Meihana Model: A Clinical Assessment Framework

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In 1984 Mason Durie documented a framework for understanding Māori health, Te Whare Tapa Wha, which has subsequently become embedded in Māori health policy. In addition, the adoption of this framework is now widespread among Māori and Iwi health and disability service providers and clinicians. Within psychological practice Te Whare Tapa Wha forms the foundation of a number of practice frameworks. This article presents a specific assessment framework, the Meihana Model, which encompasses the four original cornerstones and inserts two additional elements. These form a practice model (alongside Māori beliefs, values and experiences) to guide clinical assessment and intervention with Māori clients and whanau accessing mental health services. This paper outlines the rationale for and background of the Meihana Model and then describes each dimension: whanau, wairua, tinana, hinengaro, taiao and iwi katoa. The model provides a basis for a more comprehensive assessment of clients/whanau that then underpins appropriate treatment decisions.

When I (SP) was growing up in rural Hawkes Bay there was one question I was constantly asked each year when I returned to school after the summer break: "Did your whanau have a hangi for Christmas dinner?" I always had to answer, "No". This would invariably be met with looks, if not exclamations, of surprise. It was as if I'd broken some unwritten rule about what it meant to be a whanau at Christmas.

Just asking me one question did not reveal the whole story behind my hangi experience. It merely resulted in an absence of knowing about the other things that influenced my response; for example, people also needed to know whether or not my whanau:

- actually got together for Christmas,
- had the knowledge to build a hangi,
- wanted to engage in building a hangi

over the hot Christmas period,
- all liked to eat hangi,
- had space and resources available to build a hangi, and
- had an understanding of current council laws about building a hangi during a usual summer fire ban.

Mental health assessment is not that far removed from asking someone about whether their whanau had a hangi at Christmas. Invariably, asking a larger set of questions will lead to a greater knowing about a whanau and their circumstances (Huriwai, Robertson, Armstrong, Kingi & Huata, 2001). The risk for Māori within western-based mental health service delivery is that assessment is not based on a comprehensive set of questions within the appropriate cultural context. There are indications that inaccurate or inappropriate assessment of Māori can lead to misunderstanding, misdiagnosis

and mistreatment (Adamson, Sellman, Deering, Robertson, & de Zwart 2006, The MaGPIe Research Group 2005, Wheeler, Robinson & Robinson 2005, Simpson, Brinded, Fairley, laidlaw & Malcom 2003, Brined, Simpson, Laidlaw, Fairley & Malcom 2001).

The introduction of Te Whare Tapa Wha into clinical practice has allowed a wider understanding of the holistic nature of Māori mental health (Rochford 2004, Durie 1994, 2001). Te Whare Tapa Wha identifies four cornerstones of health and likens them to the four walls of a whare. In this way the cornerstones are seen to be interlocking and all essential to the maintenance of health and well-being.

The infiltration of this Māori framework into the delivery of health services to whanau, by iwi and mainstream providers is documented by a number of policy and technical reports (Ministry of Health 2000; Ministry of Health 2002; Ministry Of Health 2002b; Māori Health Committee 2001, New Zealand Guideline Group 2003; Public Health Advisory Committee 2003; Health Research Council 2004; Te Rapuora O Te Waiharakeke 2004; Canterbury District Health Board 2003; Whakapakari 2000) and emerging mental health research publications (Palmer 2004; Glover 2005; Durie & Kingi 1997). Such documentation has begun to clarify how Te Whare Tapa Wha is being operationalised in practice.

One journey of operationalising Te Whare Tapa Wha within the mental

health system is the development of the Meihana Model. This model was developed in three phases over approximately a 12 year period. The first phase involved the collection of information and the formation of an initial idea. In the second phase the gaps in this idea were identified and filled. Finally, the framework that had been developed was applied and peer reviewed (including in the context of teaching), leading to subsequent revisions and the framework that is outlined in this paper. This model developed from a desire to implement Te Whare Tapa Wha within psychological practice with the primary aim being to provide a set of guidelines easily applied in clinical settings.

From the beginning the Meihana model has identified the whanau as the centre of the assessment and intervention processes. This ideology locates the identity of Māori within a collective. It challenges the practitioner to see an individual as part of a whanau and to explicitly engage with and utilise the whanau as part of assessment and intervention.

Development of the Meihana Model[1]

Phase I

Psychological practice within a mental health setting is largely premised on western models of mental health and well-being (Love & Whittaker 1997; Todd, Sellman & Robertson 2002). The authors consider that the challenge is how to move from a purely western framework to one that also actively engages with Māori beliefs, values and experiences. Te Whare Tapa Wha provides a macro-level conceptual base for doing this. What is needed however is clearer identification of the micro-level, day-to-day operationalisation processes to test the practical/clinical utility of this base (Wheeler et al 2005; Cram, Smith & Johnston, 2003; Durie 2003; Manna 2002; Durie 2001).[2] The Meihana model is an attempt to further identify such processes.

The first step in developing the Meihana model was a review of existing knowledge in this area (Durie 2001). In addition to a standard literature review, 25 health clinicians (18 Māori,

7 non-Māori) within Auckland were interviewed over a 5 year period. They included: psychologists, general practitioners, nurses, social workers and special education advisors. Participants were asked to describe how they were implementing Te Whare Tapa Wha within their own practice. It became clear from these interviews that while these clinicians were familiar with the core principles they often struggled to put the model into practice within their clinical settings.

These findings coincided with a particular project development within Special Education Services (SES now GSE, Ministry of Education). Attempts to roll out a standard behaviour intervention programme led to challenges around the cultural appropriateness of the tool for working with Māori. As a result the primary author was assigned to draft specific guidelines for working alongside Māori clients and their whanau. These guidelines included information about how to amend behavioural assessment tools so that they complemented Māori values and belief systems. This process took a period of 12 months. This became the genesis of the Meihana model framework. At this stage the framework effectively re-aligned standard clinical practice to work within the broad dimensions of Te Whare Tapa Wha, intermingling mainstream and Māori approaches.

Phase II

In Phase II the primary author worked with the initial framework for six months to assess its effectiveness in eliciting relevant information from the client/whanau and their environment. This investigation was undertaken alongside clients and their whanau within educational settings, where the clients were seen as having 'severe and challenging behaviours'. This facilitated the identification of two main 'gaps' in the existing framework: firstly, the absence of a significant focus on the physical environment of the whanau (e.g., warmth of their house, access to amenities, service environment); and secondly, the lack of focus on the wider societal context within which whanau existed (e.g., societal values, laws and beliefs about appropriate behaviour).

Two dimensions were therefore added to the framework: Taiao (physical environment) and Iwi Katoa (societal context). These additions highlighted a need for all dimensions to be clearly defined in relation to the clinical context. This, in turn, led to an increased level of specificity in definitions to reflect each dimensions place within a mental health clinical assessment process. Thus, the first version of the Meihana Model was drafted.

Phase III

In Phase III the Meihana Model was tested to see if it helped clinicians to engage with Māori patients. The aim was to facilitate the drawing on of relevant information when formulating hypotheses, and more succinctly integrating both clinical and cultural elements. In the first instance this involved two psychologists, one nurse and one GP utilising the model over a five year period. They used the model within clinical settings in which clients/patients (both adult and children) had experiences of addiction, depression, trauma, and chronic illnesses. Discussion between these four clinicians provided feedback and assisted in the final revision of the Meihana Model. Over time these clinicians were able to articulate the application of the key elements in ways which moved beyond use of decontextualised check lists, simplistic stereotypes and ahistoric freeze frame notions of being Māori.

This process allowed the Meihana model to also be tested within the context of clinical teaching to ensure that the definitions and practices around the dimensions were clearly able to be understood and applied within clinical situations. This involved five years of teaching by the above four health clinicians and several colleagues in the following groups:

1. Post-graduate Health Science students in the context of child and family psychology, addiction treatment and public health,

2. Undergraduate medical students within the context of applying Hauora Māori theory in clinical settings, and

3. GP groups within the context of their cultural competency training for working with Māori patients.

This process involved developing clinical examples for teaching and using case studies, role plays, video exams and observed clinical simulated exams (OSCEs), as well as assignments with Māori patients to measure students uptake of the learning objectives.

Māori Beliefs, Values and Experiences (MBVEs)

One of the central findings of the Phase III development of the Meihana model was the need to clearly locate the six dimensions and their clinical application within consideration of Māori beliefs, values and experiences. It was found that often the integration of a holistic model such as Te Whare Tapa Wha lead to assertions of this being just 'best practice.' This discourse 'de-Māorified' key Māori beliefs, values and experiences. In this context clinicians assumed that if they work within a 'safe framework' they could utilise the same cultural check list on any of their ethnic minority clients. This in turn tended to lead to a default to predominant culture assumptions and expectations, with little if any real consideration of clients' specific cultural needs and wants.

To counter this, the Meihana model includes the core concept of Māori Beliefs, Values and Experiences (MBVEs) which overlay the six dimensions that make up this framework. Within the development of the Meihana model the need to avoid defining and constricting Māori clients/whanau on a continuum or spectrum of 'Māoriness' was clearly identified during Phase III. Thus, the Meihana model works on the assumption that any client/whanau that self-identifies as Māori is Māori, regardless of the degree to which this is evident to the clinician.

The role of the clinician is not to determine 'how Māori the client is', or their level of 'Māoriness'. It is instead to identify their beliefs, values and experiences within a Māori context, both currently and in the past. This allows the clinical team to explore how these factors influence and impact on presenting issues and how they may impact on potential intervention plans. While a number of common broad elements are apparent, there is no 'checklist' for MBVEs; as each client will present with a complex potpourri of MBVEs that clinicians need to identify and explore. The depth of such analysis will be dependent on the individual clinician's 'Māori competencies'. However a central element of exploring MBVEs lies in the willingness and ability of clinicians to seek appropriate Māori cultural advice during the processes of assessment, formulation and intervention.

The best way to explain MBVEs is to share a brief clinician example:

> *A young man tells you he is from Ngati Kahungunu, has moved to Christchurch recently to attend University. He has been involved in Kapahaka in the past, but does not intend to be involved in these activities while he is not at 'home.' He presents with visual hallucinations and often uses te reo in the midst of his sentences. You ask him whether he would like a Māori case worker and he replies that he doesn't want to be treated any differently than anyone else. It is his second admission within two years.*

Within traditional western assessment strategies we might miss some key MBVEs impacting on this young man's presentation, as well as, ways in which we can improve our practice in response to that. A number of potentially salient issues and questions arise in this case. Firstly, it is notable he knows his iwi; leading to questions about the significance of this to him. Do you know that iwi as a clinician? What does this mean in terms of further questions you might need to explore? (e.g. Where in Ngati Kahungunu is he from? Was he bought up in that area? Where do his whanau live?). What is kapahaka? How involved was he? Why has he decided not to continue that in Christchuch? Does he connect with this activity? What might be the strengths of him being involved in kapahaka? Are his visual hallucinations culturally congruent? How could you further explore this? What kind of te reo is he using? (e.g. conversational? fluent? a particular dialect?) Why is he using the words within this context? What should your level of utilisation of te reo be within this context? Why is it that he is comfortable telling you about his iwi as a clear cultural identity marker, but clearly stating that he doesn't want to be treated differently? What are his experiences of being treated differently? How might you address this?

Furthermore a clinician's investigation should also include Māori health research that might inform the depth of their assessment, for example, in relation to prevalence, patterns of presentation and diagnosis, Māori experiences in health services and access to care.

Within each dimension of the Meihana model the practitioner needs to overlay MBVEs to ensure integration of cultural realities with clinical presentation.

The Meihana Model

The Meihana Model is a framework that facilitates fusion of clinical and cultural competencies to better serve Māori within mental health service delivery. It has six dimensions that interconnect to form a multi-dimensional assessment tool. This tool is able to encompass the strengths and abilities of the clinician while taking into account the diverse needs of the client and their whanau. It needs to be clearly noted that the aim of the details outlined below is to provide a practical basis for clinical application, rather than definitive definitions of each dimension.

The main focus of the Meihana Model is to increase Māori health gain and successful outcomes within mental health settings through engaging in an appropriate assessment/intervention and monitoring process. The Meihana model is designed to be used from the first contact with a client/whanau. It aims to deliver a comprehensive picture of whanau circumstances and how the client's presenting issues fit within this context.

Due to its multi-dimensional approach it requires ongoing assessment with the client and their whanau, and may require a number of key health workers to act as informants in the assessment process. The Meihana Model actively supports an integrated health care approach and dictates the

need for a lead facilitator who, with the consent of the client/whanau will coordinate the gathering of assessment information across the dimensions.

The Meihana model has the pre-requisite that clinicians who utilise it have a clear understanding of cultural safety and cultural competency, and are able to demonstrate abilities within both of these areas with regards to Māori (as is discussed in Manna 2002; Thomas 2002). It also requires that Māori expertise is utilised throughout the entire assessment and intervention process to ensure appropriate cultural analysis of all data/information and implementation of resulting interventions The model can only be effective however, if the systemic support structures in place allow clinicians to apply it in its entirety. Therefore, the component parts will first be discussed from a systemic/service delivery perspective and then from a clinical/client based perspective.

Meihana Model – Systemic/ Service Delivery Context

Dimension: Whanau

Definition: Client support networks.

Rationale: Whanau are seen as having a key role in the assessment, intervention and monitoring process of the client/whanau.

Relationship to Service: Policies are needed to support the engagement of client without isolating whanau (Ministry Of Health 2001; Durie 2001). This involves including whanau within the assessment and intervention processes, and having space that allows this within clinical settings. Whanau should have the opportunity to identify what level of integration of Māori cultural input they want to engage in and to give feedback to services about their perceived level of cultural safety and competency.

Dimension: Tinana

Definition: Working to promote physical well-being of client/whanau.

Rationale: To ensure that the service encompasses the importance of physical well-being and its relationship to overall psychological well-being.

Relationship to Service: It is beneficial for services to have policies

and practices which enable them to refer clients for physical assessments and/or access medical information on the client/whanau, when given appropriate consent. Results from these assessments need to be clearly articulated to clients/whanau in relation to how they will inform the overall treatment plan

For this process to occur efficiently, the service will need to have clear working relationships and referral procedures in place with general practitioners and other providers of physical health care. These may be on the same or on other work sites. Referrals will ideally be made to other services that are identified as working appropriately with Māori clients. Where possible processes should be introduced that reduce cost and other potential barriers for clients to these new referral settings.

Dimension: Hinengaro

Definition: To address clear potential biases within current psychological practice.

Rationale: To ensure cultural account-ability of measures used to provide evidence that supports or challenges hypotheses around the presenting behaviours.

Relationship to Service: All assessment tools and diagnosis processes need to be placed within the appropriate cultural context to ensure valid hypotheses are drawn and that potential interventions sit within appropriate cultural norms. Services may develop practice guidelines or supervision modules that highlight potential biases or barriers when working with Māori (Ogden, Cooper & Dudley, 2003).

Policies and resources need to be developed that support clinicians to engage in appropriate supervision to ensure that the analysis of the assessment data is matched to Māori beliefs, values and experiences.

Dimension: Wairua

Definition: Level of attachment.

Rationale: To investigate factors that contribute to engagement and therefore the level of attachment the client/whanau feel to the service and the services being provided at a more general level.

Relationship to Service: This area has traditionally been labelled as spirituality. This dimension has often been neglected by clinicians who consider that they do not have competencies to work in this area, or see it is the role of others to investigate this realm. However within the Meihana model all dimensions need to be explored to ensure effective service delivery that is responsive to Māori beliefs, values and experiences. This requires explicit support and resources to enable workers to extend beyond the potentially limited focus of western paradigms.

From a service delivery perspective the Meihana model has re-defined this dimension to highlight two key areas; attachment and spiritual practice. Firstly, attachment identifies who and where the client/whanau feel connected to. Within service delivery there is a responsibility to ensure that the client feels safe and welcome so that they become sufficiently 'attached' to the service. This may be to the support worker, clinician, organisation and/or whare. This benefits both client/whanau and service as higher levels of attachment reduce rates of non-attendance and enable the client/ whanau to feel safe to articulate any current barriers to attendance.

There is a need to address attitudes, values and beliefs (within a service) that may be barriers to the client/ whanau becoming 'attached'. It is the expectation that services will support staff to evaluate their own beliefs and their potential impact on Māori clients/ whanau.

Secondly, the service needs to allocate a place for specific practices that have been identified by clients as of value to this dimension (e.g. karakia, whakawatea, whanau room) and how these will be facilitated within the service. This may include processes that support integration of wairua within assessment; the ability to identify key staff professional development areas, engaging with staff and/or accessing other external services to support whanau/clients in this area.

Dimension: Taio

Definition: The physical environment of the services.

Rationale: Ensuring physical accessibility and acceptability of the service.

Relationship to Service: Organisational facilities are not always readily accessible to client/whanau due for example to lack of parking and distance from public transport. Some facilities are not whanau friendly (e.g. small interview rooms), and do not promote inclusion of whanau during the assessment process. The lack of Māori mediums (e.g. posters, signage) within the organisation or the visible lack of Māori staff may not support client/whanau in engaging with the service.

Services need to develop policies around the pro-active recruitment of Māori staff/clinicians (Herbert 2002, Robertson, Haitana, Pitama & Huriwai 2006) and clear recruitment process and interview procedures to make this process transparent. Advice and guidance should be sought as necessary to increase the attractiveness of the services to Māori stakeholders (client/whanau/provider groups).

Dimension: Iwi-Katoa

Definition: Societal structures that impact on the capacity of the organisation to work alongside client/whanau.

Rationale: To identify current organisational strengths and weaknesses to work effectively with Māori client/whanau.

Relationship to Service: This dimension challenges the clinician to be reflective that their own social reality may be quite different from that of Māori client/whanau and how that might constrain effective delivery of processes and protocols within the service (Harris, Tobias, Jefferys, Waldegrave, Karlsen & Nazroo, 2006).

Iwi Katoa encourages services to look at the impact that service policies, processes and culture have on retaining and providing appropriate services to Māori clients/whanau (Ministry of Health 2002).

Iwi Katoa also identifies the need to look at national polices and prevailing societal attitudes and how these impact on Māori clients/whanau and may contribute to their presenting issues. There is increasing evidence that a range of systemic and structural factors have an impact on Māori access to health care (Adamson et al, 2006, Davis, Lay-Yee, Dyall, Briant, Sporle, Brunt & Scott 2006, Harris et al, 2006).

Meihana Model – Clinical/Client/ Whanau Focus

Once key systemic support structures are in place it is then possible to apply the Meihana model within a clinical setting. The following section will explore the dimensions specifically in terms of their clinical application.

Dimension: Whanau

Definition: Support networks.

Rationale: To identify and access key networks available to and impacting on the client.

Relationship to Assessment: Whanau has traditionally involved those who share similar genealogical ties and as such share land, language, history and resources. More broadly whanau can also be inclusive of peers or others who have a support role for the client, often described as a Kaupapa Whanau (Cram & Pitama, 1998). Using this wider definition within a mental health assessment has beneficial implications for both the client and their whanau (Durie, 2003). It acknowledges that a range of groups are encompassed under the heading of Whanau that are able to offer support, guidance and energy to the client. It also allows for application of the principles of whanau providing options where kin whanau resources are limited or unavailable.

Whanau are also a resource for the clinician and have provided a vehicle by which clear physical and mental health histories have been gained about the client (Durie, 2001). Whanau have also been utilised as key support people to manage and monitor the client when they are placed in 'community' care. They also establish a line of accountability for the clinician, beyond to the individual client.

Dimension: Tinana

Definition: Physical body of the patient and/or their whanau.

Rationale: To identify the impact of the physical health, functioning and well-being to the overall wellness of the patient and their whanau.

Relationship to Assessment: Within the Meihana model Tinana, is used to denote the need to explore the overall physical health status of the client and their whanau. This information can be gathered by a range of sources, including medical professionals, whanau, school, and other allied professionals. This information assists with drawing together an accurate profile of the client's physical status, allowing a comparison of current and past functioning.

Whanau physical health history also assists the clinician to develop a comprehensive assessment/ formulation. A key focus, for example, may be exploring with the client and their whanau how they have coped with physical ailments and what resources they have accessed. This illustrates the extent to which whanau are able to draw on and utilise resources and provides an opportunity to look at whanau experiences within the realm of physical health care. It also potentially identifies information that could support future mental health interventions (e.g. barriers to accessing care, low expectations of health services, negative health care experiences).

This dimension also allows an exploration of the client's physical presentation, which may influence how others interpret the client and their whanau behaviours. They also impact the expectations of society and the practitioner which need to be acknowledged. For example, some Māori patients have reported feeling marginalised because hospital services did not recognise or acknowledge them as being Māori and therefore did not offer Māori health worker support.

Dimension: Hinengaro

Definition: Psychological well-being.

Rationale: To identify the impact of intrapersonal variables with specific consideration of cultural context.

Relationship to Assessment: This dimension encourages clinicians to draw on both client and whanau mental health histories to identify alongside Māori client/whanau accepted norms and what behaviours/thoughts/feelings are seen as being outside of these.

To assist with appropriate client/whanau history taking the clinician needs to build appropriate rapport and create an environment that is safe for client/whanau to discuss historical issues. All assessments used in this process should be made clear to the client/whanau and how that information will feed into an overarching formulation. The Meihana model makes clear that appropriate cultural peer supervision should assist in deciding what assessment tools/processes are utilised within the analysis.

Dimension: Wairua

Definition: Levels of attachment and engagement with spiritual beliefs.

Rationale: To explore the client's level of connectedness to people, things and/ or places, as well as spiritual values and the impact on their behaviour.

Relationship to Assessment: The Meihana model defines the application of wairua practically in the context of assessment/intervention. It involves two key components: first of these is earthly/ grounding attachment in terms of another person(s), thing and/or a place that is seen by the client as someone, something or where they feel they belong and are supported by for example a parent or close friend, a soft blanket or toy (especially with children), a home in which they felt safe, a place where they feel at peace. In risk assessments the absence of such a connection may indicate a higher risk for self-harm behaviour. Conversely, the presence of such a connection becomes a strength to build on within the assessment and intervention process.

The second component is an exploration of spiritual frameworks – specifically around how they inform the client/whanau's values and beliefs. This may be inclusive of traditional tribal/whanau beliefs, religious beliefs and/or personal spiritual journey's that support client/whanau identity. Assessment in this area includes the clinician exploring the degree of

alignment of client's values/beliefs/ behaviour and the current presenting issues, as well as concordance with whanau norms.

Dimension: Taio

Definition: The external physical environment.

Rationale: To explore the impacts the physical environment is having on the client/whanau.

Relationship to Assessment: This dimension encourages clinicians to seek an understanding of the physical environments that the client/whanau interacts with, and draw their experiences and values from. If key risk factors exist within the client/whanau environment(s), (e.g. exposure to violence, poor housing, drugs, a lack of service access and poverty), these variables need to be built into the assessment and management planning.

Secondly, taiao explores client/ whanau satisfaction with the health care facility and explores whether it is an appropriate place to undertake the assessment and intervention. This may highlight changes needed within the facility environment and/or dictate that some aspects of the assessment and management occur externally to the service. A need for the referral to other clinical/service settings may also be identified.

Dimension: Iwi Katoa

Definition: Societal impact on the client/whanau.

Rationale: To determine the extent to which current societal perceptions, beliefs and services impact on the well-being of the client/whanau.

Relationship to Assessment: This section of the Meihana model requires identification of core societal beliefs, values, experiences and perceptions that are impacting on how the client/ whanau and how they relate to clinical presentation. Iwi Katoa also acknowledges the legal scaffolding that is set up in society and acknowledges how that may impact on the client/whanau (e.g. Mental Health Act, service process for reporting abuse).

Clinicians need to be able to explore client/whanau experiences around societal beliefs/values, to determine the impact of such things as low

socio-economic status (Robson 2004; Ministry of Health & University of Otago 2006), racism (Harris, et al 2006) and other prejudices (Ministry of Health & University of Otago 2006), including how these may act as barriers to wellness. This provides important information to enable development of assessment and intervention planning that better matches the social reality for the client/whanau.

Discussion

Working with Māori clients/whanau can not be put into an equation or oversimplified using a number of formulated tables. Psychological practice is usefully guided by frameworks that can be applied to individual circumstances and that are inclusive of individual differences. The Meihana model, however, highlights that the assessment/intervention is not limited to the interaction between the clinician and the client. It is instead a combination of multiple relationships that occur within a larger system. This model enables clinicians and services to recognise the need for development of support initiatives and policies that create an environment responsive to the needs and aspirations of Māori.

The purpose of this paper has been to present a practice-focused model that has developed by applying culturally congruent theoretical knowledge to clinical practice. It is a model that is couched within a Māori health framework, which validates Māori beliefs, values and experiences within a clinical setting. During the trialling of the Meihana model, Phase III identified that all four clinicians reported that they were able to complete more thorough assessments and provide more coherent treatment by using this framework. This was largely due to explicitly utilising MBVEs over the six dimensions within the model. This encouraged more in-depth exploration of presenting concerns which, in turn, revealed more about client/whanau history. Within a teaching context the Meihana model was seen as 'engaging and practical,' with students showing an ability to apply the model to paper cases and clinical interviews conducted for a specific Hauora Māori patient assignment (as gauged by assignment

quality/marks and student evaluation of the curriculum content).

Within teaching settings concepts promoted in the Meihana model have at times been referred to as 'just best practice.' This stance has been strongly challenged by the authors as it has often been used to nullify the unique essence of Māori models and justify deferral to dominant culture practices. What is not acknowledged is that although there are some components which may be transferable to other clinical settings, there are also some central facets of the Meihana model that are distinctively Māori. These come from Māori philosophies and paradigms that are, at least to some extent, familiar to and work well for most Māori (Huriwai et al, 2001) There is a need for clinicians to more critically appraise mainstream approaches that struggle to show successful outcomes for Māori (Adamson et al, 2006). Māori health gains in mental health are likely to increase as clinicians and mental health services recognise the benefit of working with Māori within Māori frameworks.

The challenge within the Meihana model is for services to provide adequate support and professional development for clinicians to enable them to develop a clearer understanding of Māori beliefs, values and experiences. Services also need to ensure that there are Māori peers, Kaumatua and other Māori support roles to facilitate appropriate assessment and analysis. This needs to occur in a broader context in which funders, planners and services are structurally committed to increasing success outcomes for Māori within mental health.

Limitations of the Study and Further Research

To date the Meihana model has been trialled by a small number of Māori clinicians within relatively limited clinical and teaching settings. The purpose of this paper was to provide a start point for discussing clinical application of core Māori concepts by documenting the development of this model. This model still needs to be trialled within wider clinical settings by both Māori and non-Māori clinicians, to further detail the impact of the Meihana model on the assessment and

management of Māori clients/whanau. The model requires some initial training before it can be utilised by clinicians to ensure key concepts are understood and its applicability in different settings are clearly articulated. A strength of the model is that it can be applied by both Māori and non-Māori clinician, although there is a clear need to ensure appropriate levels of support are in place and maintenance of practice within the limits of individual competence.

Additionally, there is a need to clarify the ways in which the Meihana model might be differently applied or effective for Māori and non-Māori clinicians. The Meihana model strongly promotes inclusion of whanau, as this greatly enriches the processes and information gathered within the assessment process. Elucidation of the dynamics of accessing and utilising whanau in assessment and intervention is another area in need of further exploration.

Epilogue

As a child we did have hangi for special occasions (significant birthdays, weddings, tangi) but for Christmas everyone would allow my mum, who is Pakeha, to celebrate the season with a traditional English roast (although it would often be 32 degrees). We would seek to support her cultural values, which would then be followed by 'traditional' Māori desserts such as trifle and steamed pudding (highlighting the need to ask a bigger range of questions and to understand diverse experiences of Māori whanau).

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Notes

1. The name of the model derives from Suzanne Pitama's (nee Meihana) whanau (Ngati Kahungunu/Ngati Whare) and recognises the formative work of Mason Durie in the development of Te Whare Tapa Wha.

2. Graham Smith (1997) discusses a similar relationship between theory and practice in his thesis on Kaupapa Māori education; namely that practice informs theory and theory is tested out in practice.

Glossary of Maori words not defined within the Meihana Model:

hangi - earth oven, consisting of a circular hole in the ground, in which the food was cooked by heated stones.

iwi - tribe, tribal base of which one has genealogical connections.

kapahaka - Maori cultural performing arts

karakia - prayer, charm.

whakawatea - a clearing process.

whanau - extended family.

whare - house, building

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