Journal of INDIGENOUS WELLBEING
Te Mauri - Pimatisiwin

Waka Hourua, ko au, ko koe, ko tātou Māori suicide prevention community programme

Volume 2 | Issue 3

Article 3, December 2017

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Abstract

In 2014, the first dedicated National Māori Suicide Prevention Programme: Waka Hourua was launched by Te Rau Matatini. One of its five streams was the operation of a National Coordination Centre for Māori Community Suicide Prevention. The major programme championed by the Centre included fostering Māori leadership, and building their capacity and capability to lead the development of whole of community plans. In drawing on what differentiates Waka Hourua from other programmes, it is the distinction of being privileged to work as informed insiders to Māori communities. This article provides an account of the Ko Au, Ko Koe, Ko Tātou Māori Suicide Prevention Community Programme and Māori Champions working in communities - the Pou Ārahi role.

Keywords: Māori suicide prevention, indigenous suicide prevention, community suicide prevention, Māori community leadership, suicide prevention leadership.

Introduction

Indigenous people globally have strived for a collective vision of health and wellbeing based on inclusiveness and respectful relationships within communities. This focus commits to community aspirations where indigenous worldviews are valued as an integral component of health, social policy and service development (Caldwell, 2008; Durie, 2014; Radu & House, 2012). In addition, successful local health initiatives have been known to occur when there is a dedicated group of individuals with specific skills and knowledge who can engage in equitable dialogue, initiate collective reflection, and maintain transparent and respectful communication (Caldwell, 2008; Durie, 2014; Radu & House, 2012).

Unfortunately, indigenous health development in the past and to date, continues to be hampered by the negative impact of a colonising history, a dominance from western health paradigms, and

enforced cultural alienation (Durie, 2014; Lawson-Te Aho & Liu, 2010; Tatz, 2004). The adverse result of this situation for a large number of indigenous people has become evident through the presentation of suicidal behaviour, with this concern being raised as a major public health issue. The incidence of suicide and attempted suicide internationally is excessive, predominately among indigenous populations and in this instance with particular regard to the Māori people of Aotearoa (Coupe, 2005, Mia et al, 2017, Ministry of Health, 2016).

From 1996 to 2016, Māori males have had the highest rate of suicide in New Zealand (Coronial Services of New Zealand, 2017a; Ministry of Health, 2016). For the year 2012, the Māori male suicide rate (per 100,000 people) was 25.6 versus 16.3 for non-Māori males (Ministry of Health, 2016). That is, approximately nine more Māori die of suicide compared to non-Māori for every 100,000 people. In 2016, Māori continued to have the highest rate of suicide across all ethnic groups at a rate of 21.73 compared to the national average of 12.64, deaths for every 100,000 people (Coronial Services of New Zealand, 2017[1]).

A total of 130 Māori lost their lives through suicide (provisional) in 2016, with Māori males disproportionately represented (Coronial Services of New Zealand, 2017). Furthermore, young Māori males between 15-24 years of age appear to be at greater risk of suicide accounting for 30% of the total suicides by Māori males in 2016 (Coronial Services of New Zealand, 2017). These high rates continue to remain high until the age of 39 before declining.

Government policy commitment commenced in 1998 which saw the release of the New Zealand Youth Suicide Prevention Strategy (Ministry of Youth Affairs, Ministry of Health, Te Puni Kōkiri, 1998). The Ministry of Health funded the implementation of a Māori focussed approach through the programme Kia Piki te Ora o Te Taitamariki, offered in a limited number of Māori communities, to address Māori youth suicide. Seven years later, 2005 the Kia Piki Te Ora o Te Tai Tamariki Strategy was re-focused and for Māori, this meant an 'all age' Māori suicide prevention programme offered as Kia Piki te Ora (KPTO.) The KPTO programme which was Māori focussed and driven sought to 'enable inter-agency collaboration with Māori whānau, communities, hapū, iwi, service providers and agencies to promote collaborative and comprehensive approaches to suicide prevention' (Kāhui Tautoko Consultancy Ltd, 2014).

In 2006 the New Zealand Suicide Prevention Strategy 2006–2016 (Associate Minister of Health, 2006) built on and replaced the New Zealand Youth Suicide Prevention Strategy (Ministry of Youth Affairs, Ministry of Health, Te Puni Kōkiri, 1998). A companion document was published, the New Zealand Suicide Prevention Action Plan 2008 – 2012 (Ministry of Health 2008) which espoused and advocated for Whānau ora pathways aligned to Māori development:

- the development of whānau, hapū, iwi and Māori communities
- Māori participation in the Health and Disabilities sector
- effective Health and Disabilities services and
- working across sectors

In 2009 the release of Te Whakauruora, the Māori Suicide Prevention Resource (Te Whakauruora) occurred (Ihimaera, & MacDonald, 2009) which progressed the New Zealand Suicide Prevention Strategy 2006 - 2016 (Associate Minister of Health, 2006) and the New Zealand Suicide Prevention Action Plan 2008– 2012 (Ministry of Health 2008). Te Whakauruora (Ihimaera, & MacDonald, 2009) upheld a holistic Māori world view of health and wellbeing and concurred with the Whānau ora pathways described in the New Zealand Suicide Prevention Action Plan 2008 – 2012 (Ministry of Health 2008). In this context suicide prevention approaches were to appreciate that individuals belong to a whānau, hapū, iwi, and *hāpori* (community) Māori.

[1] The information provided relates to provisional suicide figures and will slightly differ from the Ministry of Health figures. They include active cases before Coroners where intent has yet to be established therefore may eventually be found not to be suicides. In addition, Ministry of Health figures are recorded by calendar year.

Te Whakauruora was planned as a community development action focused resource to primarily assist iwi, hapū, hāpori Māori and community groups. Essentially Te Whakauruora wants to help people recognise and develop their ability and potential and organise themselves to respond to problems and needs that they share (Ihimaera & MacDonald, 2009).

Furthermore, strategic reasoning within Whakauruora advocated that successful community level response to suicide must provide information that allows opportunities to learn, know and understand relevant Māori cultural factors when developing and implementing community action suicide prevention programmes. Responsiveness to Māori approaches must support the realisation of Māori potential and ought to:

- be based on partnership, protection and participation
- support and develop Māori leadership for all initiatives
- reach whānau, hapū, iwi and hāpori (community) Māori priority population groups
- include Māori in policy, planning, development, delivery, monitoring and evaluating activities of services
- support, learn and understand how to apply Māori cultural protective factors (Ihimaera & MacDonald, 2009).

In 2013 the New Zealand Suicide Prevention Action Plan 2008 – 2012 (Ministry of Health, 2008) was further updated as the New Zealand Suicide Prevention Action Plan 2013 - 2016 (Ministry of Health, 2013). The actions advocated to:

- build the capacity and capability of Māori whānau, hapū, iwi, Pacific families and communities, to prevent suicide and to respond safely and effectively when and if suicide occurs;
- ensure that culturally relevant education and training are available to Māori whānau, hapū, iwi, Pacific families and communities that focus on building resilience and leadership;
- build the evidence base of what works for Māori whānau, hapū, iwi, Pacific families and communities to prevent suicide, through research carried out by, with and for these groups; and
- build the leadership for suicide prevention.

A key feature of this 2013 – 2016 Action Plan (Ministry of Health, 2013) was therefore a stronger focus on supporting whānau and communities, and building their own capacity to find their own solutions for preventing suicide. This involved the training of community health and social support services staff, families, whānau, hapū, iwi and community members to identify and support individuals at risk of suicide. Finally, there was a significant added focus on building an evidence base of what works for Māori and Pasifika (Ministry of Health, 2013).

In 2014, nearly a decade after the commencement of the KPTO programme an evaluation was conducted. Recommendations posed included that the KPTO programme works best when:

- there are Māori KPTO staff consistencies
- KPTO staff members have extensive community experience, and
- there are Māori leaders in the communities.

Most KPTO Māori providers had a history of service delivery in their communities and worked in partnership with key agencies in their region. KPTO also seemed to have the greatest impact where other community organisations in the region adopted suicide prevention as part of their own vision and goals (Kāhui Tautoko Consultancy Ltd, 2014).

Given the prevailing evidence for community led solutions, the first dedicated National Māori Suicide Prevention approach, the Waka Hourua Māori as well as Pasifika Suicide Prevention Programme (Waka Hourua) was launched by Te Rau Matatini. One of its five streams was the operation of a National Coordination Centre for Māori Community Suicide Prevention. The major programme championed by the Centre included fostering local leadership, and building their capacity and capability to lead the development of whole of Community plans. The following section focuses on the implementation of Waka Hourua *Ko Au, Ko Koe, Ko Tātou, (mine, your, everybody's responsibility) the Māori Community Suicide Prevention Programme (*Ministry of Health, 2014).

Waka Hourua, Ko Au, Ko Koe, Ko Tātou (Mine, Your, Everybody's Responsibility) Māori Community Suicide Prevention Programme

The Māori Community Suicide Prevention Programme was one of five streams that was implemented to achieve the goals of the Waka Hourua from 2014 to 2017. *Ko Au, Ko Koe, Ko Tātou (mine, your, everybody's responsibility)* was the name given to the Māori Community Programme. In early 2015 staff at Te Rau Matatini were invited to share their ideas about a strapline that could best depict the programmes intention and ideals. During Wave One an online survey was also conducted amongst community respondents who affirmed that suicide prevention is everybody's responsibility and thus *Ko Au, Ko Koe, Ko Tātou* was then accepted as the title for the Māori Community Programme (Te Rau Matatini, 2016).

- The methodology of the Māori Community Programme was 'Rarangahia te taurawhiri tangata' to strengthen and grow communities through weaving people together to assist whānau, hāpu, iwi, hāpori Māori and communities to establish safe and sound responses to suicide prevention and post-vention. 'Rarangahia te taurawhiri tangata' suicide prevention approach promoted:
- Utilizing he kaupapa whakahaere – a 'mā Māori mō Māori' action plan template to work with and for Māori to strengthen whānau ora
- Engaging effectively with Māori as a key priority group to ensure Māori aspirations and needs are at the center of suicide prevention initiatives
- Recognising the diversity that exists in Māori communities and lifestyles
- Bringing people together with different contributing strengths and views to make a positive difference for Māori (Te Rau Matatini, 2016).

The two key programme deliverables under the Māori Community Programme were expected through the employment of a Māori Community Champion - Pou Ārahi based in the community who would establish an advisory group (steering group), and secondly to develop a Community Suicide Prevention Action Plan (Ministry of Health, 2014).

It is reported that systems may prevent the fulfilment of health and wellbeing of Māori, and the erosion of their potential for human fulfilment (mauri ora) (Durie, 2017). This article provides evidence that community building as seen in the Waka Hourua *Ko Au, Ko Koe, Ko Tātou* Māori Suicide Prevention Community programme can be effective as a paradigm approach compared to other methods that are top down or distanced away from the people (Sewell, Morris, McClintock, & Elkington, 2017). This article provides a precis of the Pou Ārahi role, in relation to the components from the Māori Suicide Prevention community programme.

Pou Ārahi: Profile

Pou Ārahi were considered to be Māori leaders that had the *mana* (authority) to effect change – who could lead the development of a local suicide prevention action plan in their respective communities and district health board region. It was expected that the Pou Ārahi would have skills and attributes such as; ability to engage with their whānau, hapū, iwi and community, excellent communication skills, strong leadership skills, an ability to build relationships that promote caring, trust, connectedness and belonging, to have good understanding of Māori concepts, *whakapapa* (genealogy), and whānau/hapū structures within their respective rohe; and, ability to lead successful suicide prevention activities in their community (Te Rau Matatini, 2016).

Pou Ārahi were expected to engage and consult with their local iwi, and Māori communities on the approach of *Ko Au, Ko Koe, Ko Tātou.* This engagement and consultation process would include key stakeholders such as; Te Tumu Whakarae[2] Kia Piki Te Ora where there was a

[2] National Reference Group of Māori Health Strategy Managers within DHBs

program running; Waka Hourua Community Funded Projects (McClintock et al., 2017) and other community suicide prevention activities (Te Rau Matatini, 2016).

Identified as champions within communities, Pou Ārahi were recruited and employed by Te Rau Matatini with skills to identify individuals, groups and providers in Māori communities that could form local advisory groups, establish an action plan and could work together to counteract the losses associated with suicide. Principal responsibilities were to develop and maintain relationships within and between numbers of people in Māori communities (Sewell, Morris, McClintock, & Elkington, 2017; See Table 1).

Table 1: Core stages in Māori Community Capacity & Capability Building Approach (Sewell, Morris, McClintock, & Elkington, 2017).

Community Profiling	Identified community Mapping profile Identified motivators and challenges Synthesise data
Initiation & Engagement	Pou Ārahi Establish core group Generate participation Define goals, mission Clarify roles Provide information, training.
Plan	Confirm goals Establish plan Identify local resource Integrate activities into networks Chart future directions Share the plan

There were principally two foci with which Waka Hourua concerned itself. In the first wave, a focus on selected geographical communities as recommended by the Ministry of Health. In the second wave, communities with patterns of contact and connectedness with each other, sense of purpose and issues regarding loss to suicide. Examples of foci that emerged during the second wave included *Whānau* (families) centred foci, *Hapū* centred communities (tribal approach), *rangatahi* (Youth), urban, and rural communities of focus (Sewell, Morris, McClintock, & Elkington, 2017).

A national community analyses based on district health board (DHB) regions was completed before the first wave, and was updated before the second wave. This mapping process and intelligence about Māori communities was a further component to maintain in order to understand each community's dynamic and profile (Sewell, Morris, McClintock, & Elkington, 2017).

Table 2. Communities supported by Pou Arahi (Sewell, Morris, McClintock, & Elkington, 2017)

Wave one 2014 - 2016	Northland (Taupo Bay) Waikato Gisborne Canterbury (Aranui) Southern (Mataura)
Wave two 2016 - 2017	Hawkes Bay Lakes (Ngati Pikiao) Taranaki Whanganui Palmerston North Wairarapa Waikato Northland (Far North)

In Wave One there were five Pou Ārahi in five District Health Board (DHB) regions: Northland (Taupo Bay); Waikato; Gisborne; Canterbury (Aranui), and Southern (Mataura). In Wave Two there were a further six Pou Ārahi in nine DHB regions: Northland (Far North), Counties Manukau, Waikato, Lakes (Ngati Pikiao),Hawkes Bay; Whanganui, Taranaki, Palmerston North, and Wairarapa (Sewell, Morris, McClintock, & Elkington, 2017; see Table 2).

The difference with the two waves, and the employment of Pou Ārahi was the length of time of employment of the Pou Ārahi which was longer in Wave Two. Three Pou Ārahi were also expected to reach across two DHB regions, and all had suicide prevention, health promotion experience (Sewell, Morris, McClintock, & Elkington, 2017).

Pou Ārahi were deemed integral to working in Māori communities, to aid in establishing local groups, with them facilitating a localised action plan, and promoting strategies to integrate into

the plan and community networks. When communities were identified, the people within had opportunities to *hui* (meet), to talk, and share their ideas and aspirations. It was always important to ensure people could talk and share, and to agree on the processes of 'this is how we will do things' (Sewell, Morris, McClintock, & Elkington, 2017).

The community development approach focused on making meaning, and finding out what the dynamics were, the sense of purpose for a group or network that was important and their decision-making processes. In many cases it was reported that there were minimal structures, and networks prior to Pou Ārahi working in communities. Often there were no platforms where members of a community could meet in their recognition of the issues associated with suicide, nor was there anywhere to find out how they could find local resources, solutions or make decisions to address suicide (Sewell, Morris, McClintock, & Elkington, 2017).

Each Pou Ārahi established an advisory or leadership group in their communities with goals of building the capacity, capability and resilience of Māori communities. It was clear that in order for Māori communities to address the losses to suicide, they needed to develop awareness and positive responses to suicide in their community. For many groups, it required the need to challenge and change the stigma associated with suicide in addition to comprehending the enormity of the issue of suicide. To work with the community, Pou Ārahi established contacts within particular communities, developing a facilitative and leadership role. Many Pou Ārahi were later viewed as change agents who helped communities from the ground up (Sewell, Morris, McClintock, & Elkington, 2017, see Table 1).

Personal and collective growth in communities was promoted through the various networks formed and meetings held. Often the successes of these groups and networks involved the identification of local leadership, and a consensus that change was needed. Social change was of interest to most, with concerns about the interpersonal and often collective Iwi losses to suicide. With personal and whānau experiences, it was the often-interpersonal impacts that motivated the responses and reactions of individuals, groups and communities. Overall there were 12 Māori communities that Pou Ārahi supported, resulting in 11 action plans being developed (Sewell, Morris, McClintock, & Elkington, 2017).

Through participation in Māori communities there were clear examples of communities wanting control over the resources and approaches that were needed to address suicide. The characteristics in these Māori communities elaborated points such as:

- Rejection of models of mental illness and deficit approaches based on negative statistics
- Emphasis on strengths of individuals, groups, communities and Māori culture.
- Positive cultural identity
- Focus on whānau, tamariki, rangatahi and collectives rather than individuals only.
- Emphasis on prevention, and the availability of a wide range of interventions and activities such as training, wananga.
- Māori places and practices; Marae as focal point of meeting, wananga, cultural processes (Sewell, Morris, McClintock, & Elkington, 2017).

Pou Ārahi roles were significant as active advocates in and for the Māori communities. The differences between some of the Pou Ārahi roles from wave one and wave two related to the breadth of experience in suicide prevention and doing so in Māori communities as a field of work. Given the increasing rates of Māori suicide loss, the view of Te Rau Matatini is there is a need to ensure that the person employed to work in suicide prevention and in Māori communities indeed must have a set of competencies, access to training, professional development, supervision and ongoing support (Sewell, Morris, McClintock, & Elkington, 2017).

Of the key strategies that were achieved by Pou Ārahi, the following factors were identified:

- Relationship building: was a clear success factor, as relational capacity within groups and communities were built, commitment and satisfaction increased, access to knowledge and resource improved and the sustainability of the group increased.

- Group membership: recognised that the right people needed to be sitting around the table. It was clear that members of a group needed to have the mandate to make appropriate decisions.
- Leadership: with different styles of leadership noted, it was a predictor to the effectiveness of the groups and action plans.
- Coordination Support: was acknowledged in the effective communication and nature of working together.
- Commitment: was often raised, in that as a result of the Pou Ārahi and Te Rau Matatini it reinforced and prioritised suicide prevention work.
- Funding and Resources were raised as a concern, for many activities in the action plan required funding and so posed implications to the future of the plans activities (Sewell, Morris, McClintock, & Elkington, 2017).

Overall, Pou Ārahi were recognised for working in a meaningful and collaborative way in Māori communities that acknowledged the importance of their contributions and proactively engaged them in planning (Sewell, Morris, McClintock, & Elkington, 2017). The next phase for the Māori Community Programme for 2017-18 is to support features in the action plans and to review the method of investment in regard to the Pou Ārahi role.

Building the Capacity and Capability of Māori Communities to Respond to Suicide

The frame of reference explicit in the Waka Hourua programme for Te Rau Matatini highlighted the importance of Māori communities, and that suicide prevention in Māori communities cannot be realised without their leadership and cooperation. Māori community dynamics were well understood by Pou Ārahi who identify as Māori and whakapapa (genealogy) to the participating communities. These features were deemed critical to understanding the cultural, social systems and mores central to Māori development (Sewell, Morris, McClintock, & Elkington, 2017)).

The interpretation of Māori communities was defined invariably through the three-year Waka Hourua programme. This included geographical places, primary groupings living and working together or sharing other meaningful identity, such as whānau or Iwi networks, sports clubs, churches, Marae and through relationships with formal or informal ties (Sewell, Morris, McClintock, & Elkington, 2017). The views of the Māori community was concerned with interaction and meaning, raising the importance of values, interests, and a sense of purpose.

The Waka Hourua Māori suicide prevention model has promoted a Māori worldview through Māori communities, raising Māori knowledge and symbols associated with Māori culture, with *te reo me ona tikanga* (language and protocols), whilst recognising Māori diversities and strengths within the Māori collective. In previous suicide prevention approaches involving health education and awareness raising campaigns, what was discovered is that without a connection into Māori communities, or focused actions to enhance Māori directly or an understanding of the Māori narrative, that the impact of suicide prevention programmes would have minimal impact (Sewell, Morris, McClintock, & Elkington, 2017).

In the Waka Hourua approach, there is a deliberate subjectivity, with foci on the Māori experience in communities, be they of loss, life, health, whanau, autonomy and empowerment. The notion of wellbeing is also framed within the emerging collective effort that has prioritised the Māori perspective of health and meeting one's full potential, whilst acknowledging diversities and combining traditional and contemporary methods and approaches (Durie, 2017).

The Waka Hourua model of suicide prevention is concerned with unmasking the essence in Māori communities, of interaction, of relationships, fostering a unique sense of purpose and belonging, all with meaning. It involves the strengthening of the Māori community, through action to effect suicide prevention by Māori participation and involvement, and encouraging Māori to take control and power over activities and initiatives. The promising outcome is that as Māori experience the activities, they gain experience, and increase their social supports,

where there is movement and change (Durie, 2017).

Conclusion

In the past decade suicide prevention strategies in New Zealand tended to follow a bio-medical model assuming that the cause to suicide was depression or mental illness. Against the culture of silence of a "don't talk about it" attitude there seemed two approaches, one that awaited for symptoms to appear and the other that kept concerns quiet, either of which were ineffective given, that many of the people lost to suicide had not shown observable signs.

There has been a serious need for a model of suicide prevention that is directly focused into Māori communities that enhances Māori health and wellbeing. The *Waka Hourua Ko Au, Ko Koe, Ko Tātou, Māori Suicide Prevention Community Programme* under Te Rau Matatini was one of the streams implemented across the Waka Hourua Māori Suicide prevention programme 2014 - 2017. Building whānau and community capacity to respond to suicide was the key objective of this programme.

Eleven Pou Ārahi community champions able to reach into communities to develop a plan were employed across eleven regions between 2014 and 2017. Māori community dynamics were well understood by Pou Ārahi who identify as Māori and whakapapa to the participating communities. These features deemed critical to understanding the cultural, social systems and values central to Māori development.

Through participation in Māori communities there were clear examples of communities wanting control over the direction resources and approach needed to address suicide. The characteristics in these Māori communities elaborated points such as rejection of deficit models and statistics, emphasis on the strengths of individuals, communities and Māori culture, and a positive cultural identity.

The next phase for the Māori Community Programme for 2017-18 is to support features in the action plans and to review the method of investment of the Pou Ārahi role.

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