The Transformative Potential of Kaupapa Māori Research and Indigenous Methodologies: Positioning Māori Patient Experiences of Mental Health Services

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Abstract
This article presents a description of a specific Indigenous research methodology, Kaupapa Māori Research (KMR), followed by a discussion of the potential contribution that KMR and other Indigenous frameworks make toward understanding and addressing widespread mental health inequities affecting the world’s Indigenous peoples. The contribution of existing qualitative KMR to the fields of health and mental health in New Zealand is discussed, and innovative approaches employed within these studies will be outlined. This paper describes the utility of KMR methodology which informed the development of qualitative interviews and the adaptation of an analytic framework used to explore the impact of systems on the experiences of Māori (the Indigenous peoples of New Zealand) with bipolar disorder (BD). This paper adds to others published in this journal that describe the value, inherent innovation, and transformative potential of KMR methodologies to inform future qualitative research with Indigenous peoples and to enact systemic change. Transformation is achieved by privileging the voices of Māori describing their experiences of mental health systems; presenting their expert critique to those responsible for the design and delivery of mental health services; and ensuring equal weight is given to exploring the clinical, structural and organizational changes required to achieve health equity. It is proposed that this approach to research praxis is required to ensure that studies do not perpetuate institutional racism, which requires close adherence to Indigenous research priorities and partnership with Indigenous peoples in all steps of the research process.

Keywords
Kaupapa Māori, Kaupapa Māori research, indigenous methodologies, qualitative research, mental health, health equity

Introduction
Article 24 of the United Nations Declaration on the Rights of Indigenous Peoples states “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health” (United Nations, 2011, p. 18). Yet health outcome research continues to identify physical and mental health inequities negatively affecting many of the world’s Indigenous peoples (Anderson et al., 2016; Azzopardi et al., 2018; Baxter, 2008; Black et al., 2017; Durie, 2011; Gracey & King, 2009; Gynther et al., 2019; Harris et al., 2012; Hunter & Harvey, 2002; Jorm et al., 2012; Kake et al., 2008; Nelson & Wilson, 2017; Pihama et al., 2014; Reid et al., 2019; United Nations, 2016; Williamson et al., 2014). While the collection and analysis of quality Indigenous health data is essential, it is important to recognize the ways in which institutional racism within research maintains systems that produce inequitable health outcomes (Huria et al., 2019; Reid et al., 2019). To enact systemic change, future research must utilize methods that identify the impact of institutional racism on service provision to produce outcomes capable of addressing the multiple determinants of Indigenous health conditions.
(Greenwood et al., 2018; Huria et al., 2019). This applies especially to Indigenous mental health research, which the world health mental health action plan has established as a priority (World Health Organization, 2013).

Māori is a collective term used to describe the Indigenous peoples of New Zealand, who are connected through descent to various iwi (tribal groups), hapū (sub-tribes) and whānau (family/support networks). In New Zealand, mental health survey data have identified that Māori experience significant mental health inequity relative to other ethnic groups, reflected through higher rates of mental illness and serious mental illness (Baxter, 2008). The methodology and methods described in this paper form part of a wider study, the Māori and Bipolar Disorder Research Project (MBDRP), which aimed to identify knowledge and prioritize strategies to improve outcomes for Māori with Bipolar Disorder (BD).

The MBDRP involved three-phases, and employed multiple research methods. Phase 1 involved an epidemiological study of New Zealand mental health service data. Phase 2 formed the basis for this paper, and involved qualitative interviews conducted with Māori with a diagnosis of BD and their whānau. Phase 3 utilized focus groups with key stakeholders and decision makers involved in delivering mental health services to Māori with BD and their whānau.

This paper will be presented in two sections. The first section will provide a context to Indigenous Methodologies with a focus on Kaupapa Māori Research (KMR) in New Zealand, while the second section will describe the applicability of KMR to the methods employed in Phase 2 of the MBDRP to identify novel findings about mental health service delivery. It will illustrate how KMR principles were used to organize and conduct qualitative interviews with Māori patients with BD and their whānau, to guide the process of analysis, to inform the development of focus group questions for Phase 3 with participants involved in delivering mental health services to Māori with BD and their whānau.

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Global Mental Health

The need to understand and address mental health inequities between Indigenous and non-Indigenous peoples is an international research priority (Anderson et al., 2016; World Health Organization, 2013). Kirmayer and Pedersen (2014) have noted the limitations of Western science and its mental health service delivery to effectively identify, treat and reduce the inequities that are unfairly distributed among various marginalized groups including Indigenous peoples. To overcome these limitations, it is proposed that mental health research needs to effectively identify the influence and impact of exposure to the broader determinants of health, not just individual and biological risk factors (Kirmayer & Pedersen, 2014; Palmer et al., 2019). Kaupapa Māori and other Indigenous research methodologies enable the exploration of links and pathways between the differential exposure of Indigenous peoples to the determinants of health, aversive experiences within health systems, and inequitable health outcomes (Chilisa, 2012; Cochran et al., 2008; Drawson et al., 2017; Dudgeon et al., 2010; Huria et al., 2019; Pihama et al., 2002; Reid et al., 2019; Smith, 2012).

The Contribution of Indigenous Methodologies

Indigenous peoples, particularly those subject to the ongoing process of colonization, have a history of being researched “on” rather than “with” or “for” (Cochran et al., 2008; Dudgeon et al., 2010; Harris et al., 2012; Huria et al., 2019; Pihama et al., 2014; Reid et al., 2019). This approach has been used to legitimize and advance the political and social agendas of the colonizer, portraying Indigenous peoples through context-devoid and deficit-focused comparisons (Smith, 2012; Walter, 2016). There is now an established body of Indigenous health research that demonstrates the role of Indigenous Methodologies in ensuring cultural safety within the research process (for both research community and researcher), and which contributes to positive research and health outcomes for Indigenous communities (Boulton, 2005; Chilisa, 2012; Cochran et al., 2008; Cram et al., 2003; Dudgeon et al., 2010; Dyall, 2003; Eade, 2007, 2014; Edwards et al., 2009; Elder, 2008, 2013; Harris, 2014; Hotu, 2018; Hughes, 2007; Johnson, 2009; Jones et al., 2013; Jones et al., 2006; Kerr et al., 2010; Lambert, 2015; Makowharemahihi et al., 2014; McLellan et al., 2014a, 2014b; Ngata, 2014; Penney et al., 2006; Pere, 2006; Staps et al., 2019; Stevenson, 2018; Taitimu et al., 2018; Tricklebank, 2017; Wakaiti, 2007; Warbrick et al., 2016; Watkins, 2007; Wharewera-Mika, 2012).

A recent paper catalogued peer-reviewed literature and described the range of Indigenous research methods and methodologies being employed internationally with Indigenous peoples (Drawson et al., 2017). Of the 64 studies described, many employed a qualitative study design and Kaupapa Māori was the most cited of the “culture/nation-specific” Indigenous research methodologies (Drawson et al., 2017). Kaupapa Māori Research shared strengths and commonalities with other...
Indigenous approaches, including methodological innovation, the use of a strength-based frame in the qualitative research design, and the ability to ameliorate limitations previously imposed by non-Indigenous research methods (Drawson et al., 2017; Pihama et al., 2002).

**Definition of Kaupapa Māori Research**

Kaupapa Māori Research is an Indigenous methodological framework steeped in foundations of mātauranga (encompassing Māori knowledges, worldviews, perspectives and practices) designed to guide and inform the approaches taken to research with Māori (Pihama, 2010; Smith, 2012). This approach is not structured or prescriptive and occupies space alongside non-Indigenous marginalized approaches to research that were initially carved out by critical, feminist and critical race theorists (Smith, 2012). Kaupapa Māori Research recognizes the legitimacy of Māori knowledges and accepts that Māori have always held and tested what are now described as “scientific” theories. In this sense, KMR shares assertions of critical theory by seeking to challenge the universality of dominant Westernized “knowledge” systems while remaining grounded in the New Zealand context (Smith, 2012).

A KMR approach is decolonizing in that Māori worldviews are embedded in the research process and enacted by privileging Māori perspectives, Māori practices and Māori priorities (Smith, 2012). In this way, Māori beliefs, values and experiences are centralized and normalized, rather than being marginalized or viewed through the dominant Westernized lens (Barnes, 2000). Various methods can be employed in KMR, with chosen methods being those tailored to address the specific research question and study design (Pihama et al., 2015). Research undertaken within this framework must therefore: be valued by, and of value to Māori; evidence the utility of Māori involvement to the wider research establishment; and be responsive to the needs of Māori by considering the confines and context of past research in ways that seek to be transformative (Pihama et al., 2015; Smith & Smith, 2018; Smith, 2012).

**Kaupapa Māori Research in Health and Mental Health**

Kaupapa Māori Research methodologies have been increasingly recognized as necessary when designing research that is conducted for, by and with Māori and they have been used extensively to investigate various health domains (Drawson et al., 2017; Pihama et al., 2002). During the development phase of this KMR paper, a search for and examination of previous qualitative research was completed in which Māori experiences of mental health were reported. It was found that KMR was the dominant methodological approach utilized in the majority of studies reviewed (22 of 34 papers from a methodology search including four Māori centered studies). Various reasons were given for selecting a KMR methodology to study Māori experiences of mental health. Strengths in this approach included: the flexibility to use different data collection and analysis methods; the ability to ensure safety of Māori researchers and participants; the focus on producing results of value to Māori communities; and the positioning from Māori worldviews (Awatere-Walker, 2015; Boulton, 2005; Dyall, 2003; Eade, 2007, 2014; Elder, 2008, 2013; Harris, 2014; Hughes, 2007; Johnson, 2009; Lambert, 2015; Ngata, 2014; Pere, 2006; Staps et al., 2019; Sweetman, 2017; Taitimu et al., 2018; Tricklebank, 2017; Wakaiti, 2007; Walsh-Mooney, 2009; Watkins, 2007; Wharewera-Mika, 2012; Wilson & Baker, 2012). Kaupapa Māori Research methodologies were described as particularly relevant in mental health settings because they provide a protected space for Māori participants to share sensitive information, and a non-deficit framing approach positioning Māori participants as experts to critique the influence and impact of mental health systems on their overall wellbeing (Dyall, 2003; Eade, 2007, 2014; Harris, 2014; Ngata, 2014; Pihama, 2010; Reid et al., 2019; Smith, 2012; Tricklebank, 2017; Walsh-Mooney, 2009; Watkins, 2007; Wharewera-Mika, 2012).

**Innovations in Kaupapa Māori Health Research**

To date KMR employing qualitative methods has provided valuable insights into how health services can be adapted to achieve health equity for Māori (Palmer et al., 2019). Recommendations have included the need to change the ways that clinical staff interact with and relate to Māori patients and their whānau, and other health service-specific adaptations (Awatere-Walker, 2015; Boulton, 2005; Drawson et al., 2017; Dyall, 2003; Eade, 2007, 2014; Elder, 2008, 2013; Harris, 2014; Hughes, 2007; Johnson, 2009; Lambert, 2015; Ngata, 2014; Palmer et al., 2019; Pere, 2006; Pihama et al., 2002; Staps et al., 2019; Sweetman, 2017; Taitimu et al., 2018; Tricklebank, 2017; Wakaiti, 2007; Walsh-Mooney, 2009; Watkins, 2007; Wharewera-Mika, 2012; Wilson & Baker, 2012). Some have also recognized that health services need to become more holistic in their view of wellbeing, and in their approaches to service delivery when working with Māori (Boulton, 2005; Dyall, 2003; Eade, 2007; Elder, 2013; Harris, 2014; Johnson, 2009; Ngata, 2014; Palmer et al., 2019; Staps et al., 2019; Sweetman, 2017; Taitimu et al., 2018; Tricklebank, 2017; Walsh-Mooney, 2009; Watkins, 2007; Wharewera-Mika, 2012). However, few have utilized the expertise of Māori patients to advocate or co-determine systemic change.

Dyall (2003) used the foundational document of New Zealand (Te Tiriti o Waitangi/The Treaty of Waitangi signed by British Crown and some Māori chiefs) to design a framework for exploring problem gambling. This approach produced Indigenous rights-based recommendations that called for the development of public health policies and increased iwi governance to prevent further harm to Māori whānau, hapū and iwi. Penney et al. (2006) drew on KMR with an action research methodology alongside Bieman’s Access Framework, to move the gaze from exploring patient factors as barriers to access, and instead highlighted the structural and systemic barriers within the health system. This project concluded that systemic
changes resulted in increased access to quality health service for Māori patients with ischemic heart disease (Penney et al., 2006). In a similar qualitative action-based research design, Hotu (2018) explored the role of individual and systemic factors on the health of Māori patients with chronic airway disease, through the utilization and adaption of a model of patient engagement. She identified the need for system level changes by moving from a disease model to a partnership model of intervention if health equity for Māori was to be achieved.

Each of these KMR studies utilized or adapted an existing framework to shape the development of interview questions to ensure they considered the impact of structural and systemic factors on Māori health (Dyall, 2003; Hotu, 2018; Penney et al., 2006). Frameworks were selected based on the specific research question and study aim to ensure that the impact of the wider determinants of health were considered and addressed.

**Kaupapa Māori Methods in Phase 2 of the MBDRP**

This section will provide relevant background to the MBDRP including the prevalence of BD and the structure of mental health service delivery in New Zealand. A rationale will be given to explain the reasons for selecting a KMR methodology for this project, and adaptations to a cultural competence framework will be discussed which informed interview questions and the analytic frame. The research methods, including the use of a semi-structured interview design, development of an interview schedule, participant recruitment, data collection, analysis and approach to coding will be reported to demonstrate how KMR principles were employed throughout the study. The CONSoliDated critERia for strengthening research involving Indigenous peoples (CONSIDER statement) will be utilized to conclude this section (Huria et al., 2019). We report against each of the 17 CONSIDER statement criteria in alignment with Indigenous research guidelines and priorities (Huria et al., 2019).

**Māori and Bipolar Disorder Research Project Context**

Evidence suggests that Māori may experience health inequities including disproportionately higher rates of BD than other ethnic groups in New Zealand after adjusting for socio-demographic factors (Baxter, 2008; Baxter et al., 2006; Goodyear-Smith & Ashton, 2019; Waitoki et al., 2014). While it was hypothesized that differential access to quality health services, experiences of racism, greater exposure to lifestyle risks and psychosocial stressors may influence rate differences, further mental health research was needed to understand the causes of identified inequities adversely affecting Māori (Baxter, 2008; Baxter et al., 2006; Waitoki et al., 2014). The MBDRP was developed in response to this.

Differential health outcomes that negatively affect Māori remain despite the stated goal to provide a “universal, tax-funded national health service” that works equally well for all New Zealanders (Goodyear-Smith & Ashton, 2019, p. 432). The New Zealand health system is structured around primary care delivered in General Practice (GP) and community-based services as well as outpatient and inpatient hospital services that are delivered regionally by one of 20 District Health Boards (DHBs). Mental health care for BD is generally accessed via GP referral to DHBs, and can involve periods of inpatient or community-based service use delivered by multi-skilled, multi-disciplinary teams within a psychiatric care model. The composition of DHBs can differ by region in terms of the range, structure and availability of Māori mental health services, Māori support workers and Māori health practitioners—meaning Māori experiences of mental health services may differ depending on where in New Zealand a person lives (New Zealand Government, 2018).

**Application of KMR in the MBDRP study**

A KMR framework was appropriate for the broader MBDRP, as well as the Phase 2 study described in this paper (Huria et al., 2019; Palmer et al., 2019; Pihama, 2010; Pihama et al., 2002, 2015; Reid et al., 2019; Smith & Smith, 2018; Smith, 2012). In line with KMR principles the research interviews were conducted by Māori researchers, positioned within a Māori-led research team (Huria et al., 2019; Palmer et al., 2019; Pihama, 2010; Pihama et al., 2002, 2015; Reid et al., 2019; Smith & Smith, 2018; Smith, 2012, 2015). This paper and the Phase 2 study were overseen by three Māori supervisors who each have Kaupapa Māori, Māori health and health research expertise. It involved interviews that captured Māori participants’ critique of Western health systems and the impact of these on wellbeing, and required collaboration and partnership with Māori health workers and clinicians at each DHB who assisted with participant recruitment.

The ability to transform, disrupt and decolonize multiple taken-for-granted aspects of the current mental health system was therefore a necessity for this research, and a further reason for utilizing a KMR methodology (Smith & Smith, 2018; Smith, 2012). This was needed to achieve the research aim, as the research team have specialist training in Māori health, mental health and KMR, and are trained in the application of Western models and employed in Western academic institutions. At the same time, the research team are embedded within Māori communities and derive their identity through these memberships. While the research team were not clinicians in any of the mental health services that participants were drawn from, continuous support was required from local Māori mental health workers and other key stakeholders to identify, approach, recruit, and provide ongoing care for eligible Māori patients and their whānau.

The research process was transformative, by positioning Māori mental health consumers as experts in their critique of the system. The research team, with specialist training and knowledge in the field of Māori health, as well as health service partners who assisted with the recruitment process, maintained a non-expert role. This positioning was imperative to enable
participants to disclose a deep and detailed discussion about their lived experiences, sharing a problematised view of the mental health system from a Māori community perspective – to then inform the development of transformative and well-being focused recommendations. In addition, this purposive repositioning was also transformative to the research team, in that it provided opportunities for reflection and recognition of the ways in which Western training and institutions influence and dominate ideas about mental health praxis. A further transformative element of the MBDRP privileges the insights and expert critique provided by Phase 2 participants, with plans to present these at Phase 3 to those involved in the design and delivery of mental health services, and through focus group discussions will establish priorities for systemic change.

Adapting a Cultural Competence Framework

Building on the innovations and contributions from existing qualitative KMR studies, for Phase 2 we searched for a framework to assist with exploring the impact of various systems on Māori patient and whānau experiences of BD. We selected the cultural competence framework by Betancourt et al. (2003) designed to address ethnic health disparities in the United States by identifying sociocultural barriers and enablers to overcome these across three tiers of the health care system. This framework was selected as it considers how organizational (leadership/workforce), structural (processes of care), and clinical (provider-patient encounters) barriers interact to cause health inequities that privilege non-minority patients, and how cultural competence interventions might work to reduce these disparities through targeted whole system change (Betancourt et al., 2003). In line with the aspirations of KMR to be transformational, the Betancourt et al. (2003) cultural competence framework was adapted to inform the development of interview questions that would capture the impact of exposure to structural and systemic factors on participants’ wellbeing over time, and to frame the qualitative analysis for this study investigating Māori experiences of BD.

Research Methods

The MBDRP and this Phase 2 study received ethical approval from the Health and Disability Ethics Committee of New Zealand (ID: 16/STH/137), and individual locality authorization was granted by sites where interviews were undertaken. The research proposal was written and conducted in accordance with Te Ara Tika guidelines, which utilize tikanga based principles (customary values and practices) to inform the development of research that aligns with Māori ethics (Hudson et al., 2010). This involved ongoing collaboration, engagement, and project updates including face-to-face meetings with key Māori stakeholders across each DHB site, and methods of recruitment, data collection and analysis allowed provision for cultural safety practices and positioned Māori patients and whānau as expert partners in the research process.

Research Aim

The aim of Phase 2 of the MBDRP was to explore the impact of systems on Māori patient and whānau experiences of BD. To address this aim, the research question sought to explore how Māori patients and their whānau conceptualized the impact of the determinants of hauora (health) on their wellbeing over time. The term hauora was intentionally chosen because it encompassed a Māori worldview and considered the relationships between wider contextual factors and multiple dimensions that contribute to a person’s overall wellbeing (Pitama et al., 2014). The concept of hauora is therefore much broader than a Western biomedical view of health, and incorporates an exploration of the historical, social and Indigenous-specific determinants of health (Greenwood et al., 2018; Pitama et al., 2014; Reid et al., 2019).

Semi-Structured Interview Design

A semi-structured interview design was an appropriate method for Phase 2 of the project given the exploratory nature of the research question (Ayres, 2012; Nathan et al., 2018). This method also aligned well with KMR methodology through ease of incorporating Māori protocols including whakawhanaunga-tanga (establishing relationships through reciprocal information sharing) to build rapport and mitigate the power differential between interviewers and participants, and by maintaining the mana (autonomy, authority, self-determination) of the participants through the use of open-ended questions (Cram, 2006; Lacey et al., 2011; Nathan et al., 2018). Given the potential that sensitive topics might arise when exploring participants’ experiences of hauora, participants could opt to undertake the interview by themselves or with whānau.

The involvement of whānau had multiple benefits including: exploring the experiences of whānau and the impact of systems on hauora; obtaining multiple perspectives about questions posed; gaining insights about periods of acute illness that patients were not always able to remember; and, the ability of whānau to recognize and respond to any early signs of distress during or after interviews through their interpersonal attunement, shared history and knowledge. The interviews were facilitated by two Māori researchers who had complementary clinical and cultural expertise. This approach was designed to ensure the safety of participants and researchers, with support available for both before, during, and after interview completion.

Interview Schedule

An interview schedule informed by the results of a systematic review of Indigenous peoples with BD was developed to explore identified knowledge gaps (Haitana, 2017; Haitana et al., 2018). The interview schedule was piloted and amended with questions subsequently posed in a chronological order, as this assisted Māori participants to provide a life course
discourse exploring the impact of various systems on their experiences of hauora with relative ease. Five broad topics were canvassed using open-ended questions to explore Māori patient and whānau experiences of: exposure to risk factors and the impact of these prior to BD diagnosis; precipitants to the onset of BD and pathways into mental health care; the course of BD over time; health services, treatment and management of BD; and any other contributions participants would like to make of relevance to BD. Interview questions were also designed to canvas organizational, structural and clinical barriers and enablers within the health care system in accordance with the Betancourt et al. (2003) cultural competence framework. This involved framing questions to elicit Māori patient and whānau experiences of barriers and enablers to health care access, quality care, and hauora arising from interactions with the health system over time.

**Recruitment**

Participant recruitment involved an initial orientation of DHB sites to the broader MBDRP research project, which allowed lead mental health workers to introduce the Phase 2 study to Māori patients and their whānau before deciding whether to contact the research team. While mental health staff did not participate in the interviews, they facilitated the whakawhanaungatanga process in various pivotal ways. This included organizing mihi whakatau (an informal ceremony to welcome the research team and facilitate introductions between staff, interviewers and interviewees) prior to interviews, aligning interview times to coincide with patients’ other scheduled appointments, providing comfortable spaces for interviews to be conducted across DHB sites, coordinating interview dates, times, and venues, and other forms of manaaki (ways of showing respect, care and hospitality) including organizing transport to interviews or supplementing participants’ travel costs with petrol vouchers, and arranging for Māori mental health workers to be present to support participants before and after interviews.

**Data Collection**

A total of 24 interviews were carried out with participants recruited from one of three separate DHB sites. The three interview sites were selected based on their differing rural and urban loci and the composition of mental health services within them, to capture experiences representative of the range of DHB and community-based services a Māori patient might expect to access across New Zealand (New Zealand Government, 2018). A purposive sampling frame was also chosen to ensure recruitment of men and women of differing ages (ranging between 21 and 70) from the three DHB sites.

Interviews were recorded and transcribed, and ranged in duration from 30 to 90 minutes. Interviews were completed in a range of different locations, with most conducted on DHB sites, some in participant’s homes, and others at the University-based Māori research unit. For some interviews, particularly those outside of the University setting, karakia (cultural incantations) were completed by participants or Māori mental health workers before and after interviews. When requested by participants, karakia were also performed at the University site or by a member of the Māori research team.

As interviews focused on exploring participants’ experiences of hauora, and the impact of various systems on hauora, interviews were conducted utilizing the Hui Process (Lacey et al., 2011). The Hui Process is an interview structure based on Māori values and protocols, made up of four components. Firstly, mihi mihi (greetings and engagement) required the researchers to have explained the purpose of the research and their roles as interviewers, given an outline of the structure of the interview, explored the interviewee/s understanding of the research, and sought informed consent verbally and in writing before beginning the recording device. The second component, whakawhanaungatanga, was utilized throughout the interview, and involved sharing information relevant to the interview setting as a means of establishing connections with participants. Thirdly, the kaupapa (purpose of interview) required completing the semi-structured interview process, and lastly the poroaki (farewell/conclusion of interview) provided an opportunity for participants to ask any questions, allowed the researchers to explain the next steps in the research process, clarified support for participants post interview, and discussed the dissemination plan of the research. Upon completion of each interview participants were provided koha (a culturally aligned protocol where you provide a gift to recognize the expertise of the participants and enact the importance of reciprocity). For this study koha was in the form of a supermarket voucher, and food basket.

**Qualitative Analysis**

An inductive thematic analysis was chosen for this study because of the theoretical flexibility of the method, its capacity to build the repertoire of junior members of the research team who were learning to undertake qualitative analysis, and its strengths when managing large data sets (Braun & Clarke, 2006). Thematic analysis was also the most frequently employed method of analysis among the sample of KM qualitative research projects reviewed during the development of this study due to the ease of alignment with a KMR theoretical position (Braun & Clarke, 2006; Eade, 2014; Elder, 2008, 2013; Harris, 2014; Johnson, 2009; Pere, 2006; Staps et al., 2019; Taitimu et al., 2018; Tricklebank, 2017; Wakaiti, 2007; Walsh-Mooney, 2009; Watkins, 2007; Wharewera-Mika, 2012). The data management software NVivo12 was used to assist with data display and analysis, and to facilitate review of emerging codes, categories and themes by all members of the Māori research team.

**Coding Procedures**

Two cycles of coding were undertaken to explore the research question and address the research aim (Marshall, 2011; Saldaña, 2016). The first cycle of coding was employed as
Table 1. Coding notes Adapted from Betancourt et al. (2003) Framework.

| Barriers & Enablers to Health Equity | Organizational factors | Structural factors | Clinical factors |
|-------------------------------------|------------------------|-------------------|-----------------|
| Betancourt                          | Health leadership and the workforce who design and deliver health care services and processes | Structure and function of health care systems that influence access, design and deliver services | Interactions between health care providers, patients and their families |
| Coding notes                        | Top-down health care systems; Structural processes between systems; Leadership that oversee delivery/ design and implementation; Composition of teams; Links to other systems; Organizational view/response to Māori patients/whānau. | Barriers or enablers to: health care access; or quality health care. Aspects of system design impeded by complexity/funding/bureaucracy. Processes related to: referral, timing, scheduling, location of service delivery as described by Māori patients/whānau. | Interactions between Māori patients/whānau and specific staff/health services/providers. Barriers or enablers to hauora related to/arising from clinical interactions. Specific interventions and their contribution to hauora. |

First cycle coding. Two phases were planned for the first cycle of coding. The first phase involved the use of structural coding, which groups interview data into segments according to a concept or phrase that each segment of transcript represents (Saldaña, 2016). The Betancourt et al. (2003) cultural competence framework was adapted to assist with organizing the interview data, which was grouped according to whether it related to the impact of organizational, structural or clinical barriers and enablers to Hauora featured in the interviews of Māori patients and their whānau. Adaptation of the framework was necessary to ensure organizational, structural and clinical features of the New Zealand health system were considered. Coding notes were developed from the Betancourt et al. (2003) framework to ensure a consistent approach was applied across each of the 24 interviews (see Table 1 above).

This approach to coding was chosen to ensure attention was given to participants’ reported experiences of the impact of systemic factors on hauora, as well as the more commonly considered individual, clinical or service-specific factors (Palmer et al., 2019). In addition, the use of the Betancourt et al. (2003) framework required adherence to a structure that ensured participant voices remained privileged in their expert critique of all aspects of the health system, mitigating the risk of defaulting to an interpretation of transcripts based on the research team’s training in Western institutions. Structural coding was also selected to assist with beginning to organize the initially large data set, into smaller subsets that would aid in the identification and development of interrelated categories, themes and theory (Marshall, 2011; Saldaña, 2016).

The second phase of the first cycle of analysis involved the use of descriptive coding to explore the topics of discussion within the structurally organized data groupings. Descriptive coding involves summarizing the data in an excerpt using a word or phrase that reflects the topic being discussed (Saldaña, 2016). It was envisaged that descriptive coding would highlight further codes, sub-codes and emerging categories within the three structural groupings and highlight the topics of discussion within these in preparation for Second Cycle coding.

Second cycle coding. Pattern coding was chosen for the second cycle of analysis. This involved reviewing the results of the first cycle of coding, and identifying patterns within the data sets to explain the relationships between codes, and categories via emerging themes (Saldaña, 2016). This approach was chosen to answer the research question and address the aim, by identifying themes explaining the impact of systemic factors on the hauora of Māori patients with BD and their whānau. This was achieved by identifying patterns as they appeared in relation to each section of the structural and descriptive phases of analysis, which provided a way to begin to synthesize the themes that were evident from Māori patient and whānau interviews. Table 2 demonstrates how both cycles of coding were applied to one interview excerpt.

CONSIDER Statement

We include the following CONSIDER statement in accordance with Indigenous research reporting guidelines, to provide a transparent summary of the research praxis undertaken in this study (Huria et al., 2019). Domain 1—Governance: The MBDRP was developed in consultation and discussion with Māori clinicians and researchers with relevant expertise; DHB staff from each of the three interview sites including Māori General Managers; and through established and ongoing relationships with iwi and iwi-based health providers. Endorsement for the proposal was given before the research began, and authorization was granted from each DHB site prior to participant interviews which included a protocol for harm minimization in addition to harm minimization steps set out in ethics approval documents. The MBDRP was led by a Māori principal investigator, and Phase 2 was exclusively undertaken by a Māori research team. Domain 2—Research Prioritization: The MBDRP was developed by an experienced Māori research
Table 2. Example of Coding Cycles.

| Interview Excerpt                                                                 | Structural coding                  | Descriptive coding          | Pattern coding              |
|-----------------------------------------------------------------------------------|------------------------------------|-----------------------------|-----------------------------|
| What I would like to see improved, is the dialogue that goes on between the psychiatrist and the nurses, I’d like to have much more contact with the psychiatrist than I do have at present, I’d like to have, I asked for years and years and years to have a psychologist like you come and see me, for years because I didn’t think I needed antidepressants, I just needed to be able to have a different language going on in my mind, and I never got it, not once.                                                                          | Clinical & Structural              | Range of options             | Treatment plan                |
|                                                                                   |                                     | Relationships with staff     | Community of care            |
|                                                                                   |                                     | Degree of flexibility        | Structure of health services |
| Never. And I’m still on my medications. I’m still on first generation medication, I’m still on lithium and quetiapine and citalopram they’re first generation, 30 years it’s crazy, it’s crazy! I’m sure that’s because the nurse in fact supports that, that whole like, no movement. Because the nurse can’t change anything when they come and see you. They can’t change anything. They just say “Oh well, how are your pills going such and such?” And then they report back to the psychiatrist, “X said the pills are going good”. | Clinical & Structural              | Range of options             | Navigating services & systems |
|                                                                                   |                                     | Ineffective interventions    |                             |
|                                                                                   |                                     | Communication                |                             |
| It absolutely needs to move out of that, what do you call it when it’s inside the structure?                                                                                                                                   | Structural                        | Structural processes          | Context of care settings      |
|                                                                                   |                                     | hauora                      |                             |
| Never. And I’m still on my medications. I’m still on first generation medication, I’m still on lithium and quetiapine and citalopram they’re first generation, 30 years it’s crazy, it’s crazy! I’m sure that’s because the nurse in fact supports that, that whole like, no movement. Because the nurse can’t change anything when they come and see you. They can’t change anything. They just say “Oh well, how are your pills going such and such?” And then they report back to the psychiatrist, “X said the pills are going good”. | Structural & Organizational       | Suitability of systems & processes | Structure of health services |
| It needs to move out of the, you know there’s sort of this hierarchy that’s going on at the moment. And at the top it’s the psychiatrist, and then over here somewhere is the, is the patient, it needs to flatten out altogether. | Organizational                     | Delivery of interventions     | Design & implementation of interventions |

team, and Phase 2 aims and priorities were informed by two systematic reviews completed during the study period (Haitana, 2017; Haitana et al., 2018; Palmer et al., 2019). Domain 3—Research Relationships: This paper details the approach taken to adhere to Māori ethical guidelines, and the involvement of Māori stakeholders in the research process. The research team was Māori led, and included Māori health professionals and researchers with diverse and complimentary Māori health research skills and expertise. Phase 2 analysis was exclusively conducted by the Māori research team. Domain 4—Research Methodologies and Methods: This paper details the methodological approach and analytic framework which addresses the questions in this domain. Domain 5—Research Participation: Biological samples were not collected for this study. Participant resource demands were kept to a minimum by utilizing routinely collected national health data, scheduling DHB visits at times when lead or Māori mental health workers were on site, and conducting interviews in flexible locations to minimize the need for participant travel. Participation in Phase 2 was voluntary, and no pressure was placed on Māori patients or whānau to take part in interviews. Koha was provided in various forms in recognition of participants’ time and expertise. Informed consent was sought from Māori patients and whānau prior to beginning interviews. Interview transcripts were de-identified, and securely stored on the University network where they will be held for 10 years. Domain 6—Research Capacity: The MBDRP supported the development of research capacity by providing employment, support and training to a Māori research assistant, and facilitating the completion of doctoral research by a Māori research fellow. The project team was supported by kaumatua (esteemed elder with cultural knowledge and expertise) who facilitated professional development through planning and delivery of tikanga. Domain 7—Research Analysis and Interpretation: This paper details the approach to analysis and interpretation which addresses the questions in this domain. Domain 8—Research Dissemination: A dissemination plan for the MBDRP was developed in consultation with key Māori stakeholders, and included plans for a Māori/English language report to be distributed to all participants; a commitment to publish in various journals; presentation of Phase 1 and 2 findings at DHB sites during focus groups; and proposing recommendations for systemic change to the New Zealand Ministry of Health.

Conclusion

This paper illustrates the transformative potential of a specific Indigenous methodology, KMR, for investigating and addressing institutional racism within systems that cause and maintain widespread health inequities unfairly distributed among the world’s Indigenous peoples (Dyall, 2003; Hotu, 2018; Penney et al., 2006; Smith, 2012). A cultural competence framework
adapted to suit the New Zealand context elicited the experiences of participants through targeted questioning, and arranged their expert insights according to their critique of the clinical, structural and organizational aspects of the mental health system through applying an analytic frame (Betancourt et al., 2003). This approach produced expert commentary drawn from Māori patient and whānau experiences of health systems that could then be presented to stakeholders involved in the design and delivery of mental health services. This additional Phase 3 step privileges the voices and expertise of Māori patients and whānau, and challenges those involved in the design and delivery of services to identify the barriers and enablers to transforming health care and the clinical, structural and organizational changes required to achieve health equity for Māori. This response was critical as systematic review findings have shown that capturing Māori voices in research alone has been insufficient to invoke the systemic changes needed to address the causes of longstanding health inequities (Palmer et al., 2019).

Indigenous knowledges, and the methodologies that simultaneously contribute to and derive from them, have long been utilized to conduct safe, ethical, and useful research practices by, with, and for the benefit of Indigenous peoples (Chilisa, 2012; Cochran et al., 2008; Curtis, 2016; Drawson et al., 2017; Greenwood et al., 2018; Jones et al., 2006; Pihama et al., 2002; Smith, 2012; Smith et al., 2016). It is pleasing to see the value of Indigenous Methodologies being recognized more frequently by the Westernized research academy through a comprehensive and diverse body of Indigenous scholarly work and publication, depicting the skills, innovation, and expertise that has always existed in Indigenous peoples enabling their survival despite colonial and imperial agendas (Barnes, 2000; Chilisa, 2012; Cochran et al., 2008; Cram, 2017; Pihama et al., 2015; Reid et al., 2019; Smith & Smith, 2018; Smith, 2012; Smith et al., 2016). As this paper shows KMR methodology involves much more than adhering to a set of prescribed rules or methods (Smith, 2011). The process undertaken, and the ethos that underpins the work is essential because it facilitates a partnership between Indigenous participants and research teams. In this paper, the ethos of KMR was enacted by the process through which participants’ experiences were entrusted to the research team, by positioning Māori patients and their whānau as experts in their critique of the mental health system, and by adaptation of an analytic framework that maintained the mana of participants by focusing on their critique of systemic factors to facilitate institutional change.

Research praxis needs to utilize methodologies that privilege the expertise of Indigenous voices if institutional racism that unfairly advantages non-Indigenous peoples is to be recognized and addressed (Huria et al., 2019). Kaupapa Māori Research, and other Indigenous Methodologies, have great potential to identify the root causes of global mental health inequities, and to generate solutions for the world’s Indigenous peoples unbound from the systems that create them. This paper illustrates the value added when research processes are informed by an Indigenous worldview and incorporate Indigenous practices. Supporting the development of Indigenous research methodologies and praxis, and promoting an increased awareness of this praxis among the research community needs to be prioritized (Huria et al., 2019). After all, research too is a system, and we have significant work to do before we have achieved the rights set out by the United Nations, or changed the perspective of research as “one of the dirtiest words in the Indigenous world’s vocabulary” (Smith, 2012, p. 1; United Nations, 2011).

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