup as this gives a visual aid to interpreting time from an indigenous perspective. Pita suggested that investing in a tea pot for initial hui, would signal to service users and their whānau that time has been suspended for them and that in this moment and within this space, time stands still so that they have the time and space to share their story. This sentiment was also expressed by Sarah that it is a privilege to hear someone's story and in this context, we owe it to our service users to be mindful that our clinical expectations of time is different from an indigenous perspective of time.

Taking the time to implement tea ceremonies has the ability to make people relax, reduce anxiety and become comfortable in your presence with the combined factors creating a space for meaningful engagement, āhurutanga. This becomes particularly important within inpatient unit settings where the clinical environment is secure, cold and

clinical. The offer of a cup of tea and something to eat can have a settling effect for service users as a tea ceremony supports the basic human need for nourishment as Moana suggested, offering a cup of tea is:

> *"Not normally associated with clinical settings and exercised in the right way can make things relaxed. Just basic stuff, if someone is thirsty or hungry, o rātou heahea* [their difficulties] *and then you can have a good conversation without their puku* [tummy] *rumbling…Can make them feel kindly disposed towards us…because we go into some traumatised lives sometimes, whānau have been traumatised by previous services, so anything we can do to, to warm up their regard, has got to be helpful."*

This cautions practitioners to be careful not to rush through pōwhiri tikanga to achieve assessment targets as you run the risk of missing vital information. As a Māori or non-Māori practitioner, finding an equilibrium within clinical environments requires an increase in cultural competency to implement tikanga based models. It is the practitioner's responsibility to seek out the necessary training and cultural experiences to ensure a culturally responsive approach is applied.

Barriers that obstruct a reciprocal exchange of manaakitanga.

During home visits, the protocols and responsibilities of manaakitanga can create some confusion as the practitioner shifts from host to guest. When practitioners are in their place of employment, they assume the role of host. When practitioners are on home visits, they become the guest. Sarah and Lizzy are of non-Māori descent, both actively practice tea ceremonies within their clinical workspace environment, however when

attending home visits, Sarah decline offers of hospitality from the service user and their whānau. Sarah self-identified that declining the offer of hospitality, denied the service user the ability to exercise manaakitanga. Lizzy understood that declining the offer of a cup of tea could be culturally insensitive.

All practitioners interviewed acknowledged that the practice of a tea ceremony was culturally ingrained in them from their whānau and was a sentiment shared by whānau participants. This suggests that all participants hold the same value of hospitality regardless of their position. It is therefore important that the act of tea ceremonies are intentional and authentic and from a position of manaaki and aroha. There is no difference if you are the host in your clinical setting or a guest in the whānau home, as Peppa reminds us:

> *"The act of making tea with care and compassion is what matters…*[and] *if offered a cuppa tea, you always say yes, thank you and you drink it all."*

Consequently, offering and accepting the gesture of hospitality demonstrates great respect which creates a mana enhancing relationship. The only barrier to implementing tea ceremonies is the restrictions we place upon ourselves as practitioners. What we do as a job, is not all we are, but the way we behave symbolises what we believe and portrays to the world who we are.

The results suggest that declining offers of hospitality had become an automatic response for Sarah due to the lack of public toilet facilities in the rurally isolated areas of the Far North District. This view was shared by Lizzy when she worked in the United Kingdom. Peppa suggests there is an unwritten expectation, that hospitality will be

accepted and whānau can react negatively when denied the opportunity to exercise manaakitanga.

Peppa shares this example:

"If you're not going to eat my food, then how the hell are you going to help my son?"

Peppa's kōrero demonstrates how whānau can take offence from the declining of their hospitality, not due to your personal needs, but due to the fact that whānau may feel that their kai or home is not good enough. Your decline to partake in a cup of tea is an indirect demonstration of disrespect. This creates a barrier between the practitioner and the whānau because you have trampled on their mana and denied the reciprocity of manaakitanga. Additionally, as there has not been a process of 'breaking bread together' a space of whakanoa has not been achieved. Therefore, how do we achieve a positive outcome from an unsafe space?

Koha kete and reciprocity

"Nāu tō rourou, nāku te rourou, ka ora ai te iwi"

"With your basket and my basket, the people with live"

This whakataukī speaks of the sharing of resources so that the people will not just live, but also thrive (Mead, 2001)

The participants were very aware of the level of poverty within the Far North community. Taking a koha kete (resources that whānau to use to make a cup of tea: tea bags, coffee sachets, milk, sugar and biscuits) is an act of manaakitanga, the sharing of resources.

Moana explains:

We have a lot of impoverished whānau that we work with…and when we go out into the home, a lot of our whānau will try to offer us hospitality, if we are able to offer something to that also, potentially less strain on that household…again it's just the reality and the ritual itself of just being able to mahi [work] *together and to make us a little something and partake of it together, I think that would help that initial dynamic.*

Providing a koha kete supports whānau to engage in practices of manaakitanga and reducing possible feelings of whakamā (to be ashamed or shy) from whānau who may not have been able to provide resources to enact manaakitanga in their home without the contribution. Even though we are hoping to elicit an offer of a cup of tea from whānau. It is important to note that by giving a koha towards the act of manaakitanga, should not come with an expectation that whānau will offer a cup of tea in return. Koha is an expression of exercising compassion and therefore is executed without any expectation of receiving anything in return. By contributing, the aim with the koha kete is to minimise the negative effect our visit may create for service users and their whānau. For example, the added stress and pressure of having strangers in their home. Ultimately, we want to develop rapport and trust, the tea ceremony enables a safe space to be created as naturally as possible. Tea ceremonies are an acceptable and normal social practice within Aotearoa based upon tikanga Māori and infused by the English colonisers and their culture, providing a launching pad in which to develop rapport. Therefore, accepting whānau offers of manaakitanga and partaking in kai and tea ceremonies lifts their mana and in doing so, bestows mana on you as the guest. There is a possibility that hygiene may be of concern here, that's the benefit of providing a koha kete which can include inexpensive paper cups and wooden teaspoons. There is always a way in which the reciprocal tikanga

of manaakitanga can be enacted, it is only limited by our own willingness to adapt and participate.

Early intervention and authentic engagement

When practitioners connect with service users and their whānau in a culturally responsive and holistic way, whānau feel listened to and valued for their insights and respected for their role as caregivers. Often the simple things such as active listening skills and acts of kindness (making a cup of tea for others) are overlooked as we try to achieve the statistics required within pressurised and time poor clinical environments. Further constrained by limited access to practitioners and resources, especially here in the Far North.

Nīkau and Pūriri spoke of the positive and supportive actions of practitioners who had taken the time to develop the therapeutic relationship and worked collaboratively with the whānau and the service user to develop early interventions to relapse. When whānau noticed the early warnings signs of a possible relapse in mental state, whānau contacted their practitioner, who would make a home visit and sit and discuss possible triggers, review medications, review the environment and collectively develop a plan to help stabilise the service user. Waitoki and Levy (2016) make reference to having aroha for your service users and admits that sometimes it is hard to feel aroha towards some service users due to past behaviours while in full relapse. However, without coming from a place of compassion, we remain stuck in our Westernised ideology of supposed elitism. The results have pinpointed the importance of being actively present, authentic and genuine in interactions with service users and their whānau. Sometimes the intervention

was a friendly chat about medication compliance or reducing behaviours such as reminding service users about how alcohol affects their mental well-being, or the service user is finding it difficult to sleep due to stressors. These approaches supported a collaborated response between the service user, the whānau and the practitioner that helped to maintain whānau well-being. Unfortunately, under the current mental health system, there is no service provision for early intervention due to already constrained working environments and limited resources. It could be hypothesised that early intervention services could reduce the ongoing need for hospitalisation in inpatient or subacute units. This suggests that more time and resources need to be allocated to developing the therapeutic relationship and early intervention services.

Clinical development

Mental health practitioners have a unique opportunity to make a real difference in people's lives. However, in order to make in-roads into high psychosocial need environments, we need to be authentic, be actively present and honest when engaging with service users and their whānau. We need to sign post when we are using our clinical knowledge and when we are talking from the perspective as an experienced whānau member. This does not negate who we are as professionals, it celebrates our diversity holistically (Durie, 2011a).

This rangahau identified that practitioners need to share their own experiences and be willing to take along a koha kete and partake in a cup of tea or kai when offered. In addition, organisations need to create conducive environments which support the action of manaakitanga including resources to provide hospitality and whānau friendly spaces

that make service users and their whānau feel welcomed and comfortable. For example, clinical rooms that have access to kitchenettes and spaces large enough to accommodate more than two people. Manaakitanga is a reciprocal process and supports the development of trust and familiarity while achieving a state of whakanoa. In this safe space we are able to be actively present, attentive and responsive to achieve positive outcomes for service users and their whānau.

This rangahau also identified the impact mental illness has on the whānau unit which is further complicated by the lack of access to effective social service supports. It was evident that there is a disconnection between Government departments for mental health service users. This included the Ministry of Justice and their inability to consider mental decompensation affecting behaviour. Whānau advocated for appropriate accommodation solutions for service users which include independent cabins placed on whānau land or supported accommodation villages that provide opportunities for employment and social interaction in a safe and nurturing environment in which service users could become active and contributing members of society. This can be likened to the analogy of a cup of tea. The cup of tea signifies a shared neutral space expressing aroha and manaakitanga between people. It is an expression of reciprocal respect, engagement and conversation. A safe place to share experiences, hardships and celebrate good fortune and good health. A cup of tea does not solve the world's problems, but it can help reduce stress and anxiety and give time and space to put things into perspective. Practitioners want to support people towards well-being, whānau and services users want to achieve whānau well-being. It will take practitioners who embrace a braided rivers approach that accepts Western and te ao Māori worldviews into their clinical practice and implement culturally responsive approaches that encourage a collaborative therapeutic relationship.

Conclusion

This rangahau is a qualitative study using narrative enquiry intended to add to the body of knowledge of tea ceremonies within clinical environments and support bicultural professional development of practitioners to become more responsive to the diverse needs of Māori (Lyons & Chamberlain, 2005). The aim of this rangahau was to: 1) describe the practice of tea ceremonies within mental health and addictions clinical environments; 2) explore how tikanga concepts of manaakitanga and whakawhanaungatanga are implemented; and 3) to explore the potential impact of tea ceremonies and tikanga based engagement strategies for service users and their whānau. The hypothesis that tea ceremonies help to improve trust and rapport and create a safe space for meaningful engagement, was confirmed and supports the kōrero of many Māori scholars and practitioner's regarding the importance of indigenous psychologies and tikanga based models being implemented into Aotearoa clinical environments. It was identified that, regardless of the cultural identity of the participants, everyone actively practiced pōwhiri tikanga and offered a cup of tea within their clinical practice. While not all participants accepted offers of manaakitanga when attending clinical appointments or when attending home visits. It was acknowledged that the decline of a cup of tea, denies the ability to exercise manaakitanga and produces a negative effect on the therapeutic relationship. The negative effect results in whānau feeling that their kai or home may not be good enough, resulting in a mana diminishing effect.

All participants demonstrated a desire to build a therapeutic relationship built upon authenticity, trust and honesty and it was acknowledged that by expressing and accepting manaakitanga, produces mana enhancing relationships on multiple levels. Manaakitanga is a holistic obligation to care and protect people. The word manaakitanga

denotes a spiritual power and reciprocal action of care not limited to actions of hospitality alone. Manaakitanga includes the gathering and redistribution of resources, providing facilities that are adequate, well-presented and clean. It also includes advocating for services, developing responsible policies and procedures that provide care and protection for people both today and for those yet to come and to create hospitable environments in all social settings.

> *'Ahakoa he iti, he pounamu' interpreted as 'although it is small, it is (precious) as greenstone'*

This whakataukī reminds us that small items or acts of kindness are precious and worthy of our attention (Woodward Ltda, 2019; Waitoki & Levy, 2016). A cup of tea offered and served is a small and humble gesture of hospitality, but one that wields the highest respect towards others. It is a precious action of manaakitanga and a culturally accepted ritual of achieving whakanoa through the action of breaking bread together. The cup of tea is the treasure in the context of the whakataukī 'ahakoa he iti, he pounamu'. Whether you are the host or whether you wield a koha kete as the guest, sitting together and conversing over a cup of tea provides a neutral space for kōrero whakapapa and shared experiences to flow. Experiences shared, good or bad and the amount shared is only dependant on the level of comfort between the practitioner, service user and their whānau. The more experiences shared, the more similarities or commonalities are developed. This is important as it decreases the barriers of engagement with Māori service users and their whānau. Reducing cultural alienation and strengthening the cultural identity of Māori by recognising and implementing tikanga based models that supports those who wish to be Māori (Durie, 2011a).

Tea ceremonies provide an opportunity to allow for quiet pauses, to take a breath and allow for thinking before speaking. While also helping to reduce anxiety in an often new, unfamiliar or sterile clinical environment. Tea ceremonies reduce power inequity in traditional practitioner/client relationships as the practitioner humbles themselves to become the host more representative of being a servant. This small gesture demonstrates care and hospitality that welcomes service users into the clinical environment and promotes safe spaces similar to āhurutanga whereby self-determination is promoted so that service users have choice over one's personal aspirations and control in developing effective recovery treatment plans. By encouraging this safe space, practitioners are being responsive to Māori needs and implementing tika practices while engaging authentically to create trusting therapeutic relationships and in an ideal world, this leads to better outcomes for service users and their whānau.

What would be helpful in mental health and addiction services clinical environments is adequate resources and whānau friendly spaces in which to exercise manaakitanga. This would reduce the need to traverse through multiple security doors while trying to balance hot drinks, while very comical to watch, it poses multiple health and safety risks. A limitation was identified after the practitioner participant's data was collated and that it was one sided and did not consider service users or their whānau voices. The author extended the rangahau to provide balance.

Service users and their whānau agreed that engagement tikanga: pōwhiri, manaakitanga; whakawhanaungatanga are valuable and culturally responsive approaches that helped whānau and service users develop meaningful therapeutic relationships with their practitioners. The exception to the rule was in times of crisis when whānau were unable to engage in pleasantries as they were preoccupied with trying to keep their service

user safe from themselves or others. Whanau often felt they were excluded from mental health services which lead to ineffective diagnosis, treatment and recovery plans. Whanau advocate for a whānau centred approach that acknowledges the service user as part of an interdependent whānau and discourage practitioners from treating service users in isolation of their whānau regardless of possible relationship breakdowns between the service user and the whānau. As identified in Te Whare Tapa Wha, taha whānau needs to be nurtured alongside taha wairua, taha hinengaro and taha tinana to achieve well-being.

Finally, organisations need to take a leading role in allocating provisions for organisational professional development packages that support practitioners to understand Māori models of health and support them in implementing tikanga engagement practices with service users and their whānau. As all of the participants have identified in this rangahau. Everyone knows how to make a cup of tea.

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Appendices

Appendix 1: Interview Format and Questions for Practitioner Participants

The tea ceremony:

1. *Can I make you a cup of tea or coffee?*
2. *How do you take your tea or coffee?*

Whakatau:

Opening Karakia and mihimihi while enacting practices of manaakitanga (cup of tea and something to eat) and whakawhanaungatanga (developing connections through genealogy and experiences) prior to signing consent form. Recording of interview only commences after the completion of the participant information sheet inquiries and signing of the consent form.

Demographic Questions:

3. *Demographic information (voluntary information)*
    a. *Age range: 18-25; 26-40; 41-60; 60+*
    b. *Gender: Male; female*
    c. *Ethnicity and Iwi affiliation, if relevant*
    d. *Have you thought about your pseudonym (fictitious name) you wish to use in this rangahau, and what may that be?*
    e. *Please tell me a bit about your current role?*
    f. *How long have you help this role or been in a role similar?*

Rangahau Questions:

4. Please tell me about your experiences of meeting service users and their whānau for the first time?
5. When service users and their whānau come in to meet with you, do you offer them a cup of tea or coffee?
    a. If yes, when do you offer them a cup of tea/coffee?
        i. Do you make the cup of tea for them?
        ii. Are there any barriers are present that may stop you from offering service users and their whānau a cup of?
        iii. What improvements could be made to encourage the practice of a tea ceremony?
    b. If no, is this a practice you would like to implement?
        i. And if so, what barriers are present that may stop you from offering service users and their whānau a cup of tea?

ii. What improvements could be made to encourage the practice of a tea ceremony?

iii. Move on to question 12

6. Why do you offer a cup of tea or coffee?
7. Where did the practice originate from? For example, who or what may have influenced your practice of tea ceremonies with service users.
8. What happens after you offer a cup of tea or coffee?
9. So, what are the benefits of offering a cup of tea or coffee?
10. Are there times when you don't offer a cup of tea or coffee?
    a. Why?
11. Is the practice different when attending home visits?
    a. What do you do in these instances?
12. How else do you engage with service users and their whānau?
13. How effective are these practices?
14. Where did these practices come from – evolution/culture/training?
15. What practices have you heard or seen other colleagues do in their engagement with service users and their whānau?
16. When you think about your colleagues and their engagement with service users and their whānau, what strategies do you think may be helpful for them to learn to improve manaakitanga and whakawhanaungatanga within the clinical environment?

Closing statements

Karakia Whakamutunga

Appendix 2: Interview Format and Questions for Whanau Participants

The tea ceremony:

1. *Can I make you a cup of tea or coffee?*
2. *How do you take your tea or coffee?*

Whakatau:

Opening Karakia and mihimihi while enacting practices of manaakitanga (cup of tea and something to eat) and whakawhanaungatanga (developing connections through genealogy and experiences) prior to signing consent form. Recording of interview only commences after the completion of the participant information sheet inquiries and signing of the consent form.

Demographic Questions:

3. Demographic information (voluntary information)

a. Age range: 18-25; 26-40; 41-60; 60+

b. Gender: Male; female

c. Ethnicity and Iwi affiliation, if relevant

d. Have you thought about your pseudonym (fictitious name) you wish to use in this rangahau, and what may that be?

Proposed questions:

- Can I make you a cup of tea? How do you take your tea or coffee? (Is dependent on the principle researcher being the host)
- How did you become aware that you might need some extra support from mental health services?
- How did you find out who to contact?
- Can you tell me about your experiences of making contact with mental health and addictions services?
- Was the experience welcoming? How?
- We're you offered a cup of tea or other refreshment?
- Or when they came to visit, did they sit and have a cup of tea with you?
- How was this received?
- How did this make you feel?
- If you could improve that first interaction with mental health services, what would you change, keep or improve and how?

Closing statements

Karakia Whakamutunga

Appendix 3: Participant Information Sheet - Practitioners

Developing therapeutic relationships: Can I make you a cup of tea?

Locality:	*Far North District, Aotearoa*	Ethics committee ref: 4000020629
Lead investigator:	*Agnes Allen*	Contact phone number: *021 599 448*

This rangahau is a requirement of Massey University as part of the Master of Arts, psychology programme.

I am a postgraduate student with Massey University inviting you to take part in this rangahau (study) on 'developing therapeutic relationships' which is an inquiry into practices of manaakitanga and whakawhanaungatanga, in particular, where the offer of a cup of tea or coffee is part of everyday practice when engaging with service users and their whānau.

I am looking for mental health practitioners, clinicians and support workers within the Far North District, Aotearoa to take part in this rangahau. Your participation is completely voluntary, and you are able to withdraw from the rangahau at any time. You are welcome to ask Agnes any questions regarding the rangahau at any time during the project.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep. Before you decide you may want to talk about the study with other people, such as whānau, friends, or healthcare providers. Feel free to do this.

What is rangahau?

Rangahau is referred to in this context as: to seek out, investigate and research and is an approach that is grounded within tikanga Māori and ahuatanga Māori. It is an indigenous perspective with different experiences and different truths. The aim of this rangahau is to add to the body of knowledge of: manaakitanga (the cultural practice of hospitality, showing respect towards others and caring for others through the act of generosity); and whakawhanaungatanga (establishing relationships and sharing of genealogy as a way to developing connections between people) with mental health service users and their whānau, with the hope of offering a practical solution of implementing manaakitanga within clinical environments.

A single 60-90 minute one-to-one interview will be used to capture your stories (narratives) providing the data for a thematic analysis. All data collected will be used solely for rangahau purposes and may be prepared for publication in a professional journal. All personal information will be kept confidential by either self-selecting or assignment of a pseudonym (fictitious name) to each participant. All

narratives/information will be handled in confidence and recordings will be deleted after transcripts have been approved by participants. All information and data will be stored in a secure location for five years with the researcher then disposed of appropriately.

A koha for your participation will be given at the end of the interview. You will also receive a written report containing the main findings of the rangahau once data analysis and interpretation is completed.

Contact information
If you have any further questions or concerns about the project, either now or in the future, please contact me on agnesallen363@gmail.com

Specific contact:
Dr Pikihuia Pomare
Phone: +64 (09) 414 0800 ext. 43104 or email: P.Pomare@massey.ac.nz

Human ethic committee Approval Statement

"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher, Agnes Allen is responsible for the ethical conduct of this research.

If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor Craig Johnson, Director - Ethics, telephone 06 356 9099 extn 85271, email: humanethics@massey.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone:	0800 555 050
Fax:	0800 2 SUPPORT (0800 2787 7678)
Email:	advocacy@advocacy.org.nz

You can also contact the health and disability ethics committee (HDEC) on:

Phone:	0800 4 ETHICS
Email:	hdecs@moh.govt.nz

If you require additional support and your organization affiliates to the Employee Assistance Programme, you can contact them on:

Phone:	0800 327 669
Fax:	09 358 2560
Email:	Whangarei@eapservices.co.nz

Appendix 4: Participant Information Sheet

Developing therapeutic relationships: Can I make you a cup of tea?

Locality:	*Far North District, Aotearoa*	Ethics committee ref:	*NOR 20/33*
Lead investigator:	*Agnes Jenkins*	Contact phone number:	*021 599 448*

This rangahau is a requirement of Massey University postgraduate research as part of the Master of Arts, psychology programme.

Kia ora my name is Agnes Jenkins (nee Allen, of Ngapuhi descent). I am a Masters student in the School of Psychology at Massey University. My interest area is how clinical services engage with Māori whanau. If you are a Māori service user/tāngata whaiora, tāngata wha i te ora **or** a whanau member of a service user who has accessed support from mental health and addictions services in the Far North District, I would love to hear your experiences of engagement practices.

Your participation is completely voluntary and if you wish to participate either send me an email Agnes.Jenkins.1@uni.massey.ac.nz or text 021 599 448 or make contact through Facebook. You are able to withdraw from the rangahau at anytime any time before the interview and within two weeks of the interview being conducted. There is no need to provide an explanation for withdrawal. You are welcome to ask me any questions regarding the rangahau during the project. If you agree to take part in this rangahau, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of the Participant Information Sheet, the Consent Form and the questions prior to the interview. Before you decide, you may want to talk about the study with other people, such as whānau, friends, or healthcare providers. Feel free to do this.

Rangahau is an approach that is grounded within tikanga Māori and āhuatanga Māori. It is an Indigenous perspective with its own experiences and different truths. The aim of this rangahau is to add to the body of knowledge of: manaakitanga (the cultural practice of hospitality, showing respect towards others and caring for others through the act of generosity); and whakawhanaungatanga (establishing relationships and sharing of genealogy as a way to developing connections between people) with Maori service users and their whanau, with the hope of offering a practical solution of implementing manaakitanga within clinical environments.

A single interview up to 60 minutes long will be used to capture your story/experiences (narrative) providing data for a thematic analysis. All data collected will be used solely for rangahau purposes and may be prepared for publication in a professional journal. All personal information will be kept confidential by the assignment of a pseudonym (fictitious name) for each participant. All narratives/information will be handled in confidence and recordings will be deleted after

transcripts have been approved by participants. All information and data will be stored in a secure location for five years with the researcher then disposed of appropriately.

As a thank you for your participation and time, a koha of $30 Pak n Save or Countdown gift card will be given at the end of the interview. You will also receive a written summary of findings of the rangahau once Massey University has released them, estimated to be December 2021.

Contact information

If you have any further questions or concerns about the project, either now or in the future, please contact me on Agnes.Jenkins.1@uni.massey.ac.nz

Specific contact:

Research Supervisor

Dr Pikihuia Pomare

Phone:+64 (09) 414 0800 ext. 43104 or email: P.Pomare@massey.ac.nz

Human ethics committee Approval Statement

This project has been evaluated and approved by the Massey University Ethics Committee: Northern, Application NOR 20/33. If you have any concerns about the conduct of this research, please contact Dr. Fiona Te Momo, Chair, Human ethics Committee, Northern telephone: 09 414 0800 Ext 43347 or email humanethicsnorth@massey.ac.nz

If you want to talk to someone who isn't involved with the study, you can contact:

Health and Disability Advocate

Phone: 0800 555 050

Fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@advocacy.org.nz

If you are feeling worried, stressed or unsettled you can contact:

Mental Health Line who are ready to talk 24/7 Phone: 0800 111 757

The Health and Disability Advocate and Mental Health Line are free services.

Appendix 5: Voluntary Informed Consent

Please tick to indicate you consent to the following

I have read, or have had read to me, and I understand the Participant Information Sheet.	Yes ☐	No ☐
I have been given sufficient time to consider whether or not to participate in this rangahau.	Yes ☐	No ☐
I am satisfied with the answers I have been given regarding the rangahau and I have a copy of this consent form and information sheet.	Yes ☐	No ☐
I understand that withdrawing is available to me at any time before the interview and within two weeks of the interview being conducted. There is no need to provide an explanation for withdrawal	Yes ☐	No ☐
I understand that my participation in this rangahau is confidential and that no material, which could identify me personally, will be used in any reports on this study.	Yes ☐	No ☐
I understand that the interview will be audio recorded for accuracy purposes	Yes ☐	No ☐
I know who to contact if I have any questions about the rangahau in general.	Yes ☐	No ☐
I understand my responsibilities as a participant.	Yes ☐	No ☐

Declaration by participant:

I hereby consent to take part in this rangahau.

Participant's name:

Signature: Date:

Declaration by member of research team:

I have given a verbal explanation of the rangahau to the participant, and have answered the participant's questions about it.

I believe that the participant understands the rangahau and has given informed consent to participate.

Researcher's name: Agnes Jenkins

Signature: Date:

Appendix 6: Rangahau Poster Practitioners

DO YOU OFFER YOUR CLIENTS AND WHANAU A

CUP OF TEA?

IF YOU ARE A MENTAL HEALTH PRACTITIONER, CLINICIAN OR SUPPORT WORKER, WORKING WITHIN THE FAR NORTH DISTRICT, AOTEAROA AND OFFER A CUP OF TEA OR COFFEE AS PART OF YOUR PRACTICE.

I WOULD LOVE TO HEAR FROM YOU.

Tena koe, my name is Agnes Allen and I am conducting rangahau (research) on 'developing therapeutic relationships' between practitioners and tangata whaiora and their whānau. If you are interested in participating, please send me an email agnesallen363@gmail.com

Appendix 7. Rangahau Poster - Whānau

I AM LOOKING FOR RESEARCH VOLUNTEERS

Massey University Master of Arts Rangahau (Research)

"Haere mai ki te kapu ti: Come and have a cup of tea"

Are you a current or past service user/tāngata whaiora or whānau member of someone who has accessed clinical mental health services in the Far North District area - from North Cape and Cape Reinga / Te Rerenga Wairua in the north, down to the Bay of Islands, the Hokianga and the town of Kaikohe.

Kia ora, my name is Agnes Jenkins.
I am looking for participants who wish to share their experiences of mental health services with a particular interest in whether or not you felt these environments were hospitable (welcoming).

If you are interested in participating, please send me an email Agnes.Jenkins.1@uni.massey.ac.nz or text 021 599 448 or send me a msn and I'll get back to you with more information.

Participants will receive a koha at the end of the interview - $30 Pak n Save or Countdown voucher.