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Article

Mahi a Atua: A Māori approach to mental health

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Abstract

Māori are the indigenous people of Aotearoa New Zealand. European colonisation had a devastating effect on their communities and their way of life. While there is some evidence of a renaissance of Māori culture in recent years, like other indigenous people across the world, they continue to be massively overrepresented in their country's figures for poor mental and physical health. In this paper, we briefly review the literature on the Movement for Global Mental Health and review the case that has been made for the use of indigenous psychologies in place of approaches based on Western psychiatry and psychology. We present two case histories where an intervention based on an indigenous Māori approach to negotiating emotional conflicts and dealing with mental health problems was used. This approach, called Mahi a Atua, was developed by two of the authors over a number of years. We conclude that indigenous approaches to mental health offer not just an adjunct to, but a real alternative to, the interventions of Western psychiatry. They provide a framework through which individuals and families can negotiate their journeys through mental health crises and difficulties. However, such approaches can also work on a socio-cultural level to promote a positive identity for indigenous communities by celebrating the power of indigenous deities, narratives, and healing practices that were marginalised and suppressed by the forces of colonisation.

Keywords

Global mental health, indigenous psychology, Mahi a Atua, Maori, New Zealand

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Introduction

In the past 10 years, a Movement for Global Mental Health (MGMH) has emerged that seeks to provide solutions to mental health problems around the globe (Patel, Boyce, Collins, Saxena, & Horton, 2011). The MGMH is based on the idea that the answers to mental health problems are held by psychiatry and the "grand challenge" facing the world community is to make these answers available, in one form or another, to all the peoples of the planet (Collins et al., 2011). This movement has emerged from within Western psychiatry and is premised on the fundamental assumptions of psychiatry (Kirmayer, 2012). This involves a technical approach in which states of madness, distress and dislocation are understood to be states of disease that require investigation, treatment, and elimination in the same way that diseases of the body do (Bracken, Giller, & Summerfield, 2016). Progress is understood to come from research done by academics, researchers, and clinicians who are trained in Western psychiatry or psychology, or by groups who are involved in scaling up "evidence-based interventions" to reach more people (Lancet Global Mental Health Group, 2007). While the leaders of the MGMH have shown a remarkable ability to shift their conceptual frameworks in a rhetorical quest to engage with different stakeholders (Bemme & D'souza, 2014), the interventions they advocate are usually some form of pharmacotherapy or adjusted form of cognitive behavioural therapy (CBT). These are, most often, based on a psychiatric understanding of what the problems are and how they should be tackled. In a paper looking at "evidence-based" treatments for depression, for example, Patel and colleagues list only interventions developed by Western psychiatry and psychology, such as antidepressants, electroconvulsive therapy, and different forms of psychotherapy (Patel, Simon, Chowdhary, Kaaya, & Araya, 2009). The MGMH seeks to train more workers around the world in assessment, diagnostic, and intervention technologies that are premised on the idea that states of madness and distress are best conceptualised as a series of discrete entities that can be treated with a set of targeted interventions.

This movement has grown and now dominates international discussion of mental health issues and priorities. However, there is a growing counter-discourse that worries about the exportation of Western psychiatry across all the communities of the world. It is sceptical about the putative achievements and benefits of Western psychiatry and urges caution about this one-way flow of "expertise" (Bracken, Giller, & Summerfield, 2016; Fernando, 2014; Mills, 2014; White & Sashidharan, 2014). This critique urges greater awareness of the scientific limitations (Gøtzsche, 2015) and ethical corruption (Whitaker & Cosgrove, 2015) of a great deal of Western psychiatry.

Furthermore, it points to the extent and variety of very different healing systems in many communities around the world and argues that there is a danger that these will be weakened and even destroyed by the widespread transmission of Western psychiatry and its allied disciplines. This could have the effect of reducing the range of therapeutic options available to such communities (Higgenbotham & Marsella, 1988). There is evidence from Northern India that this is happening already

(Sood, 2016). According to the proponents of this counter-discourse, the world actually needs less psychiatry and more respect for the wisdom of indigenous knowledge and healing traditions. It seeks not a scaling-up, but a scaling-down of the voice of Western psychiatry.

The need for indigenous approaches to mental health

The form of psychiatry that has emerged in Western countries in recent decades is based on a particular ontology, epistemology, and ethics (Cox & Webb, 2015). This way of understanding people and their struggles has become dominant in a very particular economic and cultural milieu, one that, despite the forces of globalisation, is alien to many communities around the world. Its materialist and individualist focus means that it is often a specifically inappropriate vehicle to use with indigenous communities. Such communities are often struggling to reassert a positive ethnic identity after centuries of colonisation and even genocide (Gracey & King, 2009). Their own healing systems were often crushed and outlawed in the process of colonisation (NiaNia, Bush, & Epston, 2017). Kirmayer maintains that ''the loss, disruption or displacement of traditional healing practices went hand-in-hand with the undermining of worldviews and the destruction of a way of life'' (2012, p.253).

Thus, attacks on traditional healing systems had the effect of weakening indigenous beliefs that gave meaning and structure to life. And such belief systems can be the very things that sustain people through periods of pain and struggle. Western medicine and its institutions were often complicit in processes of colonisation and genocide. Ernest Hunter (2001) points to similarities between German medical professionals who were brought to trial at Nuremberg for their involvement with the genocidal efforts of the Nazis and those who were involved in the destruction of aboriginal families in Australia in the first half of the 20th century. He writes that the resonances between these events and settings point to ways ''in which medical professionals continue to contribute to the traumatisation of indigenous peoples in Australia through denial, rationalisation and trivialisation'' (2001, p.26).

The reality for many indigenous communities is that their cultures remain under attack from many sources. In a globalised world, many of these communities are losing their languages, and their young people are more interested in the happenings of the global media than in their own traditions and activities. Many are struggling to even survive economically, culturally, and spiritually. Many are now experiencing very high levels of distress, addiction, madness, and dislocation. While such problems are usually discussed in a language of ''mental illness'' and various diagnoses such as ''PTSD'', ''depression'' and ''schizophrenia'' are used, the highly individualised idiom of psychiatry fails to capture the ways in which whole communities are struggling and can serve to obscure the social, cultural, and economic dynamics that lead to such suffering (Samson, 2009). Commenting on the way in which many aboriginal families in Canada were destroyed by state policies

that were "motivated by a condescending, paternalistic attitude," Kirmayer and collaborators write: "The collective trauma, loss and grief caused by these short-sighted and self-serving policies are reflected in the endemic mental health problems of many communities and populations across Canada. However, framing the problem purely in terms of mental health issues may deflect attention from the large scale, and, to some extent, continuing assault on the identity and continuity of whole peoples" (2001, p.8).

Thus, there is a need to develop ways of discussing states of madness, dislocation, and distress in indigenous societies without automatically invoking the idiom, language, and assumptions of Western psychiatry. The concept of "historical trauma" has been invoked by a number of authors and researchers in an attempt to get beyond the individualising tendency of Western psychiatry. While not without its own limitations (Kirmayer, Gone, & Moses, 2014), according to Gone, "the concept of historical trauma calls attention to the complex, collective, cumulative, and intergenerational psychosocial impacts that resulted from the depredations of past colonial subjugation" (2013, p.683). Importantly, this way of understanding the suffering of individuals, families, and communities in post-colonial situations has led to a re-engagement with indigenous cultural and healing practices. These are increasingly seen as sources of resilience and strength (Denham, 2008).

The mental health of Māori in New Zealand

Māori (the Indigenous peoples of New Zealand) are over-represented in all negative health and social statistics (New Zealand Ministry of Health, 2013). Their life expectancy is markedly lower than that of the rest of the population. Thus, while Māori make up 16.5% of the under 65 age group, they are only 5.6% of the 65 and over age group (Statistics New Zealand, 2013). It is generally accepted that the process of colonization, and with it loss of lands, language, and positive identity, had a devastating effect on Māori (Durie, 1994; Jackson, 1992). Across all age groups, Māori make up approximately 15% of the population. However, 51% of male prison inmates in New Zealand are Māori and the figure for women is 58% (Statistics New Zealand, 2012).

It is clear that "mental health problems" (however limited the usefulness of the term is) are major issues for Māori in New Zealand today. Baxter, Kingi, Tapsell, Durie, & McGee (2006) found that 51% of Māori develop a mental disorder at some point in their life. The most common lifetime disorders are anxiety (31%), substance abuse (27%), and mood disorder (24%). It is known that they have approximately twice the rate of serious mental illness compared to non-Māori and are over-represented in complex and comorbid conditions (Baxter, 2008; Oakley-Brown, Wells, & Scott, 2006). They also have increased rates of suicidality and suicide attempts (New Zealand Ministry of Health, 2012).

Māori also have a different experience of mental health services. The ratio of Māori to non-Māori treated on a compulsory basis in the community, i.e. on a Compulsory Treatment Order (CTO), is 3.5 to 1 (New Zealand Ministry of Health, 2015). When admitted, they are 39% more likely to experience an episode of

seclusion compared to non-Māori (McLeod, King, Stanley, Lacey, & Cunningham, 2017). Furthermore, seclusion is experienced by Māori as punitive in nature (Wharewera-Mika et al., 2016). Perhaps understandably, Māori are observed to present "late" to services (Elder & Tapsell, 2013).

Many have argued that the solutions to these problems will not be found within Western psychiatry (Durie, 1999a). Indeed, some have argued that Western psychiatry represents one of the ways in which Māori people have been damaged by colonialism. Thus, Cohen argues that "psychiatry's role has been to pathologize the Māori people as over-susceptible to 'mental illness', particularly to severe forms of 'mental disorder' that require hospitalization" (2014, p.333).

In New Zealand, the Māori psychiatrist Mason Durie has provided a wealth of research, commentary, and wisdom in relation to the mental health needs of indigenous communities (Durie, 2011).

He has argued that Māori health is intimately bound up with Māori identity: "Autonomy is closely linked with self-esteem and the earning of respect. Both are basic and linked. Low levels of autonomy and low self-esteem are likely to be related to worse health." (Durie, Milroy, & Hunter, 2009, p.34).

In 1999 he argued for a five-pronged strategy in relation to Māori mental health (Durie, 1999b):

- The promotion of a strong and positive identity for Māori people. This involves promotion of Te Reo (the Māori language) as well as a wider national appreciation for the richness of Māori culture. It also means the promotion of respect for an individuals' whakapapa (genealogy).
- The active participation of Māori in the economy. Mental health is profoundly undermined by unemployment, unrewarding work, negative experiences of school, and socio-economic marginalization. Positive work and education experiences are key to positive mental health.
- Improving the experience of Māori in the mental health system itself. This was to be achieved by the provision of a range of *Kaupapa* Māori (initiatives focussed on Maori aspirations, values and principles) inputs. Assessments and interventions should be carried out in a way that incorporates Māori cultural elements such as the presence of *Kaumātua* (Māori elders) within services.
- Workforce development. The active encouragement of Māori people to work within mental health services.
- Autonomy and independence for Māori who are developing services. They should not always be "answerable" to others.

Mahi a Atua

This paper is a case report on the use of *Mahi a Atua*, a way of working with individuals, families, and communities that incorporates an indigenous (Māori) ontology, epistemology, and linguistic idiom. Mahi a Atua is not a therapy or a

new set of techniques. It is a process whereby Māori creation stories, or *pūrākau*, are explored and used to provide a set of words, ideas, images, and narratives that can help provide a matrix through which communal, family, and individual challenges can be met without recourse to a "psychologised" and "psychiatrised" vocabulary (Rangihuna, Kopua, & Tipene-Leach, 2018). The idea is to begin to work with Māori patients (*whaiora*), their families (*whānau*), and their communities (*iwi*) from a place that is far from the clinical gaze and the clinical mindset of psychiatry. Māori culture is socio-centric and puts a very high priority on dealing with problems at the whānau level, always understands personal struggles in relation to *whakapapa* (genealogy) and refuses to treat te taha wairua (the spiritual realm) as something apart from the rest of existence.

The practice of Mahi a Atua is centred on the idea of "*wānanga*". Wānanga is not a new concept but instead a "*taonga tuku iho*" (gift from the past) and is incorporated into Mahi a Atua as a way of being-with and engaging with whānau in distress. There is no single English language word that incorporates all the dimensions of wānanga. It is very much a concept that only has its full meaning within the context of Māori culture and epistemology. However, broadly, wānanga refers to a process involving meeting, discussing, learning, and the passing on of wisdom. An essential component of wānanga is to hold strong to the past while staying present in the moment. The belief is that holding on to the past is integral in wānanga to gain clarity about future direction.

Within a healing context wānanga is referred to as the space, time, and unique exercise where there is a "meeting of minds" to create meaning. It works based on a shared hope that the outcome will be positive. Therefore, it is not possible to predict a treatment approach until first entering wānanga.

With an emphasis on listening and responding, wānanga fosters the weaving together of many points of view. Wānanga using Mahi a Atua is based on a special kind of interaction where the way in which Māori ancestors viewed and made sense of their realities within a specific context is shared through learning about and engaging with pūrākau. Regardless of which pūrākau are shared, the basic feature is that each participant can create a shift in awareness both within themselves and within others.

The following two case histories are presented to show how Mahi a Atua was utilised with two separate whānau. The individuals and families gave permission for the presentation of their stories with the details changed to protect anonymity.

Ethical approval was granted by the New Zealand Health and Disability Ethics Committees (HDEC) and the local District Health Board.

Case history 1

The story is told in the first person by the therapist.

Judy was a 14-year-old Māori girl who was referred to the Child and Adolescent Mental Health Service (CAMHS) for assessment of oppositional behaviour at home and school. Judy refused to follow instructions from authority figures, often verbally

threatening other students and adults with objects such as scissors. She was known to continuously bully a girl whom she had disliked since they were five years old.

Judy was the youngest of four siblings who lived with their parents in a small town on the East Coast of the north island of New Zealand. Judy's mother was of Māori descent and her father was New Zealand born European (*Pākehā*). There were relational difficulties between Judy and her mother that had not been assessed in two previous referrals to CAMHS (for similar behaviour). Her psychometric testing was unremarkable at 11 years of age and a diagnosis of Autistic Spectrum Disorder was excluded at her second referral.

She was expelled from one high school and was accepted into a rural school. The index referral was made by the principal of this school. Judy was at risk of being expelled from this school because the girl she disliked was also at that school and Judy was bullying her on a regular basis.

Judy had been placed on a Ministry of Education programme that provided individual support during school hours from a youth worker who would sit alongside Judy to support her learning. The youth worker's name was Maria and she attended the first appointment with Judy and her parents.

Mahi a Atua as an intervention

At the first appointment I introduced the whānau to Mahi a Atua. This included sharing a Māori creation story (pūrākau) using visual aids. Key characters from the pūrākau were introduced to highlight different characteristics. Sharing these stories with Judy allowed her and her whānau to think about which character they resonated mostly with. Although Judy was not able to identify any goals from this story, as some people can do, she did identify the pūrākau as a way of being able to understand some of her problems. At the second appointment we repeated discussions about the meaning attached to the pūrākau. Judy was able to discuss the disconnection she experienced with some of her teachers.

At our third appointment Judy also complained that her mother communicated very poorly with her. This prompted the sharing of a pūrākau about the *Atua* (God) *Rūaumoko* (God of volcanoes, earthquakes and *moko* (Māori tattoo), renowned for his anger regarding injustice. After sharing the story and drawing symbols and art reflective of the pūrākau on the whiteboard, Judy stated that she was like Rūaumoko. Her mother identified herself as *Tangaroa*, the God of the sea and brother to Rūaumoko, who worked hard to calm Rūaumoko. The alliance established by this time allowed us to wānanga about how Judy's behaviours could be contextualised to historical, social and cultural factors that have impacted how indigenous people cope in institutions such as schools and health services.

Tangaroa and his two brothers, *Waiokiterangi* (God of Steam) and *Te Ihorangi* (God of Rain) and his four children, *Te Ao Hore, Te Aotaruaitū, Te Aotū* and *Te Aomatakakā*, were responsible for deescalating the rage of Rūaumoko (see Figure 1).

Judy was well engaged in the approach at this stage and asked to record our sessions to aid her recollection of all the pūrākau. Her ability to articulate her own

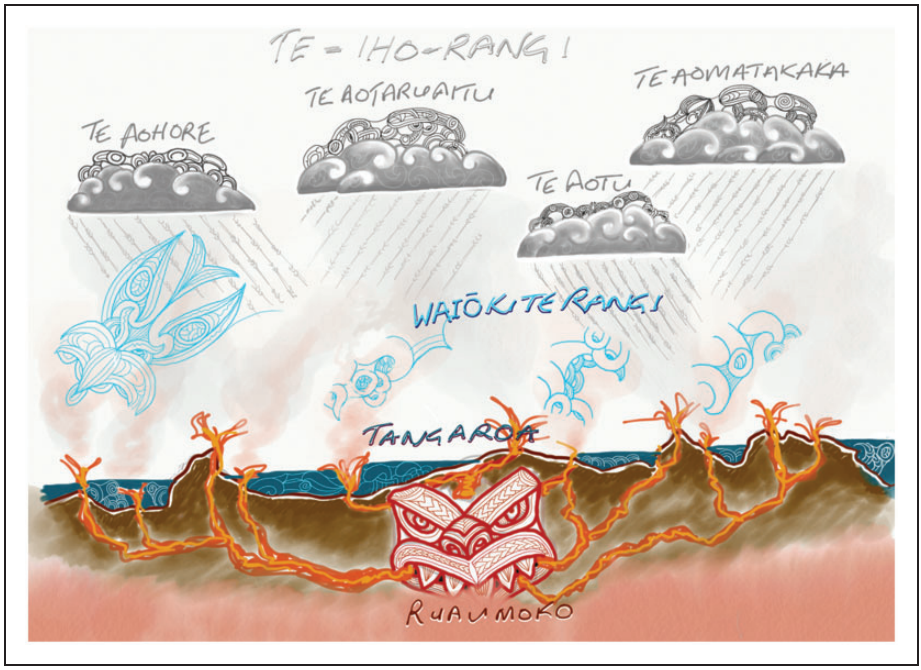

Figure 1. The rage of Ruaumoko (Permission to reproduce image provided by Artist Mark Kopua).

issues by referring to the pūrākau appeared to enrich her with a positive view of her identity as a Māori youth. Her trust in the work appeared to grow as she became more curious and there was less hesitation in her responses to my own curiosity about her situation.

Judy shared the pūrākau with her friends and was excited about learning more. At our third appointment I retold aspects of the story from our previous session, reminding Judy of how Rūaumoko was enraged due to an injustice and that, because of this, damage was inflicted on his mother *Papatūānuku* (earth mother). The pūrākau were repeated intentionally to reinforce her inner messages. Judy was able to develop mental constructs to better think and understand her own issues within a "Mahi a Atua" context.

The pūrākau about *Mataora*[1] was also shared. This incorporated an account of the origin of Māori tattoo, known as moko. Although there are many themes contained within this story, a key message is how an individual can find redemption and strive to be a better person, or, "*Whāia ngā mahi o Rarohenga*." After I shared the story of Mataora, she discussed ways of improving her own behaviour, drawing from her own ideas and using language that derived from the Māori creation stories. Judy was fully engaged and was excited about returning for a fourth appointment. We were fully in wānanga by this stage.

All of the Mahi a Atua sessions with Judy were evaluated by her, using an evaluation tool called Feedback Informed Treatment that has been successfully incorporated into a wide range of family interventions (Duncan & Miller, 2000; Tilsen & McNamee, 2015)[2]. The outcome rating scale highlighted that Judy's perception of progress had improved. When asked what may have contributed to this change, Judy stated that she had changed her attitude by faking a good relationship with some of the other students. Maria agreed that Judy had improved, but that it was difficult at school because Judy believed some of the teachers maintained a negative attitude toward her.

Her self-esteem and autonomy had improved, and she felt supported by the process.

The whānau of the child who Judy bullied agreed for Mahi a Atua to be introduced to the wider school to support an environmental shift in the way teachers (and others) behaved with Judy.

This led to a broader treatment plan involving the school. Meetings with the whānau of the child who Judy bullied, then the teachers of the school, led to agreement for the school to engage in a framework consistent with Mahi a Atua. The principal approved three of his staff to attend regular wānanga where Mahi a Atua was being used for health and non-health professionals as a training forum. These staff members have reported that Judy has continued to progress. More importantly, these staff members have promoted how their own personal and professional development has been helped by being involved with the Mahi a Atua wānanga. Judy was discharged from the service and her relationships with home and school improved.

Case history 2

The story is told in the first person by the therapist.

Tama was a 21-year-old single Māori male who presented with hearing voices. His mother, Wendy, was concerned about Tama's unpredictable and erratic behaviour after he returned to New Zealand unexpectedly from England where he had been living for two years. A primary care physician diagnosed him with a drug-induced hypomanic episode and Tama was prescribed antipsychotic medication (Quetiapine 25 mg per day) and was then referred to the crisis intervention team. He was assessed as having an elevated mood with inflated confidence and socially disinhibited behaviour.

The onset of Tama's distress was following a relationship breakup. He moved to England to start an apprenticeship in butchery and this went well until Tama and his girlfriend broke up. He abruptly changed career pathways and he started working with a shearing gang. He began using cannabis regularly at that stage.

He became gradually isolated from his friends and took a disliking to one of his workmates, Rob, whom Tama described as having a "big ego". Tama then made a rather impulsive decision to leave and come home to his whānau in New Zealand. He had a sense he needed to return home to heal.

Rob became a central character in Tama's voices. Tama felt compelled to respond to the voices at times whom he described as bullies. His hope was to "erase" the voices. He understood that his behaviour was impacting his parents and his goal was to reduce their distress. He wanted to know how to cope amongst the chaos.

Mahi a Atua as an intervention

Many pūrākau were shared within each wānanga and although there were important conversations about medication and family relational issues, these were not central to our wānanga. Artwork was introduced, and new terminology shared to rediscover Tama's experiences using a whakapapa lens. Introducing him to the pūrākau was an introduction to his ancestors. The pūrākau of his ancestors assisted Tama to create space to think about his "experiences" in a different way. He began to make more meaningful connections which were pivotal in increasing his motivation to change. A pūrākau Tama particularly connected to involved an ancestor Uepoto, who remained curious in a period where the Atua Māori were without light and were "*I noho tatapu*" (residing in a state of restriction).

Tama made associations between his whānau members' characteristics and those of the Atua in the pūrākau. He also thought deeply about his cultural identity and what mattered to him.

The most striking aspect of our wānanga was the one session Tama's father, Tom, attended. Tom was anxious about attending and was initially reluctant. We discussed a pūrākau that Tom was very familiar with. One of the principles of Mahi a Atua is to remain an active learner and I deliberately emphasised that Tom's knowledge was more advanced than mine and showed him a genuine excitement about being able to share the pūrākau together. It was through this wānanga that Tom shared an incident that involved the death of their baby child in a house fire many years ago. Tom was burnt from the fire. Their whānau narrative had not been shared with Tama until this point. They were able to weave together their own stories in a meaningful way through being with each other and bringing the many pūrākau to life as a way of better navigating through times of distress and suffering. Tama's parents were able to sit together with him and share a time when they too were distressed and how they coped.

Tama's mental state shifted from being distressed to being curious and internally motivated to learn about his cultural identity. He was attentive, focused, and his thought processes moved from difficult to follow at times to organised and goal directed. Although he continued to hear, and at times be distressed by, many voices, his understanding about the meaning attached to the voices had shifted.

Wendy's level of concern reduced, and she reported feeling proud of the shifts they were making as a whānau. Her own interest in the content of the wānanga meant that they both continued to communicate with each other about the pūrākau at home.

Discussion

Māori traditional healing practices were specifically targeted for eradication by the Colonial and missionary authorities. The Tohunga Suppression Act was passed in 1907. This banned any traditional health interventions and rituals and a number of prosecutions were made. While it didn't wipe out traditional healing, it made it firmly illegal and therefore of a second-class nature.

Mahi a Atua is one approach developed by Māori practitioners in New Zealand in an attempt to respond more appropriately to their own people. It is part of a much wider movement to nurture a specifically Māori approach to philosophy, research, social science, psychology, and community development. This development, called Kaupapa Māori, is intrinsically critical of dominant traditions of knowledge-making and research and seeks to deconstruct the ways in which Māori people and their culture, history, and spirituality have been represented in the various Western discourses that have encountered them. They accuse such discourses of being part of the colonial project and argue that they continue to serve the oppression of Māori people today. Smith (1999) cites a thesis of Leonie Pihama: ''Intrinsic to Kaupapa Māori theory is an analysis of existing power structures and societal inequalities. Kaupapa Māori theory therefore aligns with critical theory in the act of exposing underlying assumptions that serve to conceal the power relations that exist within society and the ways in which dominant groups construct concepts of 'common sense' and 'facts' to provide ad hoc justification for the maintenance of inequalities and the continued oppression of Māori people'' (1999, pp.185–186).

In place of an epistemology that incorporates a Western way of understanding the idea of ''understanding'' itself, Kaupapa Māori incorporates a ''whānau principle'' (Smith, 1999, p.187), is organised around the centrality of Māori identity and is very much allied to the current renaissance of interest in the Māori language, *Kapa Haka* (Māori performing arts), and others forms of Māori cultural practice. Kaupapa Māori involves a very different way of ''knowing the world'', a way that does not position the human ''knower'' outside of nature or apart from the society that he/she is trying to understand.

Indigenous people around the world are struggling to reassert a positive identity in the wake of colonial oppression and genocide. Many communities have extremely high morbidity and mortality rates. They are also suffering on a spiritual, cultural, and ''morale'' level. Western-based responses to the latter involve a medicalization and ''psychologisation'' of such suffering (Gone, 2008). Such responses may do more harm than good (Higgenbotham & Marsella, 1988).

While a number of commentators call for integration of local healing approaches with the practices of Western psychiatry, others point out that the different social positions of healers and health professionals will almost always lead to a secondary role for the local practices (Sax, 2014). Campbell and Burgess (2012) argue that local communities need to be empowered to have control

over health agendas that affect them. We believe that the technological assumptions of Western psychiatry (Bracken, Giller, & Summerfield, 2016) make it singularly ill-suited to help with the sort of psychological and social problems that emerge in indigenous societies in the post-colonial period. The technological mind-set that informs psychiatric theory and practice means innovation will always come from technical experts in who work with this mind-set, rather than from local communities themselves.

Conclusion

In this paper we present two case histories in which an approach called Mahi a Atua was used successfully to negotiate a way forward in two very different mental health scenarios. This intervention draws on Māori creation stories to create a psychological framework in which problems can be narrated and sense made of family conflicts and difficult emotions. This approach needs further development and research, but we believe that it offers a viable, and culturally acceptable, alternative to the theories and interventions of Western psychiatry.

Like indigenous communities across the world, the Māori of Aotearoa New Zealand suffer very poor physical and mental health. There is evidence that they are not well served by current mental health approaches (Taitimu, Read, & McIntosh, 2018; Cohen, 2014). Mahi a Atua works with a specifically Māori ''psychology'' and thus has the potential to empower Māori practitioners and communities to be creative and imaginative in their work with individuals and families. In the wider debate about ''global mental health'', we argue for a ''scaling down'' of Western psychiatry and a ''scaling up'' of indigenous approaches like this.

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Notes

1. Mataora was a paramount chief who embedded the art of moko into the physical realm after spending time with his wife's family in the spirit world. The artform became part of Maori culture and symbolises Mataora's personal endeavour to become a better person.
2. Feedback Informed Treatment (FIT) is a pan-theoretical evaluation tool that measures the quality and effectiveness of the therapeutic intervention utilised. Western measures and evaluative tools have a history of being harmful to ethnic minority groups. FIT promotes a culture that responds to real-time feedback from whānau to ensure treatment is tailored to their needs.

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