Māori women's experiences of mental health services in New Zealand: A qualitative interview study

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Kia ora, my name is Gemma Tricklebank and I whakapapa back to Tainui, Ngāti Maniapoto and Ngāti Mahuta. I am 26 and currently studying a Doctor of Clinical Psychology at the University of Auckland. My research, Māori women's experiences of mental health services in New Zealand, is an amalgamation of my identity and passions in clinical psychology, and more broadly in mental health. I hope that my research, when finished, can both recommend and improve service provisions for Māori women using mental health services in New Zealand.

Abstract

The statistics for Māori women in mental health, although improving, still highlight imbalances in engagement and outcomes. This research is being completed as part of a Doctor of Clinical Psychology degree and as yet is unfinished; however, preliminary findings will be presented. Qualitative interviews were conducted with 12 adult Māori women, asking a series of open-ended questions about their experiences of engaging as a mental health service-user in New Zealand in the past 3 years. Thematic analysis identified four broad areas focused around engagement or non-engagement in services, positive experiences within services, negative experiences within services, and recommendations made by participants that could improve future experiences for Māori women. Two preliminary themes will be discussed in this article; mental health services as allies and friends (or not), and bridging the gap between the outside and the inside.

Introduction

The statistics for Māori women in mental health, although improving, still highlight bleak imbalances. Māori women are twice as likely to have a diagnosable mental disorder compared to their non-Māori counterparts, and exhibit a greater severity of symptoms at presentation (Bushnell, 2005). Depression rates are higher in Māori, and particularly higher in Māori women compared to non-Māori women; despite this, Māori are also less likely to be prescribed anti-depressant medication, suggesting that Māori are being diagnosed, but not treated pharmacologically for depression (Tapsell & Mellsop, 2007). In general, anxiety, depression and substance abuse disorders are also higher in Māori than non-Māori (Bushnell, 2005). Given the over-representation of Māori as mental health service-users, and the under-representation of Māori as mental health professionals, I, as a Māori woman, but also as a clinical psychologist in training, am invested in working towards improving experiences for Māori in general, and with this research in particular, Māori women, in New Zealand's mental health services.

My research aims to investigate and understand the current varied experiences of Māori women, as users of mental health services in New Zealand. Specifically, I will aim to identify the positive, negative (and neutral) experiences of Māori women's mental health service use in New Zealand, and the ways Māori women experience culturally appropriate and inappropriate service delivery. My research aims to explore what might count as more culturally-appropriate mental health services for Māori women in New Zealand, and build on women's experiences to develop relevant recommendations for policy and practice. Previous research traditionally has seldom considered the perspectives and experiences of disempowered groups, and my research seeks to gain a rich and nuanced understanding of the experiences of Māori women using mental health services. It is hoped that my investigation into their experiences may provide or confirm information on changes needed to improve mental health service provision for Māori women in New Zealand.

Methods

This research is a qualitative interview study of Māori women who have had previous experiences using mental health services. It is qualitative research informed by feminist/critical gender, Kaupapa Māori, and service-user perspectives. Qualitative interviews were chosen for their ability to gather rich and detailed experiences from participants in an active interaction between researcher and participant (Fontana & Frey, 2000).

The 12 participants were adult Māori women with (a) previous experience(s) as a service-user in mental health services in New Zealand in past 3 years with 'service-user' being largely self-defined (participants ranged from having serious long term involvement in mental health services, to seeing a counsellor or therapist for a short period of time for a minor issue). Participants were also excluded according to the following additional criteria: primary alcohol and substance abuse (mental health had to be the primary service) and people who were currently psychotic or distressed. The emphasis was also on past experiences, so although some participants were still healing from current experiences, or had long term involvement with mental health services over their lifetime, they were only talking about the experiences from the past which they were now no longer distressed about, and could look back on retrospectively as a 'completed' experience.

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This study uses a qualitative, semi-structured interview design. Each interview was planned to take between one and one and a half hours to complete, however some lasted for over two hours, and others lasted only forty-five minutes.

The method of analysis used is thematic analysis, as outlined by Braun and Clarke (2006). A general inductive approach has been used (Thomas, 2006), and an inductive form of thematic analysis, grounded in the details of the data, has been used to build a story of participants' responses from the ground up. There has been no attempt to interpret the data, via a particular theory or framework. The data have been used from their raw form to build a unique understanding (Braun & Clarke, 2006). In this way, themes do not 'emerge', but are, in a sense, created, identified, or chosen by the researcher, and shaped by who I am and where I come from as an active participant in doing the research (Braun & Clarke, 2006).

In short, qualitative research was, in its essence, both practically and theoretically suited to my study. Its suitability for rich and detailed data, sensitive topics and vulnerable groups; its acknowledgement of the constraints of reality and objectivity; and its openness to reflexivity mean that I can do my research, and participants, justice.

Results

The data were first experienced in the interview, live, and audio-recorded at the time. They were then transcribed verbatim, checked, read, and re-read several times. Initial codes were generated under four broad areas: 1) ways mental health is dealt with outside of services, for example, within whanau, 2) positive/culturally safe experiences, 3) negative/culturally unsafe experiences, and 4) recommendations for the future. Identified themes will be refined over multiple analyses of the data. With each stage of analysis, the themes will be refined and reviewed further. As the themes are currently preliminary, they will likely be further refined at the completion of this research. Nevertheless, two preliminary themes are discussed below in their current state.

Theme: Mental Health services as allies and friends (or not)

The first preliminary theme identified is the idea that mental health services have the potential to be positioned as 'allies' and 'friends' to service users, and that this would be beneficial in terms of engagement, treatment, and outcomes. Being treated like a friend by mental health services meant that participants engaged with ease and wanted to return to the service. In a psychological sense, staff who were visibly unassuming, non-judgemental, did not "push it" or think the participants were "crazy", utilised normalisation, empathy, validation and collaborative processes, were greatly appreciated. Services that were clearly tailored to the needs of the participants were highly praised. In a more practical sense, accessibility, easy of transport, and practical support helped to strengthen this relationship. When mental health services were experienced as friendly, familiar, and welcoming, participants' experiences were more positive.

Participants spoke positively of having someone present who was a friend or ally (particularly during engagement or assessment), whether it was a friend or whanau member accompanying them, or simply the presence of another Māori person. One participant shared a story in which she was feeling apprehensive in the service, but immediately felt better when she came across a Māori woman who was employed in the same building, even though she was not a staff member of that particular service and would have nothing to do with the participant's involvement in the service. Just knowing that somebody who was potentially an ally was in proximity, and experiencing some familiarity in a new place, eased the participant's fear.

When mental health services were not experienced as 'allies' or 'friends', or "on your side" as one participant phrased it, participants felt alienated, and often acutely aware of the cultural isolation they were experiencing. One participant expressed her thoughts when first engaging in home visits:

> *"And, ah, I sort of like the idea of them coming but oh, I thought wow, ah, how come there's no Māori people here? Um, not, that's not to say that they're misplaced or anything but, um, then the second one came was a woman and I thought I could open up to her more. But yeah, in, in the recent one […] that to me is, ah, seems to be, has got no cultural, ah, you know, support. They need to have some brown, browning up, some brown people." P06*

This participant acknowledges that having being matched with another woman allowed her to "open up to her more", but this was not enough to instil a sense that 'someone like me' was available and willing to provide a service. Because of this, she shied away from support being offered to her. Remarkably, another participant was able to create the feeling of having an ally present, even when alone:

> *"I didn't have my aunty, but we went to a meeting [...] and I got this thing that I should take, I mean I've got like this big folder that has all our whakapapa and family korero in it, and I just got this thing that I should take that with me, and I just sat there with it on my lap. And it was kind of like that's what it felt like it was, it felt like a way of having them with me (laugh), almost like a bridge. No, not so much a bridge but a barrier between me and the doctor." P07*

In an unfamiliar situation, she was able to hold her whanau, in a physical form, close to her, in the place of her aunty who could not attend the assessment. This served not only to keep her company and feel she had some strength with her in the room, it also served to protect her, as a whanau member might advocate on her behalf if they had been present.

Given the importance of having an ally present, and the difference this can make in experiences for service-users, increasing Māori presence in the mental health workforce should be given high priority, along with a strong encouragement of friends or whanau members attending engagements or assessments with service-users. If Māori women can have an ally within mental health services (a member of staff) and/or an ally which they can bring with them (a friend or whanau member), engagement can be greatly improved and the experience is much more pleasant for service-users. To improve experiences for Māori women, a change in the relationship between services and service-users, and treating our clients as we would treat our own family and friends, should be prioritised. This, of course, will not be easy, given that professionalism must remain intact as we become more humanistic, but will be exceedingly rewarding for professionals and service-users alike.

To improve experiences for Māori women, a change in the relationship between services and service-users, and treating our clients as we would treat our own family and friends, should be prioritised.

Theme: Bridging the gap between the outside and the inside

The second preliminary theme identified is the notion that there is a 'gap' between the world outside of mental health services, and the world inside mental health services. Participants expressed negative experiences when this 'gap' was not bridged appropriately. This 'gap' appeared in many different forms. A disconnect between mental health services and other support services was expressed, meaning that participants often had to juggle a number of services, or had to negotiate between whanau support and mental health services as separate entities. They also expressed a 'gap' between Māori and non-Māori values and beliefs, for example, participants were surprised at not being asked about their religion or spirituality, or being given advice that was culturally incompatible with their way of living. Overwhelmingly, participants talked about the 'gap' between whanau involvement in their life, and whanau involvement in their mental health treatment; whanau were not often involved with services, but participants expressed that they would have liked them to be, and although this 'gap' was sometimes partially bridged, it felt strange, such as when talking about whanau with professionals, but without whanau present in the room.

One of the most common ways this 'gap' was expressed was in terms of whanau being missing or removed from the engagement, treatment, and outcomes in mental health services. One participant expressed her concern at the service seeming unwilling or afraid to engage her whanau:

> *"I just didn't think that there was enough. I, I just don't think that they were strong enough to call a meeting with the whole family." P05*

This participant expressed her sense that involving her whanau was simply 'too hard' for the service to do, despite it being of utmost importance to the participant and her recovery. Below, another participant shared her experience, which was otherwise helpful; she was actively discouraged from affiliating with a particular whanau member, a recommendation which was culturally impossible for the participant to carry out, even if she had wanted to:

> *"And it was really helpful, but the only thing that I found wasn't helpful, and maybe it's because I had a Pākehā counsellor, was the thing she said to me, maybe you shouldn't have anything to do with your sister. Like, what? She said, for the sake of your own emotional state. And I just remember saying to her, I can't." P02*

For this participant the suggestion was jarring, but the counsellor's unawareness was also surprising, particularly given the fact they had spent several sessions talking about the importance of family previous to this suggestion being made. In this case the participant also experienced ongoing pressure to follow through on this suggestion, despite making it clear that estranging herself from her sister was not an option. This gap between values meant that the participant was left alone to formulate her own, culturally possible, solution. She was wanting the counsellor to meet her halfway to 'bridge the gap', and formulate together on something that would be do-able for the participant. Ideally, the counsellor would have already been aware of why this suggestion was not appropriate and would not have continued to 'push it' after it was expressed.

To bridge these gaps, services need to be co-ordinated seamlessly for service-users; part of this process would also be to weave whanau (as they are so often the primary 'service' helping service-users) more tightly into the process. This would also address the current perceived lack of invitation for whanau involvement (as an aside, given that participants overwhelmingly made use of their whanau as a 'service' in itself, a legitimacy needs to be lent to the value of whanau support in mental health). If service-users can experience the world inside mental health services as being similar, relatable, and connected to the world outside, their engagement and experiences will be more positive. This, of course, also relates to the first preliminary theme; if friends and whanau are allowed into the world of mental health services, and more Māori health professionals or non-Māori professionals who 'get it' are visible and present, the gap can be bridged, and experiences can be more positive.

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Conclusions

Every time I present my initial findings, or write about them, I realise, to some listeners and readers, they may seem like common sense. However, common sense as they may seem, these practices need to be more visible to service-users, more consistent across and within services, and positioned and recognised as legitimate practice at an institutional level. This will not only empower service-users to feel entitled to an appropriate service (and therefore potentially increase their engagement and positive experiences, and improve outcomes), but allow those professionals who are already delivering appropriate services in this vein to do so with conviction and confidence. For those who are already supportive of or practicing culturally appropriate and culturally safe Māori mental health treatment, I hope that my initial findings encourage you to continue walking this path. I also hope that at completion of this research, I will be able to provide clear and detailed outlines for a more culturally appropriate service provision for Māori women in mental health.

Perhaps the most exciting thing about these suggestions for improvement is that implementing these recommendations into practice will have benefits for all service-users, not just Māori women. When I consider many of these recommendations (invitations to be accompanied by friends and family; non-judgemental, empathetic, genuine, and validating health professionals; engaging with professionals and services who are warm, friendly, familiar, and share the same values; being offered agency and choice in my treatment) I cannot help but think: *Who wouldn't want this offered if they began to engage with mental health services?* Being a Māori woman myself, my preferences are obviously biased, but I believe as we move towards a more humanistic approach as a broad mental health profession, we will also move towards providing a more culturally safe and culturally appropriate mental health service for Māori, and in regards to this research, Māori women.

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