Is the mental health system in Aotearoa New Zealand providing quality care to young people?

A critical analysis utilising the perspectives of mental health professionals and sociological insights.

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ABSTRACT

The increasing rate of mental illness among young people, and mental health systems inadequate responses, have been critically analysed within various academic publications and government/ international agency reports. Comparatively, a critical analysis of the systemic issues that contribute to or perpetuate these inadequacies, specifically analysis that utilises sociological perspectives, is lacking within academic literature. This thesis utilises a sociological lens to investigate the challenges present within the Aotearoa New Zealand mental health system, identifying likely systemic causes and presenting alternative approaches that may alleviate some of the challenges. Employing a qualitative, interpretivist approach, 11 semi-structured interviews were conducted with mental health professionals from various clinical disciplines, who currently work within the system in the North Island/Te Ika-a-Māui of Aotearoa New Zealand. Thematic analysis was conducted on the 11 transcripts and 6 themes were identified.

The data analysis suggests that, from the perspective of the mental health professionals, many of the current challenges within the system, specifically staffing and funding issues, are linked to operation strategies that focus on efficiency, profit margins, standardization, and individualism, all elements of neoliberalism. Other challenges identified by participants such as the reliance on biomedicine and a crisis management system, which are both approaches that encourage standardisation can also be understood as elements that are conducive with an efficiency focussed neoliberal system. Participants presented alternative approaches that they would like to see implemented in the system, these included therapeutic interventions and structural changes. The alternative approaches draw on relational concepts such as continuous patient-centred care and holism and this may be contrasted with the current standardised and efficiency-focused practices. These findings highlight two differing approaches to mental health care drawing upon contrasting ideologies. Challenges identified by participants suggest that individualist principles are underpinning the current system, whereas a more relational approach underpins the alternative models suggested by participants. Moving forward this research suggests that the mental health system might possibly consider shifting its focus from individualism and neoliberalism and instead incorporate practices that draw on relationality, continuous patient-centred care, and holistic approaches to mental health.

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I embarked on this research journey, hoping to illuminate the challenges within the Aotearoa New Zealand mental health system and present alternative approaches that could positively impact the care that young people receive. Drawing on experience from my personal life and what I have witnessed within a professional capacity, I believe that mental health system often makes young people feel ignored, worthless and unprioritized. This research thesis is first and foremost for them, the young people across New Zealand who are struggling with mental health challenges and have unfortunately been let down by a system that was supposed to be their safe space. This is also for the mental health professionals who work tirelessly to support young people, despite the limitations within the system.

This thesis is something that I was extremely motivated to complete, despite the challenges that working and studying full time present. It is now something that I am immensely proud of. However, it was a serious commitment, something that required many sacrifices and it undoubtably could not have been completed without the following people.

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~ I can do all things through Christ who strengthens me ~

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CHAPTER ONE: INTRODUCTION

1.1 The Context of the Research

A Stuff article published in September 2023 describes an interview with two parents, Leanne and Gareth who recently lost their daughter Maddie to a suspected suicide and are currently advocating for better mental health support for young people in Aotearoa New Zealand. They detail years of emergency department visits, 90 sessions with mental health professionals from the public system, over 1000 hours in hospital and countless times where 24/7 surveillance was required to support Maddie through times of crisis (O'Brien, 2023). This article respectfully presents the family's story, highlighting the heartbreak that many families feel when they witness a child suffering from mental health challenges, while also focussing on the many desperate pleas that the family made to professionals and local government officials during their daughter's life, to encourage immediate and drastic system change (O'Brien, 2023). The Minister of Health at the time, stated that the government completely understood the concerning issue and that "when people are ill, they're in care in order to be protected and when they die or are otherwise harmed in care, that is an absolute critical issue for the system to take responsibility for" (O'Brien, 2023). The Minister of Health and Maddie's parents shared similar concerns when discussing the pressing issues within the system. These issues included staffing shortages, patient rights and the need to include family/whānau in the therapeutic process (O'Brien, 2023).

The unfortunate reality is that this story is not an isolated event. Suicide rates within Aotearoa New Zealand, specifically within the youth population have been staggeringly high for quite some time. As outlined in the literature review below, we consistently have one of the highest rates of youth suicide in the OECD and local communities and media outlets have been reporting on these concerning statistics for many years, most prevalently since 2016 (McConnell, 2016; Illmer, 2017). Due to the link that many form between suicide and mental health conditions (Brådvik, 2018), and the impact that it can have on families and the community, it is therefore unsurprising that calls to protect our youth, and prevent suicide from occurring, criticise issues within our youth mental health system. However, the staggering and unfortunate reality that I have observed, as a community onlooker and professional in the mental health system, is that while changes are being made within the system and funding is increased, most recently with a $1.9 billion mental health government package (Sutherland, 2023), the problems in the system remain, and individuals continue to receive inadequate care.

The continued systemic inadequacies, despite years of community advocacy and calls for change, inspired this research thesis, alongside my own personal experience working within the mental health system, specifically within the youth mental health and addiction sector. I, like many New Zealanders, was aware of the increasing concern for young people's mental health within our community, the alarmingly high suicide rates, and the system's often inadequate response. Existing research, as outlined in the literature review, highlights the issues within the system, including insufficient resources, extensive waiting lists, a focus on crisis management rather than preventative care and a lack of therapeutic relationships (Baker et al., 2019; Brown et al., 2002; Cranage & Foster, 2022; Dawson et al., 2020; Government Inquiry into Mental Health and Addiction, 2018; Mulraney et al., 2020; Triliva et al., 2020; Westin et al., 2014). However, the root causes of these systemic issues, are not adequately addressed within the literature, and therefore this research seeks to understand these root causes by utilising sociological perspectives, to better understand and potentially address systemic issues.

An extensive literature search highlights various research publications that analyse issues within the mental health system. However, I identified some shortcomings within these pieces of literature and therefore this research seeks to bridge some of those gaps, answering questions about the mental health system in a new and relevant way. The existing research (presented in the literature review) predominantly originates from clinical disciplines and doesn’t incorporate other interdisciplinary theories or approaches. It often doesn’t utilise participant voice and is produced internationally, excluding unique Aotearoa New Zealand insights. This piece of research seeks to incorporate the valuable and relevant clinical perspectives, by utilising the voices of mental health professionals who currently work within the system, whilst also applying a sociological understanding during the design and analysis phase to provide an understanding of systemic root causes. This research has also been conducted exclusively within Aotearoa New Zealand, to provide a unique and currently absent local perspective.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction to the Literature

Since its first reference in English literature in 1843, referred to as mental hygiene (Bertolote, 2008), mental health has been the focus of a wealth of literature, spanning many academic disciplines and languages. However, there has been a significant increase in the amount of literature on mental health and its place within society in the last few decades. This reflects an increase in public awareness regarding mental illness towards the end of the 20th century, the move to destigmatise it, and the policy changes that subsequently occurred (Hinshaw & Cicchetti, 2001). A vast majority of mental health literature published in the last two decades has examined the shortcomings of the mental health system. Much of the current literature agrees, mental health systems internationally and locally are inadequately meeting the needs of those suffering with mental health challenges, specifically adolescents and this literature is analysed in-depth below. Despite the accumulation of literature within this field of inquiry, some prominent shortcomings were identified. A significant proportion of the international literature originates from clinical disciplines such as mental health nursing, psychology, psychiatry, counselling, or social work, with a significantly smaller proportion of the literature critically analysing the mental health system from a sociological perspective. In addition, literature addressing the mental health system and its challenges from a sociological perspective within Aotearoa New Zealand based academia, was almost completely lacking. Furthermore, a piece of literature that incorporated both sociological and clinical perspectives, located within an Aotearoa New Zealand based context, that specifically analysed the youth mental health system, rather than mental health generically, while drawing upon the valuable voices of mental health professionals as participants, could not be identified.

The sociological lens, has been effectively used to critically analyse society and its many facets for centuries, successfully enabling individuals to consider and participate in social change and support the wellbeing of others (McManus et al., 2019; Pescosolido, 2010). Furthermore, sociologists have been analysing health inequalities, the influence of social stratification and differentiation on health outcomes and encouraging other disciplines to incorporate similar considerations for over 100 years (Pescosolido, 2010; Rodriguez et al., 2019). Arguably, the sociological lens is an asset within the field of mental health academic inquiry and the disconnect between literature that analyses clinical challenges and incorporates sociological insights is disadvantageous. Therefore, the present research, attempts to bridge that gap, applying sociological understandings to the perspectives shared by clinical professionals. I will first present literature that highlights the increasing mental health problems globally and locally, specifically within adolescents, justifying the need for research within this area. I will then outline and examine the existing literature, that predominantly originates from clinical specialisms. I will then present literature that critically examines the mental health system from a sociological perspective and identify the limited articles that combine both perspectives together within an international content. Relevant literature that supports discussion statements and conclusions made in later sections of the thesis, specifically feminist literature, critiques of neoliberalism and critical disability scholar insights will then be briefly described and examined. I will also outline and examine additional relevant literature such Kaupapa Māori insights into mental health and other alternative therapeutic approaches that lie outside the dominant model, such as collaborative care and holism. The presentation of this literature will illuminate the gap that is present within academia and outline the relevance of this research thesis that attempts to bring together the clinical perspectives and the valuable insights within sociology.

2.2 International Statistics and Reports

The number of people internationally and locally, suffering with mental health challenges is steadily rising. The World Health Organization reports a 13% increase in mental health conditions in the last decade (World Health Organisation, 2023), and adolescents are particularly impacted (Mojtabai & Olfson, 2020; NHS Digital, 2022). Reports from Unicef state that 16% of 1.2 billion adolescents (10-19 years of age) globally, are suffering from a mental health condition, such as anxiety or depression (Unicef, 2019). Furthermore, approximately 75% of mental health conditions manifest by the age of 24 (Unicef, 2021) and suicide is within the top five causes of adolescent deaths in four out of the six regions in the world (Unicef, 2019). Reports from the World Health Organisation (2021) echo similar statements, claiming that 1 in 7 young people (aged 10-19) experience some form of mental disorder, and suicide is the fourth leading cause of death for 15–29-year-olds globally. While the exact numbers fluctuate slightly depending on the organisation's reporting and the year in which the data was gathered, the World Health Organization (2021) made an overarching statement, independent of time or locality, claiming that a failure to address adolescent mental health conditions, impairs that individual's opportunity to lead a fulfilling life as an adult. Many international reports state that mental health concerns among children and adolescents are directly linked to challenges in other areas, including education, emotional regulation and stress management, substance use, physical ailments, problem solving, interpersonal skills and increased risk of suicide, self-harm, and other dangerous behaviours (Centres for Disease Control and Prevention, 2023; Unicef, 2019; Unicef, 2021; World Health Organisation, 2021). Reports also indicate that vulnerable populations such as individuals living with chronic illness or disability, groups who have been marginalised, individuals living in vulnerable settings and those exposed to violence or abuse are often more severely impacted by mental health issues and the associated risks (Unicef, 2019). These statistics clearly outline the prevalence of adolescent mental health concerns across the globe and present a clear narrative regarding the negatively impacted lives of the adult generations to come, if mental health conditions are not addressed.

2.3 Aotearoa New Zealand Statistics and Reports

Here in Aotearoa New Zealand the prevalence of mental health conditions, specifically amongst adolescents, has also risen significantly over the past 10 years. Ministry of Health (2022) statistics state over the last ten years, for young people aged 15 and over, anxiety or mood related disorders have increased by 7.7%, experiences of high/very high psychological distress has increased by 6.6% and depression diagnosis have increased by 5.1%. Increasing numbers can also be observed within children and younger adolescence, anxiety increased by 1.9%, emotional or behavioural problems increased by 3% and ADHD increased by 1.5%. However, it must be acknowledged that reported statistics are very limited for young people under the age of 15. Unicef New Zealand (2021) state that around 21% of adolescents within Aotearoa live with a mental health disorder and these disorders can significantly harm a young person's capacity within education, health, financial earning, and overall life outcomes. According to the Mental Health Foundation (2023) mental health concerns, and attempted suicide is of particular concern among Māori and Pasifika youth. A 2019 study claimed that the number of Māori and Pasifika young people who had attempted suicide increased from 6% to 13% over 12 months, and the number of young people suffering from significant depressive symptoms rose from 14% to 28% within a similar time frame (Mental Health Foundation, 2023).

While organisations such as Unicef and The World Health Organisation have presented many strategies and targets for countries to address the increasing number of people who need support (Unicef, 2019; Unicef, 2021; World Health Organisation 2020; World Health Organisation 2021), the Mental Health Atlas 2020 states that only 53% of countries, globally, have an adolescent or child mental health policy or plan. The Western Pacific Region, which includes New Zealand, stated that only 46% of their countries have a plan, and this region is therefore ranked second lowest in the world (World Health Organisation, 2020).

The increasing number of young people suffering with some form of mental health related concern across Aotearoa New Zealand has been significantly reported upon, by the media and government reports. Community concerns about the increasing numbers, and the system's inability to manage referrals has dominated recent media reports with titles such as "Auckland Teen Reveals Desperate Battle for Mental Health Help in New Zealand" (Hendry-Tennent, 2022), "Youth Mental Health Wait-times in Wellington Double over Four Years" (Trigger, 2023), and "Almost a Quarter of Young Kiwis Struggling with Mental Health – Report" (Roberts, 2023), have flooded New Zealanders' desk-tops or newspapers. Overall, the media depicts a community of frustrated young people and their concerned families, expressing outrage over system inadequacies. Many publications focussed on the exceptionally long waiting lists, crisis management where many young people are not seen until they are extremely unwell, the focus on quick discharge and the unavailability of long-term counsellors (Hendry-Tennent, 2022; RNZ, 2023; Roberts, 2023; Trigger, 2023). Comments from young people quoted in the articles express the desperation, stating "How sick do I have to be? At what point do I have to be before I am bad enough?" (Hendry-Tennent, 2022), "I'm sure there are a lot of people like me, where it's a miracle they're still alive," (Trigger, 2023), "Based on these figures, our country has become a much less safe place for children and young people" (Roberts, 2023) and, "Over the last decade, moderate-to-severe mental illness has risen by nearly 40 percent […] But the system isn't keeping up" (RNZ, 2023). Other comments regarding staff shortages (RNZ, 2023), additional contributing factors such as housing issues, mental health amongst minority groups and the increase in sexual abuse (Roberts, 2023), alongside suggestions for improved care (New Zealand Herald, 2023), were also made.

An extensive literature search also illuminated many government reports on youth mental health statistics and the system's response. The Te Hiringa Hauora Mental Health in Aotearoa (2020) report stated that within Aotearoa New Zealand mental distress is highest amongst young people aged 15-24 years and the proportion of New Zealanders with high levels of mental distress is trending upwards overtime, reinforcing claims made by the Ministry of Health (2022). The Government Inquiry into Mental Health and Addiction (2018) report, restates many of the claims made above regarding the high levels of mental distress within young people, increasing suicidality and self-harm, elaborating further on the mental health system's response. The report states that the child and adolescent mental health system's current response to the 'tidal wave' of new, and often very complex referrals, is based on a 'patch-up' mentality, with a pressure to produce outcomes and case closures rather than long term or significant mental health support. The report states that a continuous, therapeutic relationship between a professional and a young person, based on trust and respect, is essential to providing quality care, and the system's inability to facilitate this is harmful and inappropriate (Government Inquiry into Mental Health and Addiction, 2018). The Government Inquiry into Mental Health and Addiction (2018) and The Mental Health Foundation (2023) both outline the concerning youth suicide statistics. Aotearoa New Zealand's youth suicide rate is the highest in the OECD (important to note this fluctuates year to year, however the country consistently has one of the highest rates), 6.2% of young people in New Zealand had attempted suicide and 19% have had difficulty getting support for emotional concerns related to suicidality (Mental Health Foundation, 2023). The Government Inquiry into Mental Health and Addiction (2018) claims that these statistics are a national disgrace and that many individuals within their data set expressed extreme anger at the shortcomings of the mental health system, specifically its inadequacy in preventing suicidality. The report calls for a significant increase in suicide prevention programmes, alongside a range of other improvements regarding access, waiting lists, funding, and preventative care.

Another government report, released more recently in 2023, outlines similar issues to the ones above. However, it places more emphasis on how the system can move forward, echoing many of the claims made in later sections of this thesis. The Cross-Party Under One Umbrella Report (2023) was commissioned by a cross-party mental health and addiction wellbeing group and sought to understand gaps within the current system, focussing on how these gaps prevent young people from engaging with services. The report identified a significant need for collaborative care between services, encouraging cross-sector, integrated care for young people within the public health system. This report places emphasis on united, rather than decentralised mental health services, elevates youth one stop shops and makes recommendations for how the system can move forward (Cross-Party Mental Health and Addiction Wellbeing Group, 2023). While this report does not include the sociological insights that this thesis will provide, it does address many of the questions and concerns that are discussed within this research thesis.

2.4 International Literature Examining Mental Health from a Clinical Perspective

Academic literature that analyses the challenges within the mental health system has primarily been conducted internationally. The literature discusses the mental health system in more generic terms, and research that is specific to the youth sector is limited. This reinforces the relevance of this Aotearoa New Zealand, youth focussed thesis. This literature, from an international and clinical perspective, identifies three prominent concerns; a lack of resources, significant wait times and a need for more patient centred, therapeutic care. The first prominent concern is a lack of resources, and this element can be understood as a lack of staff and a lack of other financial or material resources such as beds, programmes, care packages, equipment, or general funding for the entire system (Brooker & Coid, 2022; Gulland, 2016; Petersen et al., 2017). A lack of funding was an established concern within almost all the publications cited in this literature review; many authors formed causational links between other concerns, such as staff shortages and the lack of government funding (Parish, 2018; Triliva et al., 2020). However, as established by the wealth of literature, the most prominent resource concern was a lack of staff. Staff shortages were linked to unsafe work environments for both patients and fellow colleagues (Baker et al., 2019; Cranage & Foster, 2022; Huxley et al., 2005) and a rise in mental health concerns amongst mental health professionals, most commonly referred to as staff burn out (Luter et al., 2017). Staff burnout has been linked to high staff absenteeism, reduced job engagement and eventually high staff turnover (Luther et al., 2017), which in turn continues what the research referred to as the ‘vicious cycle of staff shortages’, where the environment produces and perpetuates a culture that negatively impacts professionals and patients (Baker et al., 2019; Crange & Foster, 2022; ‘15% Drop In’, 2016; Huxley et al., 2005; McMillan, 2002; Oxtoby, 2023; Parish, 2018; Petersen et al., 2017; Rimmer, 2021; Triliva et al., 2020). Overall, the research clearly indicates that the lack of resources, staff, funding, or material supplies, are all interconnected with one another. However, the staffing shortages were presented as the most pressing concern (Baker et al., 2019; Brooker & Coid, 2022; Cranage & Foster, 2022; Dawson et al., 2020; “15% Drop In”, 2016; Gulland, 2016; Huxley et al., 2005; Lacobucci, 2022; McMillan, 2002; Oxtoby, 2023; Parish, 2018; Petersen et al., 2017; Rimmer, 2021; Sprinks, 2016; Triliva et al., 2020).

The second prominent concern was the extensively long waiting lists. This was also something that was examined and identified as a challenge by the Aotearoa New Zealand government reports and media articles outlined above. Waiting lists that are beyond the recommended length, the subsequent crisis management system, and the amount of people who wait on a list, feeling that they haven’t been prioritised or getting steadily more unwell, is a prominent concern across the world (Anderson et al., 1987; Brooker & Coid, 2022; Brown et al., 2002; Gulland, 2016; Mulraney et al., 2020; Sacco et al., 2022; Triliva et al., 2020; Westin et al., 2014). The third prominent concern, as outlined by the literature was the lack of patient centred or therapeutic relationship focussed care. This was also outlined by the Aotearoa New Zealand government reports above, specifically the Government Inquiry into Mental Health and Addiction (2018). The relationship between a patient and professional, specifically a trusting, therapeutic relationship is a foundational element of practicing mental health support and ensuring that the patient feels safe (Baker et al., 2019; Cranage & Foster, 2022; Duncan et al., 2022; Hartley et al., 2022; Matos & Dimaggio, 2023; Triliva et al., 2020). As established in chapter four, this relationship is especially significant for young people.

The literature outlines that therapeutic relationships and patient centred care, specifically patients playing an active participation role in their own support journey, is something that is encouraged within the mental health system, yet due to the system's inherent challenges, often isn't utilised or prioritised (Baker et al., 2019; Cranage & Foster, 2022; Jørgensen & Rendtorff, 2018; Lempp et al., 2018; Paton et al., 2021; Triliva et al., 2020). A lack of sufficient inter-agency or inter-disciplinary professional collaboration, a standardised biomedical approach, a lack of family involvement and time or resource constraints, were all identified as factors that prevented patients and professionals from developing therapeutic relationships and care plans that were patient centred (Baker et al., 2019; Cranage & Foster, 2022; Jørgensen & Rendtorff, 2018; Lempp et al., 2018; Paton et al., 2021; Triliva et al., 2020).

2.5 International Literature Examining Mental Health from a Sociological Perspective

Comparatively smaller in quantity, but equally valuable in content, the following pieces of literature examine health care settings, predominantly mental health care systems from a sociological perspective. Various sociological theories have been applied to health research, including feminist theory and critical disability studies, among others. Feminist theory, specifically feminist ethics of care, are utilised within the analysis section of this thesis, presenting an alternative approach to caring that directly contradicts what Virginnia Held (2006) refers to as the 'masculine' ways of understanding that dominate the current mental health system. An explanation of Virginnia Held's (2006) feminist ethics of care, and its relevance within this research thesis is outlined in a later section of this literature review. Feminist theory has been critiquing the field of mental health, specifically psychiatric and psychological diagnostic approaches for decades, examining how clinical fields perpetuate traditional gender roles, patriarchal and capitalist power (Cohen & Hartmann, 2023), prevailing norms regarding sexuality, the gender order, heteronormativity (Marecek & Gavey, 2013) and overarching misogyny (Payne, 1991). Research based on feminist theory outlines how dominant perspectives within mental health have ignored and oppressed the concerns of women, often attributing all female mental health concerns to hormonal changes or characteristics that have been socially ascribed to being female (Payne, 1991). Furthermore, feminist theory outlines the feminisation of many mental disorders that have arguably contributed to the alienation of women from many areas of the workforce, reinforcing social expectations regarding traditional femininity and its association with family life and 'keeping house' (Cohen & Harmann, 2023). Drawing on similar perspectives detailed in feminist ethics of care as outlined by Held (2003), Marecek & Gavey (2013) also state that the diagnostic and statistical manual of mental disorders (DSM) is inherently individualistic, whereas feminist scholars assert that mental health related concerns are inherently relational, heavily influenced by broader social, political, and economic contexts.

Critical disability theory shares many insights that can be applied to mental health also, especially within the youth sector. Brady and Franklin (2023), draw on understandings from medical sociology and critique terms such as healthy, unhealthy, normal, and abnormal, questioning who has the power to define these labels and who they become associated with, specifically within the context of disabled children. Critical disability studies assume the position that disability is a socially constructed issue, and that the labels, diagnoses, and social stigma that are subsequently associated with it are a figment of that construction, rather than an innate consequence of something natural (Brady and Franklin, 2023). Mac Carthaigh (2020) applies similar logic to Autism, challenging conventional conceptualisations, positioning autism spectrum disorders as a difference rather than a deficit. McLaughlin et al., (2016) draws on sociology of the body, critical feminist studies and symbolic interactionism, to present an account of how observation and medical intervention impact a child’s relationship with socially constructed categories of identity and normality. While these publications don’t all directly speak to mental health, the critical understandings of social norms, diagnoses and categories of citizenship are arguably valuable insights to consider when discussing mental health diagnoses and lived experiences. Additional articles of sociological research expand upon statements about diagnoses as a social construction, claiming the potentiality that mental health in its entirety is a socially constructed phenomenon (Bowers, 1998; Cohen, 2016).

2.6 International Literature That Incorporates Both Clinical and Sociological Perspectives

There are also some publications that have addressed similar concerns to this thesis, pairing sociological insights with clinical experiences or perspectives. However, the distinguishing factor is that they were crafted and published internationally and therefore elements unique to Aotearoa New Zealand have not been addressed. Additionally, many of these articles do not draw extensively on participant voice or share the perspectives of mental health professionals. It must also be acknowledged that these publications are still in the minority.

Arguably the most noteworthy article in relation to this thesis, is the work of Dawson et al., (2020), positioned in Australia, examining the influence of neoliberalism on mental health systems, particularly in relation to the time and resource constraints that occur within an efficiency focussed model. Various other articles have analysed how neoliberalism, and its prevailing nature within society, impacts the care that health systems can provide (Brown et al., 2022; Cohen, 2019; Moncrieff, 2018; Rizq, 2014; Zeira, 2021). Brown et al., (2022) analysed the connections between neoliberalism and the dominance of the biomedical model, specifically the prevalence of short term, efficiency focussed models of care. Moncrieff (2018) applied a critical Marxist lens when analysing how the concept of mental illness supports the modern capitalist system by locating problems within the self, rather than addressing social challenges such as class relations, working conditions, wealth inequality and loneliness (Zeira, 2021). Cohen (2019) and Rizq (2014) both outline how efficiency, privatisation and general bureaucracy has removed the autonomy of caring from the professionals, enforcing adherence to policies and 'evidence-based' practice, which often contradicts, undermines, and perverts the course of therapy. Cohen (2019) defines this as the proletarianization of doctors, however this lack of control over the production and design of practice can be applied to all mental health professionals. Mcgregor (2008) provides a comprehensive examination of neoliberalism itself and its motivation to encourage biomedicine, standardisation, and efficiency, based on the innate characteristics that drive its dominance such as self-sufficiency, individualism and competition. Barnett and Bagshaw (2020), outline similar concerns to the ones above, within a New Zealand context, examining the specific impact on Māori individuals. It is important to note that the Aotearoa New Zealand located work of Barnett and Bagshaw (2020), speaks to neoliberalism's impact on health generally and doesn't utilise the voices of mental health professional or analyse the youth or mental health sector specifically.

2.7 Sociological Perspectives, Theoretical Frameworks, and their Connection to this Research

There are relevant sociological theories that have not yet been applied to the understanding of mental health systems. For example, scholars who detail feminist ethics of care highlight its relevance within health care settings, yet a review of the literature above particularly the research within clinical environments, outlines a complete absence of these theories. The analysis process of this research, utilised these sociological perspectives extensively. They provided a more in-depth understanding of the challenges within the mental health system and the suggestions for how it may be improved. Therefore, these pieces of literature have been included in this literature review and are heavily drawn upon throughout the thesis.

2.7.1 Feminist Ethics of Care

The ethics of care is a theory that has close affinities with caring professions such as nursing (Edwards, 2009). Ethics of care can be loosely defined as a "compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility" (Held, 2006, p.10). Ethics of care recognises that humans are dependent for many years of their life, including infancy, childhood, through illness, disability, and old age, requiring community and relationships during those times. Despite dominant rationalist approaches and moral theories that devalue the emotional, feminist ethics of care states that when evaluated and properly implemented, sympathy, responsiveness, empathy, and caring relationships, as exemplified by the one between mother and child, are elements that should be cultivated and encouraged (Held, 2006). Ethics of care, in its various forms, operates on the understanding that persons, in times of dependency or not, are innately relational rather than self-sufficient, as presented by other dominant moral, economic or political theories (Held, 2006), such as neoliberalism.

Feminist ethics of care challenge what can be referred to as traditionally "masculine" understandings by taking the experiences of those within caring environments and activities associated with femininity such as mothering, celebrating the inherent emotional values within these practices, applying them to wider contexts, such as health care systems, businesses or political structures (Held, 2006; Johansson & Wickstrom, 2022; Lawrence & Maitlis, 2012; Phillips & Willatt, 2019; Raghuram, 2019). In contrast masculine understandings often refer to generalised moral principles or universal rules, that rely on abstraction, rationality, and reason (Johansson & Edwards, 2021; Machold et al., 2008).

Gilligan's empirical studies (1982, as cited by Held, 2006) were pivotal in the rise of feminist ethics of care, stating that the moral development and ability of a woman is not less than her male counterpart, even though she may not display high moral reasoning in accordance with traditionally masculine ethical understandings, her depiction of morality is simply different. While male participants in Gilligan's (1982) study emphasised morality through the importance of individual autonomy, female participants constructed morality through caring relations (Held, 2006; Machold et al., 2008). Gilligan argued that these are different approaches to morality and she challenged the assumption that one understanding of morality should be valued over the other. Gilligan’s studies within feminist ethics of care provide a foundation of understanding, enabling us to understand how gendered power relations influence the significance society places on feminine or masculine constructions of caring and morality. This is important to consider when we examine the dominance of traditionally masculine ethics or the subordination of feminist ethics within the mental health system in later chapters. The emotional values or characteristics that feminist ethics of care highlights such as nurture, love, empathy, concern, and drive for community, are all characteristics are associated with femininity (Held, 2006; Johansson & Wickstrom, 2022; Machold et al., 2008; Nicholson & Kurucz, 2017; Phillips & Willatt, 2019), and are therefore gendered.

Feminist accounts have varied in the “extent to which they view care as a disposition intrinsic to women” (Raghuram, 2019, p. 614), and within this research, caring relations are understood in relation to feminist ethics of care, or masculine ethics of care and not attached to a specific sex or gender. Furthermore, Rughuram (2019), drawing on Gilligan (1993) and Hollway (2006), states that the experience of being cared for as a child, is a foundational experience most can relate to, irrespective of gender, and therefore feminist ethics of care can apply to all. These articles of research, specifically the detailed comparison between feminist ethics of care and traditionally masculine ethics of care which draw on self-sufficiency and rationality, are practically relevant when we discuss the difference between relational approaches to mental health and the dominant model which draws on neoliberalism and individualism. This comparison is outlined in more detail in later chapters.

2.7.2 Biomedicine and the Medical Gaze

Foucault, through his written works, specifically ‘The Birth of the Clinic’ first published in 1963, presents an understanding of the relationship between power and knowledge within medicine and the concept of the ‘medical gaze’ (O’Callaghan, 2022). Foucault’s understanding of the medical gaze describes how medical professionals fit a patient’s story into the biomedical paradigm, and subsequently only focus on elements of the story relevant through the biomedical perspective (O’Callaghan, 2022). The concept of the medical gaze, and arguably the biomedical system itself, is caught up in a strange endless cycle of reciprocity. Classification terms, such as disease, various diagnoses and subsequently cure, only exist within the constructed, biomedical space. In theory as this space, or the system, obtains its aims of treatment, it proceeds to continually efface, gradually neutralising itself (Foucault & Sheridan, 2003). What we currently see through “the standardisation of biomedicine and its accompanying medical gaze”, is dehumanising, impairment focussed attitudes, primarily concentrating on identifying perceived problems within a patient’s mind or body (Mac Carthaigh, 2020, p. 53). Critically analysing the medical gaze and its influence on how we understand disease or diagnosis, can enable us to consider an alternative lens through which to view physical or mental differences (Mac Carthaigh, 2020), understanding that the prevalence of these classifications’ rests only on the dominance of the biomedical space.

2.7.3 Critical Disability Studies and their Approach to Norms and Diagnosis

Our understandings of ‘normal’, ‘healthy’ or arguably even ‘neurotypical’ are based on socially constructed understandings of health, through a biomedical perspective. The aim of this thesis is not to completely discredit biomedicine or the work it does. However, a critical examination of knowledge, where it comes from and the assumptions it is based upon, helps us to understand the impact it has on individuals. The perspectives of disability scholars, and their experience analysing how the biomedical model can perpetuate “discourses of personal tragedy” to explain differences in human function, subsequently utilising interventions to ‘extinguish’ perceived problems (Mac Carthaigh, 2020, p. 58), can broaden our understandings of the biomedical model and the impact it is having on young people with mental health challenges. Social understandings of what is deviant from the norm, or classified as a mental or physical deficit, rests on socially constructed understandings of what normal is. Research within critical disability studies states that deafness and blindness are only deficits in societies where individuals communicate via print or speaking (Garland-Thompson, 1997). Those who use wheelchairs are only considered impaired, because we live in a world made of stairs rather than ramps (Garland-Thompson, 1997), and the same can be said for mental health challenges. Obsessive compulsive disorder, anxiety or attention deficit/hyperactivity disorder are only considered a deficit because the medical model have defined them in this way and because some individuals within society do not experience them.

The normal and the abnormal are in relationship with each other, co-defining each meaning, and therefore children, or young people, who are categorised in each of these terms, are consistently compared and valued against each other (McLaughlin et al., 2016). While these norms that critical disability scholars are examining, may be considered socially constructed, their impacts are real, with ‘othered’ young people playing a crucial role in the continued validation of the “right kind of children” (McLaughlin et al., 2016). This places young people on a hierarchical continuum where ‘disabled’ or ‘mentally unwell’ individuals are often subject to social judgement and exclusion. This concept of being compared to one another on a hierarchal continuum, and the impact this can have, is briefly described within this thesis, through understandings shared by Sparke (2016), who described an individual’s mental health challenges or experiences as Capital. Capital which young people must enter into a system that then triages them, comparing their sensitive lived experiences to others. Research conducted by disability scholars state that there are no inherent physical flaws that categorise disability or ability, rather society legitimises and values some physical characteristics, imposing the role of inferiority on others (Garland-Thompson,1997; Mac Carthaigh, 2020; McLaughlin et al., 2016).

This thesis draws upon this research and can utilise these understandings to critically engage with the concept of pathology.

2.8 Alternative Therapeutic Perspectives and Theoretical Frameworks - Connections to this Research

There is an extensive amount of research that has been conducted critically analysing the mental health system, as outlined above. Many researchers have moved beyond the critical reflection of its challenges and have conducted research on therapeutic models or practices that may improve clinical practice. These publications do not directly draw on sociological understandings. However, they are relevant within the context of this research project, and the analysis chapter applies the sociological understandings above to the approaches outlined by participants and the literature below.

2.8.1 Collaborative Care

Research defines collaboration as the relationship between two or more people, groups or organisations working together to define and achieve a common purpose (Hornby & Atkins, 2001). Within the mental health sector collaborative care is a care delivery system that is increasing in popularity as alternative approaches to mental health are developed, to address the inadequacies of current treatments and dominant models (Lake & Turner, 2017). Collaborative care within the youth mental health sector occurs when a team of multidisciplinary professionals work together, alongside patients and families, to address shared goals, supporting people holistically, considering the symbiotic relationship between various clinical psychological factors and sociocultural factors that influence mental wellbeing (Archer et al., 2012; Lake & Turner, 2017; Reist et al., 2022; Thota et al., 2012). These factors can include education, housing, justice, employment, or family concerns, among others (Garrett et al., 2019). Within this team, professionals from varied disciplines, are each responsible for a different component of wellbeing and they are facilitated by a case manager or primary carer, who is responsible for the initial assessment, the ongoing treatment reviews, and the coordination between the multidisciplinary team (Archer et al., 2012; Lake & Turner, 2017; Reist et al., 2022; Thota et al., 2012). The specifications of each collaborative team, for example the number of members within the team, the types of clinical specialists, who is appointed case/care manager and the processes they adopt to ensure positive outcomes for the patient are varied (Archer et al., 2012; Bower et al., 2006; Reist et al., 2022; Thota et al., 2012). However, the multi-professional approach, to support the 'whole' patient, drawing significantly on the concept of holism, produced improved overall clinical outcomes and involved the patient in their own treatment journey (Reist et al., 2022; Thota et al., 2012; Trenoweth & Margereson, 2009).

2.8.2 Kaupapa Māori Approaches

Levy and Waitoki (2016) state that a truly Mātauranga Māori informed approach to mental health, in comparison to the dominant western approach, places significant focus on adding value to Māori lives, knowledge, and communities. The principle of 'adding value', arguably through holistic approaches that cater to the individual (treated as a whole) and the community, is fundamentally different to the "deficit-focussed frameworks that result in the individualisation of issues, with risk factors conceptualised in terms of the individual and/or family deficiencies and dysfunction" (p. 29). Levey and Waitoki's (2016) claim about the 'deficit focussed model', is arguably highlighting the prevalence of the biomedical diagnostic model, which is the preferred model within the current system, focussing on labels that can often be stigmatising, implying that an individual is flawed or compromised (Boggs, 2014; Martin et al., 2000; Nelson, 2019; Thachuk, 2011). One example of a

Mātauranga Māori, collaborative approach that has been adopted within the mental health system, yet could be utilised more extensively, is the Whānau Ora framework (Taskforce on Whānau-Centered Initiatives, 2010). Research on the Whānau Ora approach states that it is a "culturally based, and Whānau-centred approach to wellbeing focussed on Whānau as a whole, as the decision makers who determine their goals and aspirations. Building the strengths and capabilities of Whānau and wrapping the necessary services and support around them to get better outcomes and create positive changes" (Whānau Ora, 2023). The Whānau Ora approach, both in theory and practice, shifts the focus from 'services for individuals', which we arguably see within the individualistic nature of the current system, to 'wrapping services around a family', adopting a holistic view, placing whānau at the centre (Whānau Ora, 2023). Whanau Ora as an organisation, partners with predominantly Kaupapa Māori community organisations alongside marae, to enable specialist staff across the country, to help whānau find the support they need (Whānau Ora, 2023).

The 'Whānau Ora: Report of the Taskforce on Whānau-centred Initiatives' (Taskforce on Whānau-Centred Initiatives, 2010), provides us with an example of how the Whanau Ora approach would work practically. The report depicts a sole parent mother who has three children, each experiencing challenges, including gang related activity. As a Whānau they are also facing housing challenges, and to support the family financially the mother must work long hours. The family has multiple services involved, including the New Zealand Police, Work and Income, Child, Youth and Family (now renamed Oranga Tamariki) and the education system. Due to the variety of services involved, a referral to Strengthening Families (a service analysed in theme two in the analysis section) has been made and a subsequent referral to a Whānau Ora provider. Each of these services, is providing individual interventions for individual family members. Utilising the Whānau Ora approach, the provider works with the Whānau to build honest and trusting relationships, that allow the provider to identity the core issues within the family, formulating a plan that focuses on the Whānau as a whole. The provider then presents potential solutions and supports the family to act upon them (Taskforce on Whānau-Centred Initiatives, 2010).

The Whanau Ora approach as a philosophy is not new. Service providers have been operating with the aim to support Whānau collectively for years (Taskforce on Whānau-Centred Initiatives, 2010), and Whānau Ora as an umbrella organisation has also been supporting communities across the country for many years also (Whānau Ora, 2023). However, the implementation of the approach has often been, and arguably still is, constrained by "narrowly constructed sectorial boundaries" (Whānau Ora, 2023). These "sectorial boundaries", within the context of the mental health system are arguably the system's standardised processes, its inability to consider or implement alternative approaches, its innate focus on crisis management and subsequent one-size-fits-all short-term strategies, all elements that are discussed in the analysis section of this thesis. The Taskforce on Whānau-Centred Initiatives (2010) states that the Whanau Ora approach recognises the causational link between individual and whanau issues, stating that when caring for individuals it is "not just about crisis and intervention, it's about a holistic approach", issues must be addressed focussing on long term strategies that support the whole family, rather than an individual deficit focussed model (pp. 32). Boulton et al., (2013) states that the Whānau Ora Model has the potential to radically transform the way health and social services are delivered, particularly for vulnerable Whānau across New Zealand. However, Boulton et al., (2013) elaborates further, stating that the model cannot be properly implemented into communities until systemic challenges are addressed. These challenges include.

- Recognition within public services that there needs to be an increase in care collaboration and coordination, working across sector and organisational boundaries to ensure seamless integrated patient care.
- An acknowledgement that Māori health providers adopt a holistic view of health, appreciating an individual as a whole rather than separate components and that the Whānau Ora approach formalises this holistic view of health, removing abstract boundaries between different services, redirecting the focus of care to an approach that is Whānau oriented.
- Greater acceptability of "Mātauranga Māori, Tikanga Māori and Māori ways of being" within the health system, valuing their approaches and benefits for Māori individuals and families.

(Boulton et al., 2013, p. 29).

Research into Kaupapa Māori approaches, specifically the Whānau Ora approach present an alternative way of delivering mental health care and these approaches are considered in more detail by participants and throughout the analysis process as outlined in chapter four.

2.9 Concluding Remarks Regarding the Literature

As outlined above, there are various international and local government reports, statistical findings and media articles that express concern regarding the increasing number of young people requiring mental health support, and the system's inability to provide adequate care. These examples of literature highlight the relevance of this thesis. An extensive literature search illuminated many publications that examine the challenges with the system, however they predominantly originate from clinical disciplines. These clinical insights are valuable, however this research intended to provide a more nuanced view, incorporating the clinical, while also applying sociological understandings. A limited sample of literature has successfully delivered on the intentions of this research project, most prominently the Australian work of Dawson et al., (2020). However, this research was conducted internationally and is limited in quantity. A clear gap in the literature can be identified, therefore justifying the relevance of this research project that aimed to combine clinical and sociological insights, while incorporating the voices of participants within an Aotearoa New Zealand context. Further literature that will be drawn upon throughout the analysis section of the thesis was also outlined in this section, providing brief definitions and commentary, positioning the relevance of theories and frameworks originated from sociological, clinical and Kaupapa Māori disciplines alike.

2.10 Positioning the Researcher

It is important to briefly position myself within the research, especially due to the heavy use of an interpretivism-oriented research paradigm and my current role within the mental health system. At the time of writing, I am a 22-year-old female of European descent/ Pākehā, residing in Aotearoa New Zealand, working for a non-governmental organisation that supports young people with mental health and addiction challenges. Prior to completing this research thesis, I completed a Bachelor of Social Sciences, double majoring in sociology and human development, and since its completion I have worked in my current role within the system. Due to my tertiary training, the extensive professional development I have received within my professional role and my personal experiences within the system, I am confident in my ability to comprehensively understand the mental health system, its inner workings and how it impacts the lived experiences of young people. I also believe that my personal experience enabled me to form an empathetic connection with the participants. This connection between researcher and participant experience resonates with other qualitative studies (e.g. [Banfield et al., 2018; Hofmann & Barker, 2017]). I therefore believe that my interpretations and influence as a researcher has enhanced rather than hindered this research project. However, it is worth noting that throughout this process I relied heavily on the guidance of my supervisor, insights from previously completed research, brief cultural guidance from experts in Mātauranga Māori approaches to mental health and the perspectives of the participants.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction and Overview

In this chapter I will provide an overview of the Methodology used in this research project. This overview will be divided into two sections: Research design and Research processes.

The research questions that informed this research project are as follows:

1. What understandings do mental health care staff across specialisms bring to systemic issues in youth mental health care?
2. How do mental health care staff across specialisms think systems could better serve young people and what can a sociological lens contribute to this thinking?
3. What models of care and sociological understandings can guide improvements to youth mental health care in Aotearoa New Zealand?

The questions in the interview guide (Appendix E) were constructed using these three questions as a foundation. This interview guide was used synchronously as a prompt, a discussion starter and as a thoroughly followed guide.

3.2 Research Design

> *"Qualitative research is a situated activity that locates the observer in the world…Qualitative research consists of a set of interpretive, material practices that make the world visible… This means that qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them".*
>
> *(Denzin & Lincoln, 2011, p. 3)*

3.2.1 Paradigm and Approach

When choosing a research approach for this thesis the following statement accurately represented what I, as a researcher, was trying to achieve. "Qualitative research makes the world visible" (Denzin & Lincoln, 2011) a phrase that is simple in nature, yet when observed within the context of this research study, is profound. As outlined by the literature review above, the Aotearoa New Zealand Mental Health system is arguably failing to accurately provide care to young people in need. I intended to make these challenges visible to the world, shining a light on the flaws, investigating the impact they have on young people and elevating the voices of professionals who experience these issues daily. Qualitative research is inherently driven to answer questions by examining society and the individuals who inhabit it (Berg & Lune, 2011). Therefore, for this research project, a qualitative approach enabled me to answer research questions regarding the state of the Aotearoa New Zealand Mental Health system, by utilising the voices and perspective of those who inhabit the mental health system within a professional capacity… hence forth, making the subject matter "visible" to wider society.

According to Lichtman (2014) qualitative research is the perfect research approach if you want to learn more about human interactions or experiences. Unlike quantitative research, qualitative research does not deal with variables, treatments, or hypothesis testing (Lichtman, 2014). Instead, it begins with a set of assumptions, a specific worldview, or questions about a social phenomenon, which informs how the study is implemented (deMarrias, 2003). Qualitative research poses research questions with the intention of analysing the meaning an individual or group ascribes to a social problem (Creswell, 2007). The data is gathered within natural settings, sensitive to people and places, and subsequently undergoes an analytical process that establishes patterns or themes (Creswell, 2007). For this research study, a brief literature review was conducted before completing participant recruitment and interviews. This brief literature review informed the initial research design, specifically the interview questions, by providing the set of assumptions, a world view, and a theoretical lens. The reviewed literature outlined existing issues within the mental health system, both internationally and nationally; provided some alternative solutions that may improve quality care, and some sociological theoretical frameworks that could inform systemic changes. This informed my perspective on the topic and provided me with material that structured the questions for the interview. However, as a researcher employing researcher reflexivity, I approached the interviews open to exploring epistemological viewpoints and perspectives that may be different from my own. I was seeking the participants authentic perspectives, rather than imposing my own preconceived ideas on the subject matter (Watt, 2007).

It must be acknowledged that the following statement is an oversimplification and there will always be variations in a researcher's approach, Rosaline (2008) claims that people who lean towards calculating, hypothesising or searching for variables are prone to quantitative research. Whereas those who lean towards pondering or contemplating, most often about social issues, worldviews or experiences, are more likely to follow the path of qualitative research. Rosaline (2008) further outlines how there is an important link between research method and researcher, with most researchers favouring methods that require skills they already possess. For this research project, and for myself as a researcher, the statement above is correct. Qualitative research is not only relevant to this research project due to its intrinsic ability to project the perspectives and lived experiences of participants within their natural setting (Berg & Lune, 2011), it also corresponds to experiences and skills that I am familiar with. This will be discussed in more detail later in this chapter, but it is also relevant to note that at the time of writing I hold a professional position within the Youth Mental Health sector. Therefore, I felt passionate about utilising the voices of fellow mental health professionals, which I argue is most accurately portrayed through qualitative research.

Used commonly within qualitative research, I also drew heavily on an interpretivist research paradigm. This paradigm enables a researcher to gain, understand, and interpret a participant's authentic, subjective opinions, perspectives, or retellings of lived experiences (Bhattacharya, 2017; Cohen et al., 2018; Dezin & Lincoln, 2011). This research paradigm assumes the epistemological viewpoint which claims that knowledge as something that exists, and can be found, yet it can be understood and interpreted in various ways (Bhattacharya, 2017; Cohen et al., 2018; Williams, 2016). This approach views social realities as phenomena that will be understood differently by each person, acknowledging the variations in each individual's perspective and the different meaning they will ascribe to a topic or experience. The interpretivist research paradigm encourages researchers to seek these unique, subjective interpretations of reality, and through analysis, interpret them (Bhattacharya, 2017; Cohen et al., 2018; Dezin & Lincoln, 2011).

During the design phase of this research thesis, whilst conducting preliminary literature searching, I also conducted some informal conversations with mental health professionals. These conversations were a continuation of conversations that occurred while working within the mental health sector, often arising between equally frustrated professionals. These conversations, and the associated preliminary literature searching, specifically the Government Inquiry into Mental Health and Addiction (2018) report highlighted publicly released figures regarding funding, staffing or waitlists. These are quantifiable elements which can be objectively analysed. However, the sufficiency of these figures, or their impact on the community are subjective interpretations based on an individual's experience or beliefs. Therefore, an interpretivist research paradigm enabled each participants perspectives to be shared and then interpreted, providing additional insight into the quantifiable numbers. This research paradigm, and its implementation through a qualitative approach, enabled the research intentions to be achieved, while also aligning with my personal ideologies and tendencies as a researcher, recognising that reality is tangible, yet it can be interpreted in various ways, and the reported research should reflect those unique interpretations.

3.2.2 Chosen Research Methods

The following section outlines each research method that I employed during this research project. This includes the methods of gathering data and the methods of data analysis. Each of these methods were chosen in alignment with a qualitative research approach, while also utilising the strengths of the researcher and considering the setting in which the research occurred.

3.2.2.1 Semi-Structured Interviews

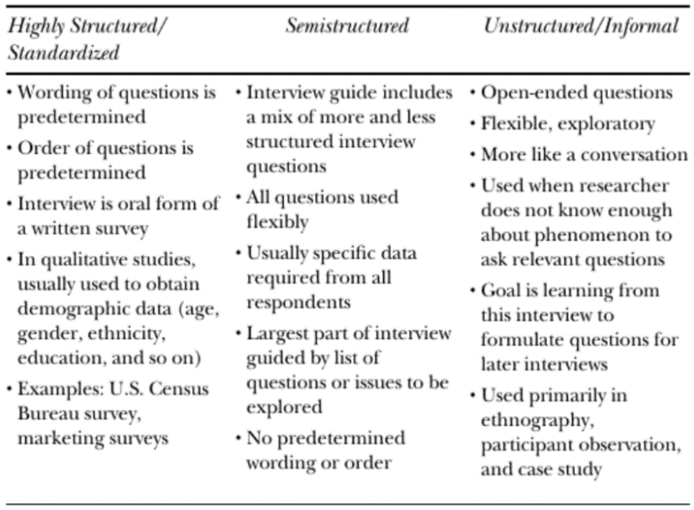
Sharan Mirriam, the author of a variety of literature on qualitative research, states that most forms of qualitative research use interviews to collect a majority of, if not all, their data (Mirriam & Tisdell, 2015). An interview, specifically within the context of qualitative research can be defined as "a process in which a researcher and participant engage in a conversation focussed on questions related to a research study. These questions usually ask participants for their thoughts, opinions, perspectives, or descriptions of specific experiences." (deMarrais, 2003, p. 54). For the purpose of this study, where the primary aim was to gather the perspectives of professionals working within the youth mental health sector, an interview was the most appropriate method for gathering data.

Interviews, rather than quantitative research or other qualitative methods such as focus groups or online short answer surveys, allows the participant and researcher to develop a rapport. This rapport, developed most effectively via face-to-face interviews, often through appropriate listening and subtle prompting (Miller, 2017), provides an opportunity for the collection of rich and significant data as the participant may feel more comfortable sharing sensitive or in-depth information

(Cohen et al., 2018). The use of interviews as a research method also allows for the exploration of complex issues through follow up questions as there is opportunity for the researcher or participant to clarify or explain questions and answers (Cohen et al., 2018). There is also flexibility to explore different subject matter unique to the individual's experience in the mental health system that may vary from other participants. These elements of interviewing are arguably less possible, or entirely impossible through quantitative research or other forms of qualitative research (Cohen et al., 2018). Arguably, the flexibility in questioning, the use of follow up prompts, and the development of rapport are most effectively achieved through semi-structured interviews (Denzin & Lincoln, 2000; Cohen et al., 2018; Merriam & Tisdell, 2015; Phillipowsky, 2020).

The table below differentiates between structured, semi-structured and unstructured interviews.

TABLE 5.1. INTERVIEW STRUCTURE CONTINUUM.



Highly Structured/ Standardized	*Semistructured*	*Unstructured/Informal*
• Wording of questions is predetermined • Order of questions is predetermined • Interview is oral form of a written survey • In qualitative studies, usually used to obtain demographic data (age, gender, ethnicity, education, and so on) • Examples: U.S. Census Bureau survey, marketing surveys	• Interview guide includes a mix of more and less structured interview questions • All questions used flexibly • Usually specific data required from all respondents • Largest part of interview guided by list of questions or issues to be explored • No predetermined wording or order	• Open-ended questions • Flexible, exploratory • More like a conversation • Used when researcher does not know enough about phenomenon to ask relevant questions • Goal is learning from this interview to formulate questions for later interviews • Used primarily in ethnography, participant observation, and case study

(Mirriam & Tisdell, 2015, p. 110).

Upon reviewing this table, it was clear that this research project required a semi-structured format. A semi-structured interview works off a series of suggested prompts and open questions. However, the specific wording or sequencing of these questions can be altered to fit the natural line of conversation and to suit the participant (Denzin & Lincoln, 2000; Mirriam & Tisdell, 2015; Phillipowsky, 2020). The flexibility that this format allows for, enabled me to be adaptable and responsive to the participant, following the natural line of conversation. While also following a set of predetermined conversation prompts or questions that allowed me to maintain a focus that was relevant to the research project (Jamshed, 2014).

As outlined in the table, semi-structured interviews typically use a range of tools and question types to gather data from a participant (Mirriam & Tisdell, 2015; Galletta & Cross, 2013). These can include open-ended questions, questions based on theoretical models, secondary or follow up questions that follow the lead of the participant (Adams, 2015) or physical resources. Within the semi-structured interviews, I used a combination of all the question types outlined above. This semi-structured format enabled me to have a natural, flexible "conversation with purpose" (Mirriam & Tisdell, 2015), suiting this research most appropriately rather than the highly structured or unstructured approaches.

For this research project I created an interview guide (Appendix E) and followed this relatively closely in each interview. The questions in this guide were predominantly open ended and allowed me to gather the relevant data for this project. However, in each interview differing follow up questions were used, and different physical resources or theoretical frameworks were referred to. The first two interviews I completed were an opportunity to review the interview guide and assess its effectiveness. Upon reviewing the first two transcripts, I could identify that the interview guide was working well, however small adjustments to my follow up questions and responses as a researcher were required to ensure that the questions remained open and gained authentic participant perspective. Other variations in the interviews occurred due to the variety of mental health specialities participants came from, and the different theoretical frameworks, experiences, or models of care, that were relevant. Detailed information about the interview process can be found in the 'Research processes' section of this chapter.

3.2.2.2 Thematic Analysis

Thematic analysis can be defined as; a research method which analyses qualitative data by searching through data sets identifying, examining, and then reporting common trends or themes (Clarke & Braun, 2006; Clark & Braun, 2021; Kiger & Varpio, 2020). According to Clarke & Braun (2014), the field of health and wellbeing has a history of producing strong qualitative research, which has been completed using a variety of differing methodological approaches. However, in the last two decades, primarily due to the work of Clarke and Braun (2006, 2013; 2014, 2016; 2021), thematic analysis has become one of the most well used research methods throughout many health and social research projects. Thematic analysis is a flexible approach, it is simply put, the examination of patterning, and therefore doesn't require any adherence to a specific theory, framework or academic discipline (Clarke & Braun, 2013; Nowell et al., 2017).

Clarke and Braun (2019) believe that their approach to thematic analysis is directly influenced by values that underpin qualitative research. Thematic analysis allows for both descriptive and interpretive research, however Clarke and Braun (2019) assume that any piece of qualitative research is somewhat interpretive, as the purpose of qualitative research is to give voices to the participants and then interpret accordingly. For this research project, the statement above holds true. This research project is descriptive, in the sense that the data describes the state of the mental health system and some of the participant's answers can be understood quite literally. However, it is predominantly interpretive research, as outlined by the chosen research paradigm. Many of the participant's answers can be understood in relation with other answers, with pre-existing literature and with sociological models or frameworks, enabling me as the researcher to interpret deeper meanings from the transcripts.

For this research project, the data set consist of transcripts of 30 – 60-minute interviews which were then transcribed into 12-20 pages of single space dialogue. This is an extensive amount of data to review and interpret, therefore organisation is significant if the researcher is to understand and accurately interpret meanings (Creswell, 2012). The organisation of data can occur in a variety of ways, however for this research approach I utilised inductive approaches to theme identification (Clarke & Braun, 2006; Kiger & Varpio, 2020). Inductive approaches were relevant within this research thesis, as I intended to gather the participants perspectives and ensure that the research accurately represented their thoughts and opinions. An inductive approach to theme identification also provided a broader and expansive analysis of the data (Kiger & Varpio, 2020), enabling me to acknowledge participant perspectives that didn't align with pervious findings from the literature, or my own personal experience working in the mental health system. I utilised my personal experience and subjectivity as an asset in the data analysis process (Clarke & Braun, 2021), drawing significantly on the interpretive research paradigm, while also employing researcher reflexivity which is outlined in-depth below. This process identified common themes, many of which were best understood within the context of pre-existing sociological and therapeutic frameworks (Clark & Braun, 2006; Kiger & Varpio, 2020). It must be stated that the purpose of this research project was to gather a wide scope of perspectives and subsequently understand the current state of the Aotearoa New Zealand Mental Health system, rather than conducting interviews based on pre-existing assumptions.

The thematic analysis process in this research project was conducted according to the six phases of thematic analysis, as outlined by Clarke and Braun (2013). The six phrases are as follows: familiarisation with the data, coding, searching for themes, reviewing themes, defining, and naming themes and the write up.

Stage One: Familiarization with the Data

For this research project I recorded each interview twice on separate devices. I recorded the raw audio in its entirety using voice memos, while simultaneously recording the interview on a secure, paid for app (Otter.AI), that dictated voice and produced pages of unedited dialogue. I used this two-fold approach for a few reasons. Firstly, having the pages of dialogue, while unedited and sometimes inaccurate, was a starting point for typing up the transcripts, saving me immense amounts of time. This time saving strategy enabled me to interview more participants. Secondly it allowed me to fully familiarise myself with the data. After each interview was completed, I would set aside time to listen to the entire audio recording uninterrupted. Then I would listen to the audio a second time, while I went through the pages of dialogue, listening and editing the transcript accordingly. I found that the app was relatively successful in picking up correct dialogue, however it could not determine one voice form another, and therefore careful attention was required to produce accurate transcripts. To ensure the transcripts were completely accurate, I was often re-listening to the audio multiple times and this repetitive process allowed me to completely familiarise myself with the data, prior to coding or interpreting.

Stage Two: Coding

After each transcript was complete, I began the process of coding. I used colour coding to highlight different sections of the transcript, linking each colour with a descriptive term. This was a process of preliminary coding, that allowed for data reduction and some initial analysis ahead of more in depth coding (Coates et al., 2021 & Clarke & Braun, 2013). A table of the 79 preliminary codes can be found in the appendices section of this thesis (Appendix F). After conducting preliminary coding on all the transcripts, I met with my supervisor and we conducted a more thorough coding process, refining the codes and beginning the process of 'searching for themes' (Clarke & Braun, 2013). A table of the refined codes can be found in the research process section of this chapter on page 54.

Stage Three, Four & Five: Searching for Themes, Reviewing Themes and Defining and Naming Themes.

These phases of thematic analysis were a recursive rather than a linear process (Clarke & Braun, 2006 & Clarke & Braun, 2013), and therefore the exercise of theme identification through Clark & Braun's (2013) four later phases, was a back-and-forth process. Using the codes as building blocks (Clarke & Braun, 2016), I was able to take sections of transcript and use them to find similarities in the data and form conclusions. Many of the participants shared very similar thoughts, regarding the issues present within the mental health system and the potential solutions. The coding process enabled me to refine these similarities and form a list of identified themes. I conducted this recursive process with the support of my supervisor, through many emails and in-person meetings, where we analysed the transcripts and preliminary codes, interpreting themes in accordance with existing literature, frameworks and other participant answers. Once the themes were identified they were then subject to a review process. This evaluative process assessed the themes against the transcripts to ensure that the identified themes accurately represented the perspectives of the participants. This review process included the collision of some themes, the subtraction of others and at times the redefining of themes altogether (Clarke & Braun, 2013).

This was a process that occurred over many months. It started while I was conducting interviews, as interpretations began to percolate in my mind, and finished during the write up of the thematic analysis. Towards the end of this process the themes were defined and named, and then used to inform the entirety of the thesis. A table of the named and defined themes can be found in the research process section of this chapter on page 55. After naming and defining the themes, I completed an informal write up on each one (Clarke & Braun, 2013) to use as a point of reference for the rest of the thesis.

Stage Six: The Write up.

The write up was part of the analytic process and deepened my familiarisation and interpretation of the data. According to Clarke and Braun (2013) this write up process involves weaving together the “analytical narrative” and sections of the transcript to tell a persuasive story about the data, within the context of existing literature (Clarke & Braun, 2013), specifically sociological frameworks and therapeutic models of care. The informal ‘write-ups’ about each identified theme was another stage of data analysis for me as a researcher. However, a large majority of this written content was then also used to directly inform the results and discussion section of the thesis as well.

3.2.2.3 The Role of the Researcher – Researcher Reflexivity

As I have outlined in the beginning sections of this thesis, at the time of conducting this research, I also hold a professional position within the youth mental health system. To ensure the privacy of my colleagues and the young people we work with, I refrain from identifying the organisation I work for within this thesis. This position is what encouraged and inspired me to complete this research project, due to the systemic flaws I observed that were limiting quality patient care. Arguably my role within the mental health system has positively impacted this research project as it allowed me to connect with more interview participants, to structure relevant research questions and to draw on my own personal experiences when gathering literature. However, it is vital that I acknowledge the biases and influence my personal experiences could have had on this research and outline the practices that I utilised to ensure the continued validity of the project.

According to Pillow (2003) researcher reflexivity is the increased attention to researcher subjectivity throughout the process of conducting research. It is an increased focus on questions such as "who am I?", "what do I think?", "how do I feel?" and how do these personal experiences or thought processes impact data collection and analysis? It is important to distinguish the difference between reflexive and reflective practices. In qualitative research these practices are not synonymous (Shelton & Flint, 2019). Reflection, while it may be an important skill, does not require another person. Whereas practicing reflexivity demands another, and a degree of self-consciousness to understand the impact we may have on others or a research project (Shelton & Flint, 2019). In comparison to the post-positivist or positivist research paradigms, that value objectivity, utilizing neutral and distant observations often through quantitative methodology (Joy et al., 2023; Taylor & Medina, 2011), researcher reflexivity, and reflexive thematic analysis, celebrate researcher subjectivity stating that it is an essential tool, enhancing the research project (Clark et al., 2023; Cohen et al., 2018). When harnessed through reflexivity, subjectivity can be a key aspect of the analysis process, providing deeper understandings (Joy et al., 2023), and emphasising the reliability of the researcher's interpretations (Shelton & Flint, 2019).

Within this research project, researcher reflexivity was an exercise of critical self-evaluation and a process of active acknowledgement and recognition that my personal position may have an impact on this research project (Cummins & Brannon, 2021). During the preliminary literature review, the interviews or throughout the write up process, it was important for me to clearly state and recognise the influence of my personal position, as the first strategy of researcher reflexivity. Therefore, in the initial communication with potential participants, I explained my current professional role, my reasons for completing the research project and how I intended to utilize the understandings I could bring to the research project (Joy et al., 2023), without letting them direct, or distract from the valuable insights participants shared.

Reflexivity enables researchers to find strategies that question their own thoughts, feelings, values, attitudes, and prejudices (Nilson, 2017), to question who we are and what we bring to the research (Joy et al., 2023). The purpose of this research project was to understand the participants' perspectives, to gain insight into Aotearoa New Zealand mental health system, rather than resting on my own opinions and beliefs alone. However, drawing on an interpretive research paradigm, and understandings within research reflexivity, I can acknowledge that my personal experiences, biases and interpretations, will be an inevitable and valuable part of the research project (Joy et al., 2023; Taylor & Medina, 2011), while using processes of self-evaluation to ensure that they sit alongside, instead of directing the results of the research project.

The first reflexive strategy that I employed was an interrogation of my own epistemological standpoint and internal assumptions, predominantly through journaling and critical reflection. This occurred during the initial phases of research design and throughout the data collection and analysis phases. It was clear that elements of a positivist paradigm, and its focus on objectivity was something that I frequently, and often without knowing, relied upon. Joy et al., (2023), refers to this the “positivist police”, outlining how even if an individual, such as myself, has rejected the notion of complete objective truth and seeks to complete a research project that values subjectivity and interpretation, they can still feel like objectivity is the ‘right thing to do’ due to the emphasis society and academic institutions have placed upon it. Reflecting upon this regularly, and utilising the interpretive paradigm and researcher reflexivity, enabled me to utilize my personal understandings to enrich the thematic analysis and subsequent write up, whilst presenting the participant voices as the primary focus of the research project. I also journal regularly, also recommended by Joy et al., (2023), reflecting on my personal beliefs and experiences, and analysing how they may be influencing the research, aiming to utilize these understandings to further, and not hinder the research project.

The second reflexive strategy I employed was through the transcribing process, where I was able to analyse my questioning abilities and critically evaluate how the questions could be more neutral, open ended or less presumptuous. Critically listening to the interviews and reflecting on the likely power imbalances between researcher and participant, enabled me to notice moments where a participant may not have felt entirely comfortable (Cummins & Brannon, 2021). This analysis process enabled me to identify areas where I could improve my interviewing approach to ensure that my biases or personal perceptions did not influence the direction of the interview and the subsequent participant answers. This process was also supported by sharing anonymised transcripts with my supervisor who could provide an external perspective regarding the content of the interview and my abilities as a researcher.

Researcher reflexivity was particularly relevant during the second section of the interview when discussing potential solutions for the mental health system. Through critical self-evaluation, I identified that this was an area where my biases were potentially more prevalent. Throughout the process of creating the interview guide I acknowledged this bias and altered the questioning accordingly to be more neutral. Following this standardised interview guide, and only asking follow up questions that deepened my understanding of the participants answers, enabled me to truly gain insight into what models of care or systemic approaches the participants wanted to see implemented, rather than what I believed would be beneficial. Utilizing research reflexivity during the entire research processes enabled me to value my subjectivity as a researcher, particularly within the analysis and write up stages of thematic analysis, where I presented my interpretations of the research. However, during the interview process, I took active steps to ensure that my subjectivity did not block authentic responses from participants.

Throughout many of the interviews there was a significant focus on Kaupapa Māori Models of care. Many participants identified this as a focus that was lacking in the current system. It was particularly important for me to utilise researcher reflexivity during this section of the interview and during subsequent analysis to ensure that I was acknowledging the impact of dominant western world views and the role that I play in that as a pākehā woman. According to Nilson (2017) qualitative researchers can often be unaware of how their ethnicity, class, gender, background, and beliefs can affect the construction of reality within a research setting. It was important that during this research project I utilised reflexive practices to recognise my pākehā background and constructively analyse how it impacts my understanding of Kaupapa Māori informed care. Acknowledging my perspective as a Pākehā individual, and using reflexivity to investigate how my previous, and evolving understandings of Kaupapa Māori informed care, sit alongside literature and advice from the mātauranga Māori experts I spoke to was a significant aspect of this research project. The other practices I employed to ensure that this research project was culturally responsive are discussed in the cultural considerations section of this chapter.

3.2.3 Ethical Considerations

"Sociologists, like other researchers, are committed to the advancement of knowledge, that goal does not, of itself, provide an entitlement to override the rights of others" (British Sociological Association, 2017).

This section of the chapter explains the measures I took to ensure that this research project was ethically and morally sound. High quality education and research studies are bound by a set of established ethical rules that protect the participant, the researcher, and the associated academic institution (British Sociological Association, 2017). For this research project I utilised the British Sociological Association (BSA)

Statement of Ethical Practice (2017), and the Human Research Ethical Guidelines set out by the University of Waikato. The subjects in this research project were human participants and therefore careful considerations were implemented to avoid harm. This section outlines these ethical considerations, which are as follows: confidentiality and anonymity, informed and educated consent, culturally responsible practices and the provision of support for participants. Each of these elements was considered and implemented prior to and during the recruitment, data collection and data analysis process.

Confidentiality and Anonymity

When a participant is asked to share their thoughts, perspectives, attitudes or experiences with a social researcher, it can be viewed as a depreciation of privacy, especially if the content shared may be sensitive (Boruch & Cecil, 1979). For many research projects the assurance of confidentiality is an essential aspect of gaining the individuals trust and subsequent participation. Furthermore, it is an essential aspect of research that is often required by various ethical committees. In the context of research, confidentiality can be defined as an "agreement to limit access to a subject's information" (Ethicist, 2015, p. 100). Ensuring confidentiality implies that you will limit the information you share with others, to ensure that individual is not identifiable (Macleod & Mnyaka, 2018). This information that you choose not to share differs vastly depending on the research context, for example within this research I did not share the complete transcripts or the list of participant names with anyone, including my supervisor. Confidentiality is an overarching concept that allows researchers to maximise the possible benefits, while reducing possible harms. More specifically, a researcher can also ensure anonymity by removing identifiable features such as legal or preferred name, geographical location or ethnicity, among others (Macleod & Mnyaka, 2018). For this research thesis, participants names were replaced with randomised numbers, for example 'Participant #19'.

To maintain my own ethical principles and those outlined by the BSA and University of Waikato Ethical Guidelines, it was important for me to ensure confidentiality in this research project. I did this by removing all identifiable information before sending any transcripts to my supervisor for review, completing the interviews in a private location that the participant chose, listening to the raw audio and completing the transactions in a private location and deleting all raw audio and identifiable data after the anonymised transcripts were complete. Identifiable information included a participant's name, location, clinical or non-clinical job title/place of work, age, gender, and background. Through the process of transcription, I removed identifying phrases and replaced them with descriptive terms. For example *[participant name]* or *[mental health service].* Participants may have shared anecdotes during the interview process and to ensure the transcript remained accurate these were not removed. However, sections of transcript that did contain potentially sensitive or identifiable information were not quoted as data excerpts in the completed thesis.

While qualitative, social science research doesn't pose the same risk to the human body as medical research, it would be naive to state that it is without risk altogether (Gibson et al., 2013). When participants are discussing potentially sensitive information, the experience can be distressing and there can be momentary discomfort for some (Gibson et al., 2013). Within this research project participants had the potential to share sensitive stories concerning young people, to outline issues they had in their workplace, with their management or the mental health system in general. These are all potential topics that could cause some distress, especially if the participant's name was attached to a statement they did not want to share publicly.

Informed and Educated Consent

According to the BSA statement of ethical practice (2017), participation in a sociological research project should be based on freely given and informed consent from those being studied. The responsibility lies with the researcher to ensure that the research project is explained in appropriate detail and in terms meaningful to the participant. The researcher must explain what the research is about, who is undertaking it, and what will happen to the data once the interview is complete. I argue that this statement draws on the concept of educated rather than just informed consent. For this research project I intended to gather consent that was not just informed, but educated and considered. Gathering consent can often be a passive process, relying on practices that present the information at the beginning of research project, without considering each participants cultural, community or comprehension differences (Oey-Gardiner et al., 2023). For this research I wanted to present the information to each participant in a way that considered their individual differences, adopting a flexible approach (Oey-Gardiner et al., 2023). I wanted to gain their consent ensuring that they truly understood the research process, its implications and their rights to withdraw from the project. I also wanted discussions regarding their consent and willingness to engage in the research be an ongoing process throughout the research project, treating the participants as individuals to be continually interacted with, rather than research upon (Oey-Gardiner et al., 2023; Olson, 2011)

Drawing on the principles outlined in the BSA statement of ethical practice, it was important for me to ensure that the participation information sheet (Appendix C) was written in terms relevant and understandable to a potential participant. It was also important that I then clarify this information with the participant and allow time for them to ask questions. I ensured that participants understood that they could withdraw their consent at any time during the interview, or afterwards (up until the period specified on the consent form – Appendix D). Drawing on the work of Oey-Gardiner et al., (2023) and Olson (2011), I can see that these steps ensured I was on the path to educated consent, rather than just informed consent.

Culturally Responsive practices

Despite the promises outlined in the Treaty of Waitangi, the colonisation of Aotearoa New Zealand and the subsequent social, political, and economic domination by the Pākehā European majority, has lasting impacts on Māori (Bishop, 1995 & 1998) Particularly within academia where initiatives and policies promote Pākehā knowledge, instead of, and often at the expense of Māori (Bishop, 1995). Therefore, as a Pākehā woman, it was important for me to consider what frameworks of knowledge my research would present and examine the impact this would have on the continuation of western knowledge within Aotearoa New Zealand. The subject matter of this research project is completely intertwined with culture and ethnicity-based issues, specifically in relation to Māori. As the literature review outlines, Māori youth are significantly over-represented within mental health statistics and research indicates severe health inequities for Māori who enter the system (Theodore et al., 2022). Therefore, when conducting this research, it was essential that I incorporated questions that provided a space for critical reflection about inequalities and discussions concerning culturally appropriate models of care.

However, as a Pākehā woman I felt that it would be inappropriate for me to conduct interviews containing these questions or models of care, without consulting an expert on the subject matter. I reached out to three experts on mātauranga Māori approaches to mental health and they provided me brief guidance, pointed me in the direction of informative literature and outlined some models of care developed through a Kaupapa Māori lens. I did not intend to conduct research on the mental health system through a Kaupapa Māori lens. Instead, I intended to paint an accurate picture of the system, which could not be done without considering the impact the system has on Māori and how Māori frameworks and knowledge could be better implemented.

Provision of Support for Participants

It is not uncommon for an interview participant to react emotionally to some research topics or interview questions (Magnusson & Marecek, 2015). This is not surprising as a large majority of research projects, specifically qualitative studies within the social sciences, deal with complicated or troubling topics (Magnusson & Marecek, 2015). Sometimes these emotions may be mild or manageable and the interview can continue. However, ensuring the welfare of the participant and responding accordingly is a vital aspect of the research process. This is particularly relevant due to the nature of this research project. According to (Volpe et al., 2014) helping professionals (individuals who work in professions where a significant and sustained emotional relationship is required) are likely to experience distress and negative emotions in the workplace. These professionals are also considered to be at high risk of 'burn out', often due to the emotions they are exposed to daily, which when unmanaged, may interfere with personal wellbeing (Volpe et al., 2014). Indicted by these research findings and the supporting literature, working in a mental health system that is inadequately meeting the needs of its patients, can place great emotional strain on the professionals. This was something that needed to be considered when interviewing the participants. Asking individuals to discuss their experience working in the mental health system, specifically within Aotearoa New Zealand system which is currently struggling to meet the needs of patients, could be a distressing experience for some individuals.

During an interview, if a participant was to become distressed, the interview recording would be suspended temporarily, and the participant would be given a moment to recover. At this time the participant would have the choice to leave the interview room and experience some privacy if they wish. It is important to note that an interview should never become a therapy session (Magnusson & Marecek, 2015). However, if a participant became distressed, I argue that it was my role as a researcher to provide support. Some participants may wish to discuss their feelings to aid the emotional process, and this is something I would have facilitated as the researcher; however, this section of conversation would not be recorded (Magnusson & Marecek, 2015). The participant would then have been presented with a choice to either continue the interview, postpone it to a later date or cancel the interview all together. As outlined in the consent section above, in the consent form (Appendix D) and participation information sheet (Appendix C), if the participant did choose to cancel the interview, they may also withdraw their consent entirely and therefore any previous interview recording would be deleted. If the participant wanted to continue the interview, I would have continually monitored the situation and ensured that the participant understood that they could choose not to answer specific questions or terminate the interview at any time.

Any individual who became distressed during the interview process would have been encouraged to discuss the experience and the distressing feelings within a professional counselling space. Most mental health professionals who were recruited and interviewed for this research project had access to professional or clinical supervision. Alternatively, there are professional counselling services that provide a few free counselling sessions to mental health professionals who have experienced distress. This information was presented to participants and encouraged during the interview process.

3.3 Research Processes

This section of the thesis outlines the practical steps and processes I followed during the recruitment, interview, and analysis section**.**

3.3.1 Recruitment

I began recruiting participants for this study at the end of April 2023 after receiving formal ethics approval from the Human Research Ethics Committee at the University of Waikato (Appendix A). Most of the participants were recruited using connections I had within the youth mental health sector, due to my professional role. I emailed the recruitment poster to colleagues, both within my service and within other mental health services. Paper copies of the recruitment poster were also advertised within various mental health services, particularly within staff rooms. I also had many colleagues that shared the recruitment poster with their own professional and personal networks, and it disseminated from there. Participants were also recruited when family and friends put the recruitment poster up in various staff rooms within the Ministry of Health and the Ministry of Education. The recruitment phase concluded in June, once Eleven Participants were gathered. This sample size was primarily chosen due to the constraints of a masters thesis. However other considerations also included the overwhelmed nature of the mental health system, and the subsequent time constraints that prospective participants were subject to.

3.3.2 Sampling

The chosen sample for this research project was mental health professionals who currently worked in the system or had done so within the last 10 years. I gathered participants from a variety of different specialisms and professional roles. These included Psychologists, Mental Health Nurses, Counsellors, Social Workers, Youth Workers, Mental Health and Addiction Clinicians and Mental Health Case

Managers. These participants came from a range of services, some public, government funded services and others from privately funded organisations. The services ranged from general mental health support to more specialised support, for example specific mental health conditions or specific cultural approaches. The participants were gathered from four regions across the North Island/Te Ika a Maui. These four regions are Northland, Auckland, Waikato, and Taranaki. The participants were various ages, genders, and ethnicities.

3.3.3 Interview Process

At the beginning of each interview, I explained the process that we would be embarking on, specifically drawing the participant's attention to the recording device, explaining the brief structure of the interview question guide, reiterating confidentiality, and explaining their rights to terminate the interview or refuse to answer a specific question. The beginning process of the interview also included some whakawhanaungatanga, building of rapport and when necessary, I paid attention to the participant's language style and behaviour so that I could adjust mine accordingly (Magnusson & Marecek, 2015). Some participants approached the interview in a relatively casual manner, others approached it more formally, and I responded accordingly to ensure that the participant felt comfortable.

Throughout the interview I used the interview guide, and associated questions as prompts to keep the interview on a relevant course, guiding the conversation back to the questions where relevant. However, I also allowed the participant to speak freely and discuss topics they felt were relevant. All of the interviews were between 30 and 60 minutes in length, with each of them following the interview guide smoothly, whilst also allowing for natural, participant led conversation. Each of the interviews were held at a location of the participant's choosing. Eight of the interviews were held in person and the remaining three interviews were held over the phone or zoom. The in-person interviews occurred in booked library rooms, at participants' workplaces or public places such as secluded outside areas. These in-person interviews occurred in various regions across the North Island/Te Ika-a-Māui. Each of the participants that participated in online interviews lived outside of my region and when asked, their preference was to conduct the interview online. I did not observe any differences in the quality of the participant's answers, when comparing the in-person and online interviews. However, the in-person interviews did allow for some deeper understandings and more follow-up questions due to the developed rapport that was more achievable in person. It is worth noting that there was only a minimal difference and the online interviews still produced rich, substantial data. Each of the participants were very respondent to the questions, many of them coming prepared with notes they had written and topics they wished to discuss based on their daily observations.

3.3.4 Data Analysis

I began data analysis after each interview, conducting the 'familiarisation with data' and 'coding' stages of thematic analysis on each transcript. Once the recruitment and interview phase finished in June, I met with my supervisor, and we began the 'searching, reviewing, defining, and naming themes' stage of thematic analysis. This process occurred over two months. The tables below (Table One & Two) outline the list of grouped and refined codes and the named and defined themes. An extensive list of the original codes (79 codes) is attached in the concluding sections of this thesis (Appendix F).

Table 1

List of Grouped and Refined Codes

Group One: Points to Individualistic/Neoliberal Thinking and Systemic Issues	Funding Related Issues (Codes 11, 12) Staffing Related Issues (Codes 52, 51, 29, 19, 20, 57, 78) A Lack of Kaupapa Māori Informed Practices (Codes, 21, 22, 44) Quick Fix Culture (Codes, 15, 17, 48, 58, 69, 74)
Group Two: Points to Individualistic/Neoliberal Thinking, the Impact of Systemic Issues on Professional Practice and Young People	Waiting Lists and Therefore Only Dealing with Crisis Management (Codes, 3, 4, 5, 8) Professionals Becoming Robotic Due to Time Constraints (Codes, 33, 17, 50, 58). Lack of Collaborative Care, No Time For Services to Work Together (Codes, 14, 15, 32, 48) Focus/reliance on the Biomedical Model, and No Time for Alternative Models (Codes, 48, 58)
Group Three: Stories shared about the Experiences of Mental Health Professionals	Staff Burn out/High Staff Turnover/Staff not Supported/ Staff Feeling They Can Not Support Young People (16, 17, 20, 29, 34, 36, 41, 51, 52, 57, 78)
Group Four: Stories Shared By Professionals About Young Peoples Experiences.	Young People Distrust the System, Lack of Therapeutic Relationships is Damaging, Impact on Family, Fragility of the Young Person and How the System Further Impacts This (Codes, 6, 9, 10, 15, 16, 28, 31, 38, 50, 61, 62, 70, 75).
Group Five: Relational Thinking, Alternative Models, Therapeutic Practices, etc…	Benefits of Therapeutic Relationships (Codes 10 & 62). Benefits of Collaborative, Integrated and Holistic Care (Codes 13, 18, 25, 55). Benefits of Kaupapa Māori Informed Practices (Codes 22 & 23)

Group Five: Relational Thinking, Alternative Models, Therapeutic Practices, etc…	Benefits of Alternative therapies that are not Standardised (Codes 27, 54, 63)
Group Six: Relational Thinking, Participants Newly Designed Systems, Youth One-stop Shops, Collaboration, Umbrella Approaches	Codes 13 & 18 Sections of Transcript from Participants #11 and #15

Table 2

List of Defined and Named Themes

Theme One: Individualistic Thinking. A Health Care System Driven by Business Ideologies and the Organisational Challenges that Are Subsequently Present.	**Theme Two:** Individualistic Thinking. Crisis Management and a System Focussed on the Medical Model.
Theme Three: Experiences of Those within the System: Experiences of Mental Health Professionals.	**Theme Four:** Experiences of Those within the System: How Mental Health Professionals Perceive Young People's Experience in the Mental Health System.
Theme Five: Relational Thinking. Relational Models and Practices, An Alternative to the Current System.	**Theme Six:** Relational Thinking. Participant Proposals. Designing a New System.

These six themes were formed by utilising the information that the participants shared and the interpretive analysis process, which was heavily influenced by sociological theories and ideologies.

CHAPTER FOUR: ANALYSIS, RESULTS AND DISCUSSION

4.1 Introduction and Overview

After completing eleven semi-structured interviews and subsequent thematic analysis and coding, six prominent themes were identified. Within this chapter the interview results are presented in a way that is structured by the six themes, paired with analytical discussion, based on my interpretations as a researcher, drawing significantly on international and local literature. The first two themes outline the concerns that participants shared, which are all arguably linked to the individualistic nature of neoliberalism and the role it plays within the current operational model of the Aotearoa New Zealand mental health system. Theme one outlines broad organisational challenges linked to neoliberalism, such as funding and staffing related concerns. Theme two analyses the direct consequences of these neoliberal organisational challenges, such as a reliance on crisis management and the biomedical model. These two themes are intrinsically interlinked, upholding and reinforcing one another in a cyclical fashion. Therefore, while they are two distinct themes, with theme one addressing the broad causational issues and theme two addressing the practices that directly impact young people, they are best understood in relationship with each other.

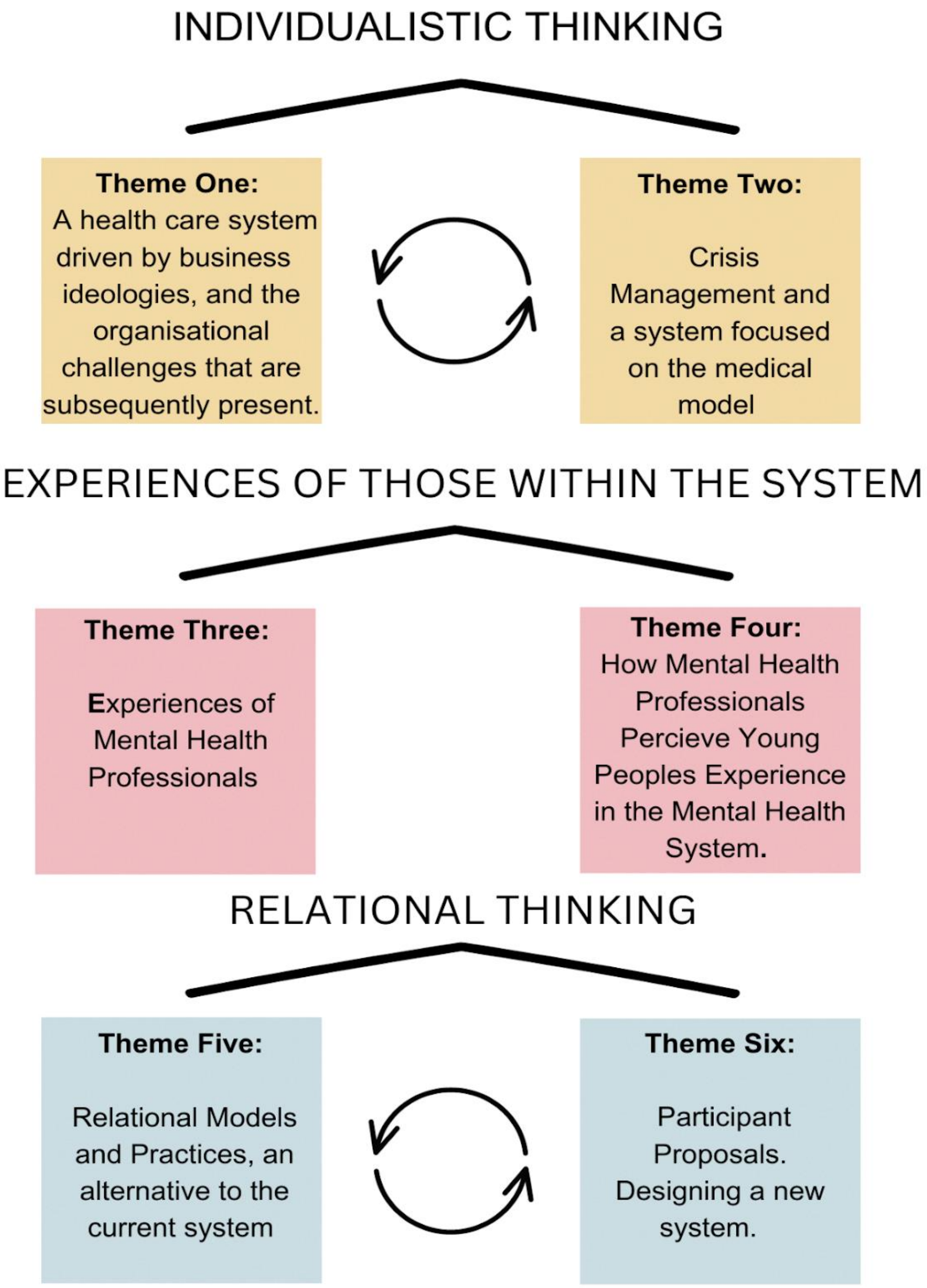
Themes three and four detailing the experiences of mental health professionals working within the system, and the experiences young people have while seeking care from the system. These themes also draw heavily on each other, and on themes one and two, providing a brief, yet in depth understanding of the impact that these individualistic and neoliberal driven practices have on the people of Aotearoa New Zealand. Themes five and six draw on potential alternative solutions to the issues presented in the first half of this analysis section and each of these alternative approaches, draw heavily on relational ideologies such as collaboration and collectivism. The argument I develop here, does not detail exact processes by which people can 'fix' the mental health system, rather it presents compelling evidence and alternative models or practices that highlight the importance and effectiveness of relational approaches. This is a direct contrast to the individualistic approaches that appear to be connected to many of the concerns that participants outlined.

Theme five outlines specific alternative therapeutic practices and models of care, drawing significantly on the importance of therapeutic relationships, Kaupapa Māori informed approaches, collaboration between individuals and organisations and increased flexibility to create an approach that fits an individual, rather than fitting the individual into a standardised approach. When discussing these alternative models and practices, I draw on feminist ethics of care and the understandings that disability scholars bring to concepts such as diagnosis and social norms. At the end of each interview participants were encouraged to be creative, to adopt 'blue skies thinking' and to design their ideal mental health system. These designs, and other existing systems that could be an alternative to the current systemic approach, are outlined in theme six, drawing heavily on the concept of centralised, collaborative support. These themes are arranged linearly and can be comprehensively understood in this way. However, the themes are best understood within the context of each other, drawing significantly on comparisons between the current individualistic approach, and the potential benefits of more relational ideologies and approaches to youth mental healthcare.

Figure one demonstrates these six themes visually.

Figure One

Diagram of Confirmed Themes.



4.2 Theme One: A Health Care System Driven by Business Ideologies and the Organisational Challenges that are Subsequently Present

A health system operating as a business, calculating efficiency, concentrating on inputs and outcomes, overworking, and undervaluing staff members and determining financial decisions without consulting the professionals working with patients. This is the mental health system that the participants I spoke to described. Participant #86 narrated their experience working within an environment that over many decades became more business focussed stating, "*over time we were more and more lead by a board who became more and more commercial business people…. All of the people who I consider were heart and head people. Once they left the board, they were being replaced by corporate thinkers. And it wasn't very long until first of all, [young people] were only allowed to have five sessions. Then it went to three. And, you know, it was just… ahh it was just appalling really. And I just found myself really at loggerheads with the culture of quick fix*". This participant is describing changes to the number of sessions a young person was granted and this will be explored more within theme two. However, this statement is applicable to many of the organisational issues that participants outlined. After performing interpretive analysis on all of the transcripts, this analysis suggests that the neoliberal capitalism-based business model that the Aotearoa New Zealand Mental Health system is arguably currently operating from, influences the organisational issues expressed by participants.

Each of the participants I spoke to, in one way or another, stated that organisational issues prevented them from providing quality care to young people seeking mental health support. Participants stated that these organisational issues were:

- Funding issues, particularly in relation to bureaucracy and high-level managers incorrectly allocating funding.

- Staffing issues, particularly in relation to staff shortages, staff having to complete work that should be allocated to a different professional, staff being inadequately trained and the accumulation of each of these factors leading to staff burn out.
- A lack of Kaupapa Māori informed practices and the reasons contributing to this deficit.

When we apply a sociological lens to the participant's answers describing the organisational issues, we can interpret that these are issues that are a direct consequence of a health system which is operating on a traditional business model, influenced by capitalism, neoliberal policies, and individualism. Drawing on international examples, supporting literature and excerpts of participant voice, I will explore this below.

4.2.1 Funding Concerns – A Health Care System Operating on a Neoliberal Business Model

Within this research project all the participants I spoke to stated that funding and the subsequent pressure to use time efficiently was an issue. Some stated that there was a lack of funding altogether, with Participant #17 describing the underfunded system as *"put together with a piece of tape and a bit of string"* or Participant #23 who stated *"it's just a funding thing […] it's a question of mathematics […] no funding. No psychologists? No therapy gets done*". Other participants stated that they believed that there was adequate funding but that it was allocated incorrectly due to *"people making decisions without understanding the full story or understanding what the community needs"* (Participant #19). While discussing the $1.9 billion that the system received in 2019 (Sutherland, 2023), Participant #15 expressed that it couldn't be a lack of funding, rather the funding wasn't received by those that needed it most - *"I think primarily* *that the funding doesn't translate to more staff on the ground. So you're not having as many staff that are sort of the face of mental health services and the ones that are actually meeting and building relationships with young people and their family".*

Participants also discussed bureaucracy and the role it plays in preventing funding from reaching those who need it. Participant #23 stated "*there's too many middlemen in the system, particularly middle management, I think a lot of the funding kind of gets paid out to people who are on the boards of organisations […] from a corporate background, and they'll be getting their six-figure salary. So, then the people getting paid the most are really not the people that are doing the actual work*". Participant #19 echoed this claim stating *"There's a lot of just unnecessary layers of management and unnecessary jobs being created that just silo everyone and fragment everything […] there's a lot of bureaucracy and it ultimately means we, the frontline staff, miss out […] most of that funding should be for increasing FTE and also increasing budgets for support packages…. not paying a manager like 200,000 to manage another manager, managing another manager".*

Participants expressed that that they were frustrated with financial decisions, for example the payment of board members rather than increasing funding for support packages, or the lack of funding allocated to increase the number of psychologists. Participants didn't specifically state that neoliberal policies or capitalism were the issues directly impacting the care that young people receive. However, applying a sociological lens, and drawing on Dawson et al., (2020), enables us to see that decisions to increase efficiency and profit margins, by cutting costs, are the direct consequence of a health system based on neoliberalism.

Neoliberalism is a political approach, a business strategy, the subject of rigorous academic investigation for many sociologists, and arguably the driving force behind challenges within the Aotearoa New Zealand Mental Health system. As defined by Gane (2014), neoliberalism in the theoretical sense and as a real-world model of governance, is based on principles of competition and self-interest, that when applied, infiltrate all aspects of society and culture. A global phenomenon that has colonised political, economic, and cultural structures (Heymen & Robbins, 2005), neoliberalism is most commonly understood within the context of expanding disembodied market forces (Sparke, 2016), the international movement of capital, market deregulation, minimised price controls and the reduction of state influence over the economy (Venugopal, 2015). Sparke (2016) claims that the influence that neoliberalism has on the global market can often seem invisible or abstract. That is not to say that the consequences are not real and severe, however they can be vast, multi-layered, and intricate to unpack. In comparison Sparke (2016) outlines how neoliberalism and its implications on health systems are deeply tangible and consequential.

Sparke (2016) elaborates on this, explaining that on a macro scale neoliberalism is simply put, a set of governmental norms that guide capitalism. However, on a more personal level, through a micro lens, we can see how neoliberal capitalism enlists individuals into becoming competitive agents, investing their own human experience, or physical embodiment of health as capital. People seeking health support, in this case young people, are constantly calculating their own worth and experience in comparison to others (Sparke, 2016), based on the competitive ranking system, that a health system influenced by neoliberalism requires them to participate in. We can see this expressed in theme two when we explore the triage-based waiting lists and the current focus on crisis management. However, we can also see how an individual's embodied experience is used as capital when they enter a health system that is more focussed on organisational factors that increase efficiency and profit margins, rather than individual health and wellbeing.

A defining element of neoliberalism is a reduced welfare state and therefore reduced public expenditure on systems such as health and social services (Poirier et al., 2022; McGregor, 2008). Under neoliberalism there is no "legitimate role for the welfare of people, communities or societies" (McGregor, 2008, p.84), it operates on the assumption that human beings will always favour oneself and strive to act independently of others, pursuing self-interest rather than mutual interest (Podsiadlowski & Fox, 2011) This arguably directly contradicts the values and ethical practices associated with caring professions. Navigating the space between these contradictions within the mental health system can be a challenge. Professionals are working within a system, resembling other large corporations, that is focussed on individualism, profit margins and efficiency, whilst also trying to deliver outcomes for young people in accordance with caring, often collective values and codes of ethics (Gheradi & Rodeschini, 2015).

Dawson et al., (2020) provides us with an Australian example that resembles the Aotearoa New Zealand mental health system that was described by participants. Drawing on this international example, helps provide context, and supports the statements that the participants I spoke to expressed. Dawson et al., (2020) states that since the introduction of deregulation, increased efficiency, and an escalated focus on profit margins introduced through neoliberal policies in the 1980s/1990s, the Australian mental health system has seen a significant shift. Dawson et al., (2020) goes on to state that these neoliberal policies align well with the individualistic approach we have also seen in the mental health system over the last few decades. This is because neoliberal policies reflect individualism when they emphasise competition, self-interest, and efficiency. When describing the state of the Australian mental health system, due to individualism and neoliberal policies working hand in hand, Dawson et al., (2020) paints a picture almost identical to the one described by the participants I spoke to here in Aotearoa New Zealand. Two of the most prominent issues that the Australian participants outlined, was limited funding and limited staffing. Australian participants expressed that "every single minute and hour is scrutinised" and that there was organisational pressure to economically justify every decision, in alignment with efficiency and increasing profit margins rather than best clinical practice (p.283).

A system that is built upon and subsequently prioritises the neoliberal ideologies that are outlined above, might impede the provision of quality care. This is arguably outlined by many of systemic challenges that are analysed within theme two. It could also be argued that unnecessary levels of overpaid management, with a financially subordinate working class, draws on some broader ideologies connected to capitalism concerning the concentration of wealth and economic power. However, that is another argument entitled to its own research project, separate from this piece of work.

Participants also expressed that a significant proportion of the funding allocated to youth mental health went to crisis management teams, rather than community-based teams or prevention-based teams. The nature of a crisis management focussed system will be explored in more depth in theme two. However, according to Brown et al., (2022) mental health professionals who are pressured to adopt short term strategies, such as crisis management rather than preventative care, are directly suffering from, or being influenced by the nature of a neoliberal, economically restrained health system. Participants fervently expressed that they would prefer to work in a system that prioritised preventative, long term focussed strategies to support youth mental health, however they felt that the current funding allocation inhibited this. Participant #11 expressed that the current system feels like it is *"waiting at the bottom of the cliff, rather than a preventative approach.* Participant #19 reiterated this claim by stating *"The funding, we get…. majority of that money goes into crisis development teams, the likes of ICAMHS".*

As expressed by the literature in chapter two, there is an increasing number of young people requiring mental health support. This is also reflected in the increasing waitlists as expressed by participants. Participant #17 expressed, *"I'm not kidding our waitlist is over two years"* and Participant #11, who is from a different geographical location echoed a similar sentiment, *"we're hearing about a year now".* Participants were not suggesting that the current allocation of funding to crisis management teams be reduced, the waitlists clearly indicate a need for this service. However, as outlined by Brown et al (2022) a neoliberal capitalism-based system is innately driven to focus on financial shortcuts and efficiency, therefore extra money is not allocated to preventative care or long-term strategies and instead we see 'quick fix' approaches.

Overall participants from this research project outlined funding as one of primary issues preventing quality care for young people. Most participants mentioned it within the first few minutes of each interview, highlighting to me as a researcher, that it was one of the issues at the forefront of their mind. While it must be acknowledged that the factors preventing quality care are complex and interlinked and it is difficult to identify one instigating factor, Participant #53 perfectly articulated how funding plays a massive role in this; *"Despite all the, you know, potential blockages that I've been talking about, there's still people who are ready and willing and wanting to go and who meet service entry criteria who are on waiting lists. So that to me, is clearly a funding issue".* Participant #53, alongside the participants quoted above, describe how funding related concerns are preventing quality care. Utilising a sociological lens, forming connections between funding related concerns and neoliberalism (Brown et al., 2022; Sparke, 2016), and drawing on international examples such as the work of Dawson et al., (2020), allows us to infer that the funding related concerns outlined by participants reflect issues within the wider organisational culture. A culture that is focussed on profit margins often through cost cutting, efficiency, competition, and self-interest. All elements that point to a system based on the principles of neoliberalism.

4.2.2 Staffing Concerns – A Health Care System Operating on a Neoliberal Business Model

Research suggests that the Aotearoa New Zealand mental health system and similar systems overseas, are not capable of providing quality care for the "tidal wave" of referrals they have received in recent years (Baker et al., 2019; Brooker & Coid, 2022; Government Inquiry into Mental Health and Addiction 2018; Paton et al., 2021; Petersen et al., 2017; Triliva et al., 2020; World Health Organisation, 2020). Arguably part of the reason for this inability to deal with increased referrals is linked to the financial factors that participants outlined above. However, another significant factor is an inadequate number of staff, as outlined by Participant #76 who stated services were *"snowed under [...] they have long waitlist, they're tired. They're understaffed, like, the whole mental health sector is".* Simply put, the current system does not have enough staff to deal with the number of referrals they are receiving. When we pair this issue with incorrectly allocated funding, the system doesn't have the resources to cope with the pressures associated with increasing youth mental health challenges.

One of the direct challenges associated with staff shortages is the extreme waitlists experienced across Aotearoa New Zealand. When discussing the current staff shortages participants expressed that *"we're all busier. We're all doing more than we probably should"* (Participant #17), *"staff shortages […] results in high caseloads […] big backlogs and waitlists of clients that don't get seen. I think we've got clients on our waitlist that haven't been seen for over a year…. we just don't have enough people to get through them all"* (Participant #23). Participants also expressed that staff shortages influenced the type of work they were required to do. For example, a shortage of psychologists or psychiatrists directly influenced the case load of other professionals such as counsellors, social workers, or mental health nurses. Many participants expressed that they felt they had to personally upskill or work outside of their scope in order to provide essential support to young people, who may not get it otherwise.

"I'm doing the work of psychologists and more […] we were all trained up. But we've taken that in terms of our own professional development. Yeah, I know about dialectical behavioural treatment and CBT and ACT, and blah, blah, blah it's just that it wasn't my degree".
(Participant #53)

"it's definitely not really my work, but I'm going to take them on, because no one else can see them […] in reality, I'm only taking them on because they won't be seen by someone else"
(Participant #11)

"there's probably not enough highly trained professionals out there to do the work, even if there was the money to pay them"

(Participant #35)

Participants painted a picture of extreme waiting lists, busy and tired staff members who have to take on more work than they should, and staff members who personally upskill or work outside their scope due to their personal and ethical drive to help young people in a failing system. Due to the organisational culture that is focussed on financial efficiency, participants said that staff are often also insufficiently compensated. Participant #11 explained this, specifically analysing the influence this has on staff wellbeing. *"From what I'm aware, we are underpaid. And therefore, people aren't as interested to come to the sector because of the wages or the salary. They're like…...Why would I not prioritise sanity […] if I could work in another sector […] there should be some compensation".* Participant #11's comments about sanity and staff members mental wellbeing draws significantly on the concept of staff burnout, which was a prominent theme expressed by all participants I spoke to.

Via et al., (2022) defines staff burn out, specifically within the mental health profession as "a complex state manifesting in emotional exhaustion, diminished personal accomplishment, and depersonalization" (pp. 339). Staff burn out is common in many organisations but specifically within "caring" professions such as the mental health sector, due to the emotional labour that is required when caring for mentally unwell individuals (Johnson et al., 2018; Via et al., 2022). While it must be acknowledged that working in a profession that requires high levels of emotional labour will always have its challenges - due to the nature of supporting people dealing with mental health conditions, suicidality, or addiction, among other issues - it is not so clear cut. Research does not indicate that every professional who enters the mental health sector will automatically experience staff burn out. Instead, Luther et al., (2017) states between 21% - 67% of mental health professionals will experience burnout and the variation in these statistics is due to a variety of contributing factors.

Johnson et al., (2018) and Luther et al., (2017) explain some of these contributing factors including; having to work overtime, or complete work outside of the job description, dealing with staff shortages, a lack of professional support and underfunding directly resulting in "services that are stretched beyond their resources, placing greater demands on staff and creating a stressful and pressurized environment" (Johnson et al., 2018, p. 23). These factors outlined by Johnson et al., (2018) and Luter et al., (2017) directly reflect the concerns expressed by the participants I spoke to here in New Zealand. For example, Participant #35 stated that *"because of the shortage of staff, you've got people with really heavy caseloads, they're getting burnt out. They're not getting much support from their managers".* Almost all of the participants I spoke to described staffing issues, subsequently linking cumulative issues to high levels of staff burn out and therefore staff turnover. Luther et al., (2017) elaborates on this further, explaining that high levels of staff burn out doesn't just directly impact the level of staff turnover, it is also directly linked to staff absenteeism and reduced job engagement, therefore producing a lower quality of care provided. The Government Inquiry into Mental Health and Addiction (2018) provides an Aotearoa New Zealand perspective on these issues, stating that "workers are often stressed and unable to work in the way that they want to and that would most benefit their clients" (pp. 70), and that directly contributes to a high turnover of staff and major difficulties recruiting new staff members.

Participant #15 described their experience of staff burn out within the mental health system stating "*you come into the field or the service to provide support. And your wings are clipped […] then that leads to like, I guess morale for staff. I think that gets impacted a lot because most of them are trying to do the best they can […] But then the system burns them out, processes impede them from being able to do the work that they want to do*". Some of the processes that Participant #15 is referring to are the financial and staffing limitations that prevent professionals from doing what they believe is best for young people. Arguably these staffing and financial limitations are a direct consequence of a health system that is operating on neoliberal policies and is therefore more focussed on service efficiency through quick fixes, short term strategies and cost cutting measures, rather than creating a health care system conducive with quality, long term care for young people.

4.2.3 Lack of Kaupapa Māori Informed Practices – A Health Care System Operating on a Neoliberal Business Model

The colonial foundations of neoliberalism have significant implications for indigenous cultures, here in New Zealand and globally (Poirier et al., 2022). Māori culture is innately collective, placing high importance on obligation to others, interconnectedness with Whānau and Iwi and emphasis on group determination or interdependence rather than self-determination or independence (Amundsen & Msoroka, 2019; Fox et al., 2018; Podsiadlowaki & Fox, 2011). The individualistic nature of neoliberalism and arguably the nature of the mental health system itself, completely undermines these collective values, neglecting the influential or therapeutic impact they may have on families (Podsiadlowski & Fox, 2011; Poirier et al., 2022). Individualism and collectivism operate on differing ends of a spectrum (Triandis, 1995); therefore, we can understand why people or organisations who closely associate with one construct may struggle to implement the other. As highlighted by participants, there is an undeniable lack of Kaupapa Māori informed practices within the system. Participant #11 stated *"there is always a multicultural Kaupapa Māori lens to it, but it's definitely not at the forefront […] for our Māori young people that need more collaborative Kaupapa Māori based principled care, it's definitely lacked".* Participant #11 echoed claims made by other participants who expressed a desire to incorporate Kaupapa Māori principles into their work, however due to practical organisational challenges they felt these practices could not be utilised frequently. In this section, I explore factors contributing to this deficit, analysing the difference between the collective values that Māori culture draws upon, and values associated with individualism that the mental health system is built upon.

According to McGregor (2008) individualism is one of the three central components of neoliberalism, alongside the pursuit of self-interest, and a deregulated "free" market. Neoliberalism operates on the assumption that an individual is innately driven to favour themselves instead of others or the environment. Therefore, concepts of public good are redundant and responsibility, success, or failure falls on the individual or family (McGregor, 2008). Properties of neoliberalism in the New Zealand Mental health system such as the reduction of publicly funded welfare services (Poirier et al., 2022) and a focus on profit margins or financial efficiency (Sparke, 2016; McGregor, 2008) can be seen through the funding and staffing issues that were outlined above. Other concerns that are arguably also a direct consequence of the neoliberal model of operation such as a lack of collaborative care, the crisis management system and how young people's experiences are used as capital, are explored in theme two. However, what is clear from the staffing and funding issues outlined above is that the Aotearoa New Zealand mental health system is operating on a neoliberal model, and the literature clearly outlines that individualism is a central component of this. Therefore, when analysing the lack of Kaupapa Māori informed practices within the system, reflecting on the conflict between the collectivist nature of Māori culture and the individualistic nature of the mental health system, may provide elucidation.

Some participants I spoke to expressed that Kaupapa Māori principles were lacking within the system all together. For example, participant #17 stated *"here in [location] you're lucky to get a Karakia [...] Considering the actual whenua here…...You'd think they would be all over it, but they're not. And that's a shame, because I think if you're dealing with, you know, Tamariki and Rangatahi, they need a Kaupapa Māori lens, otherwise they don't heal"*. Comparatively, other participants expressed that Kaupapa Māori principles were incorporated within the system, however they were incorporated in a disingenuous and tokenistic way. Participant #15 stated that genuine cultural training for staff needed to increase – *"more upskilling for existing staff, that's needs to be more than just a one-day training. That's more than just the tick box"*. Participant #19 stated *"I'm not a big fan of [...] let's say you do an interview. And then you ask someone their understanding of tikanga based on the three P's, that's just tick box, singing a waiata for the sake of it. You have a lot of organisations that meet that on a very token scale"*. Came et al., (2019) elaborates on these claims, highlighting how cultural advisory groups, which are created to improve equitable health outcomes for minority groups, reinforce inequalities within the system, due to advisory group members feeling that their presence and engagement was tokenistic and racially discriminatory.

When discussing the reasons behind the lack of genuine cultural approaches in the mental health system participants stated that *"lack of staffing makes it really hard for those processes to be reinforced in the care of our young people [...] there's time constraints, there's a lack of funding, lack of staff and all that, which means that the time that we spend with our clients is limited so this model of care isn't, transferred* (Participant #11), *"I don't think staff have the capacity to, I guess, fully focus on every individual's mana [...] we've become quite robotic, and we've got no choice to because there's so many clients to deal with"* (Participant #19). The neoliberal model of operation and the challenges it presents in relation to staffing, resourcing and time limitations is arguably hindering professionals from incorporating Kaupapa Māori approaches into their clinical practice. Kaupapa Māori approaches, drawing on collectivism, often take a relational, integrated approach, incorporating families and the wider community (Came et al., 2021). This collective approach requires dedicated time and resources, therefore directly challenges the efficiency model that neoliberalism and individualism rely on.

The New Zealand Government and therefore the youth mental health system is required to provide equal, and equitable health care to all individuals. The Treaty of Waitangi/Te Tiriti o Waitangi, specifically the Māori translation of Article two, promises Māori the protection of their health as a Taonga (treasure), stating that the crown must not interfere with the rights of tribes to exercise sovereignty over their own affairs (Beutow & Coster, 2001; Te Ara, 2016). Article Three and the preamble statement elaborate more on health outlining Oritetanga (equality and equity between Māori and non-Māori) and affirming the positive rights of Māori to partnership, participation, and active protection of Māori interests (Beutow & Coster, 2001; Te Ara, 2016). While it must be acknowledged that there are translation differences between The Treaty of Waitangi and Te Tiriti o Waitangi, and subsequently decades of institutional racism have permeated New Zealand, which through decolonisation the health system is still addressing (Came et al., 2021). The Treaty clearly outlines parameters for equitable health care for both Māori and non-Māori and ensures the protection of Māori interests and affairs (Beutow & Coster, 2001; Te Ara, 2016). This is also supported by the United Nations Declaration on the Rights of Indigenous People (United Nations, 2007) and the New Zealand Public Health and Disability Act 2000 (New Zealand Legislation, 2022), both setting guidelines and criteria for health equity and the protection of indigenous and minority groups. Despite the documentation, the statistics in the literature review clearly show that our health system is not providing equitable health outcomes for Māori, specifically in relation to youth mental health. Māori youth have more unmet mental health and addiction concerns than other surveyed ethnic groups in 2021/2022 (Ministry of Health, 2022).

Echoing the claims that participants made above, recognising the absence of Kaupapa Māori practices within the system, the Waitangi Tribunal and Came et al., (2021) present restorative future focussed suggestions that would transform the mental health system, shifting from the current model of operation and moving towards a holistic, relational and Māori tino rangatiratanga (absolute sovereignty) driven mental health system. The need for a Māori driven mental health system as a process of decolonisation is a research project within itself, and one that I as a Pākehā woman should not presume to conduct. However, the idea of a Māori informed mental health system presents an alternative to the current model of operation due to the direct contrast between individualism and collectivism. The idea of a system based on collectivism rather than individualism, raises concepts of collaboration and solidarity, directly supporting many of the potential solutions participants suggested and sociological thought processes that will be drawn upon later in this section. The importance and benefit of utilising Māori informed practice and commentary on how these practices align with other beneficial approaches participants suggested, are explored in theme five and six where I outline relational thinking as an alternative to the current model of operation.

4.2.4 Theme One Conclusions

New Zealand's mental health system does not have the resources to address the increasing levels of youth mental health (Baker et al., 2019; Brooker & Coid, 2022; Government Inquiry into Mental Health and Addiction 2018; Paton et al., 2021; Petersen et al., 2017; Triliva et al., 2020; World Health Organisation, 2020). Participants described a system where professionals were just doing what they could to 'stay afloat', completing the prescribed tasks and unfortunately not exploring alternative therapeutic avenues, long term strategies or preventative approaches. Participant #15 described it as *"really focused on like, inputs and outputs […] Sort of Band-Aid crisis management"*. Participant #15 illustrates a system that due to the neoliberal model of operation, is under resourced, and therefore only has capacity to deal with short term strategies, coined by many of the participants as "quick fix culture".

A system shaped by neoliberalism rationalises short term strategies or 'quick fixes' instead of alternate therapies, and pressures professionals to adopt them, primarily due to the 'one size fits all' approach that maintains efficiency within the organisation (Brown et al., 2022). A system that is "snowed under" or struggling to "keep afloat" (Participant #76 & Participant #11), due to staffing, funding, and resourcing issues, is going to rely on short term fixes due to their efficient nature, therefore, neoliberalism's focus on efficiency becomes a cyclical process. Brown et al., (2022) states that this creates an environment where dominant approaches such as the western biomedical model take precedence over alternative models. Applying a sociological lens to issues that have been primarily researched in other academic disciplines, allows us to infer that these organisational issues are a direct consequence of the neoliberal model of operation. In theme two I will elaborate more on these organisational elements directly impacting the quality-of-care young people receive.

4.3 Theme Two: Crisis Management and the Medical Model

The Theme One analysis suggested that the Aotearoa New Zealand Mental health system is currently functioning on a neoliberal model of operation, drawing significantly on individualistic thinking. This has created many organisational issues, as identified by the participants I spoke to. The secondary question I posed to participants when discussing these organisational issues was "how does that impact young people and the care they get?" Participant answers varied; however, three sub themes were recurring; the nature of a crisis management system and how that impacts a young person's mental health; a lack of collaborative care and the impact that has on a young person's trust in the system and the limitations of working solely within the medical model and how this impacts a young person's right to tailored treatment. My analysis of the data suggests that the organisational issues outlined in theme one and the issues described in this theme, uphold each other, operating symbiotically. Understanding the two themes in relation with each other, enables us to see the far-reaching impact of the neoliberal model and individualistic thinking, beyond the funding and staffing related concerns outlined above.

4.3.1 Crisis Management: The Focus of the System

Due to a shortage of staff and a lack of correctly allocated funding, the Aotearoa New Zealand Mental Health system is at full capacity and therefore has extensive waiting lists (Government Inquiry in Mental Health and Addiction, 2018). The New Zealand Government Inquiry into Mental Health and Addiction (2018) provides some valuable insights into the system's current overwhelmed state, expressing the following; the demand for specialist mental health services, specifically Infant, Child and Adolescent (ICAMHS or CAMHS) services has drastically escalated; specialist mental health services are operating at full capacity and therefore only have the ability to see those in the highest levels of distress; the waitlists for people aged 0-19 are longer than any other age group and while there is a valued workforce, it is small and underfunded. These claims reinforce concerns expressed by participants who stated that the current system primarily deals with crisis management only and a consequence of that is professionals having to triage, prioritising one young person over another. *"Because we have this big waitlist, there's an ethical kinda… do we continue with this one, but then someone else misses out so… it's tough to make that decision"* (Participant #23), *"The types of issues that I now deal with are way more high level. And, and I'm no longer really even able to work with people who are at lower levels, because of the volume of work coming our way"* (Participant #53). Triage and crisis management was clearly an ethical dilemma for participants, who all appeared uncomfortable discussing their experiences making those difficult decisions.

Participants also discussed the reality for individuals who don't make it to the top of the list and wait many months to be seen by a mental health professional. Participant #53 stated *"so they're not taking people on that I think they should be taking on because they are saying, we don't have space for this person who is not acutely suicidal […] someone has like, you know, like, absolutely clinical level anxiety say...but is not threatening to kill themselves or cutting terribly, so not sure that CAMS are gonna take them on".* Participants #15 , #76 and #11 elaborate on this claim, explaining how a young person's mental health challenges can escalate while they are waiting to be seen - *"either waiting for an assessment and waiting to get support for that, but aren't able to because of the year plus waitlist. And because they may not necessarily be in crisis, they have to wait that full time. And while that happens, things can get worse for them" (#15), "it's terrible. The amount of young people I work with that have said they've tried reaching out for help and not been given help or been put on a waitlist, by the time they get seen, they're in crisis mode, it's too late" (#76) "the lack of staff then means that clients will be waiting on waitlists getting worse and worse" (#11).* Every single participant drew connections between the lengthy waiting lists and organisational challenges such as funding or lack of staff.

“The implementation of waiting lists is conventionally viewed as a necessary response when mental health provider capacity is outstripped by high demand for services” (Brown et al., 2002, p. 218). As outlined by the perspectives of participants and the Government Inquiry into Mental Health and Addiction (2018), the system arguably meets the criteria outlined by Brown et al., (2002), resulting in significant waiting lists across a variety of services, public and private. The length of the waiting list varies, with some participants stating it is over 2 years (Participant #17) and others stating it around 1 year (Participant #11, Participant #15 & Participant #23). These differences are arguably due to diverse levels of individual need and population density within different geographical locations. Waiting lists, specifically within health services are organised based on the degree of urgency required when providing support to a patient (Parkin et al., 2003). This organisational concept is often referred to as triage, defined by Grigg et al., (2007) as “rapid assessment, problem identification, determination of acuity and the deployment of the required resources to respond to a person’s health needs…... triage is used in a range of health settings that require the accurate prioritisation and categorisation of patient treatment” (pp. 239).

Within a mental health setting, factors that influence triage decisions and therefore a young person’s position on a waiting list, are: their previous diagnoses, perception of current and historical risk (risk can include risk to self, risk to others and risk from others), their location, their connection to support systems such as a carer or parent and the individual judgement of the professional completing the assessment which may be influenced by years of experience or amount of training (Grigg et al., 2007). The intention of most mental health services is to complete triage, and then through effective treatment, professionals can move through the waiting list in a timely manner (Brown et al., 2002). However, this unfortunately doesn’t always happen. My intention is not to discredit the importance of triage, and I do not believe that the participants intended too either. Triage, closely associated with emergency medicine and drawing on principles of utilitarianism, is required to ensure that human life and health are protected in accordance with fairness, providing the greatest good for the greatest number of people (Moskop & Iserson, 2004). Specifically, within the mental health system where professionals are dealing with varying levels of risk, including suicidality, triage enables them to provide support to those who are at the highest risk of harming themselves or others first. However, when the health system is operating on a neoliberal model where staff are over worked and services are under resourced, the waiting list is not cleared in a timely manner and young people who are not deemed 'the highest risk' suffer the consequences.

Earlier in this section I outlined the work of Matthew Sparke (2016), who claims that under the governance of neoliberalism individuals "are enlisted into becoming competitive agents who invest their human capital as entrepreneurs and who reimagine the meaning of their lives, citizenship and individuality – including their personal health – as calculating consumers constantly comparing metrics of ownership, mobility and social ranking" (Sparke, 2016, p. 238). Generically, capital refers to a person's accumulated labour or status, within a stratified society (Bourdieu, 2002). Classifications of capital may vary - and many provide insight into other important considerations not touched on here, such as socioeconomic factors or inequalities (Bourdieu, 2002; Shim, 2010). However, broadly and in relation to this research project, we can understand capital as a young person's lived experiences, physical embodiment, cultural and social connections, among other elements, that they must invest into the mental health system, which upon assessment will determine their position on the waiting list. Drawing on Sparke (2016) a young person's capital is invested, objectivity analysed, quantified, and then compared to the experiences of other young people on the waiting list. This experience raises questions associated with a young person's feelings of self-worth, as their mental health challenges and potentially traumatic experiences are ranked, causing many of them, drawing on the words of Sparke (2016), to reimagine, and arguably question the meaning of their lives, their experiences, and their individuality.

Participant #19 describes their experience working with a young person who was on the waiting list for the public system and was feeling the need to increase their self-harm or suicidality to be taken seriously and get moved to the top of the list - *"that person was frustrated and said, should I just hurt myself even more"* (Participant #19). Unfortunately, this distressing experience is not unique, and many young people on the waiting list, or within the community feel the same. Participant #53, #11, #23 and #15 described very similar situations, each telling a story clearly laced with intense frustrations, with some participants visibly feeling quite emotional. While triage and waiting lists are an expected part of most health care systems, the length of the current waiting list is deeply consequential, leaving young people feeling unprioritized or that their lived experiences are not 'bad enough' to be at the top of the list. Due to the organisational challenges outlined in theme one, the system is not equipped to adequately move through the waiting lists and therefore we have a system that predominantly only deals with those in the highest levels of distress. This also draws on the concept of 'quick fix approaches' that was discussed in theme one, where under neoliberalism, short term strategies are encouraged to maintain organisational efficiency (Brown et al., 2022). Crisis management is arguably a short-term fix, and we can see that this approach is prioritised over long term strategies. Arguably this is because the long-term strategies, most of which are outlined in theme five and six, require more resources, which despite their potential ability to shorten waiting lists, are not harmonious with the neoliberal model of operation and its focus on profitability.

The last consequence of a system focussed on crisis management, as identified by participants, is the systems inclination to quickly discharge young people from the system. Participant #35 stated that *"people are overworked, or their caseloads are too heavy. So, they're just palming people off as quickly as they can to reduce their workload".*

Echoing Participant #35, Participant #15 stated that *"there's always a push to discharge so that you're not overwhelmed with a massive caseload".* While quick discharge may be damaging to young people, within a system that is attempting to maintain organisational efficiency, it can be observed as logical. Unfortunately, literature describing the impacts of early discharge for young people struggling with mental health challenges, nationally or internationally is very limited. However, the perspectives of participants I spoke to indicate that it can create a general distrust in the system (Participant #76, #19, #53), can prevent quality, therapeutic relationships, subsequently hindering a young person's ability to heal from trauma or cope with mental health conditions (Participant #11, #53, #15, #86, #35), it can make young people feel abandoned (Participant #53, #86) and make a young person reluctant to engage in further support (Participant #53, #76).

According to participants the reasons for a quick discharge, under the current system, included a lack of Whānau engagement, not showing up to appointments regularly, or if the young person was not willing to dedicate themselves to the process (Participant #53, #35, #15). While some of these reasons may be justified, Participant #53 outlined how discharge based on these factors ignorantly dismisses cultural and social differences – *"they have a very clearly stated policy […] we will only work with the young person when they're ready to dedicate themselves […] not showing up […] that's how a lot of my clients […] it's in their sort of community manners […] their society practices".* Participants didn't state that young people who don't engage should be 'kept on the books' despite continuous lack of engagement, that would unsustainable. However, it was clear that due to the nature of the neoliberal system, professionals are pressured to discharge young people, and therefore could not make continual allowances, or consider family, social or cultural practices that may be influencing a young persons limited engagement.

Participants stated that the pressure to quickly discharge people, prevents professionals from developing strong or therapeutic relationships with young people. Participant #15 stated that *"You're cautious not to build too strong of a relationship in case you can't continue to provide support".* Participant #15 was referring to quick discharge here, however they were also discussing the limited number of sessions a young person has access to in the public system stating, *"it's all about timeframes and deadlines […] there isn't much room to be able to spend that quality time, it's more quantity in and out, get the tick boxes done"* (Participant #15). Other participants also discussed this pressure to move through young people or only provide limited sessions before discharge. Participant #11 stated that "*People try tell me 'you need to work faster [...] I feel like what they're trying to say is I need to not put as much time into my clients"* , *"I've got [manager] who's now you know, sort of going, oh, my gosh, [participant name], you can stay with that person for years. So again, the most vulnerable, don't get their needs met"* (Participant #53). Participants were visibly frustrated when discussing the pressure, they feel to move through an extensive waitlist, to discharge quickly and only provide a limited number of sessions. However, once again, despite mental health professional's reservations, this model of operation is a logical consequence of neoliberalism.

Some participants outlined a specific limited number of sessions they were able to provide (Participant #17 & #86), others said it was determined by the needs of the young person, but all participants stated that it was never enough and there was a pressure to discharge after the bare minimum was completed. When we look at the limited number of sessions provided to young people, the quick discharge that occurs and pair that with the high turnover of staff (as outlined in theme one), we can see three factors contributing to an environment that doesn't foster the development of strong or therapeutic relationships. The importance of a therapeutic relationship and the role it plays in supporting young people with mental health challenges will be discussed more in theme five.

4.3.2 The Neoliberal System's Reliance on the Medical Model and its Limitations

Within theme one, I referenced the research of Dawson et al., (2020), outlining how the Australian mental health system, reflecting many properties of the Aotearoa New Zealand mental health system, is operating on neoliberalism, drawing significantly on the principles of individualism. The same piece of research forms linkages between neoliberalism, individualism, and biomedicine, or the 'medical model'. Dawson et al., (2020) states that "biomedicine fits well with market principles due to its emphasis on standardised treatments, such as medication, for individual pathology. Biomedical approaches also lend themselves well to care that is delivered through itemised and standardised systems so that economic costs and benefits can be assessed" (pp. 278). This draws on the research of Brown et al., (2022) who outlines how "one size fits all" uniform approaches maintain neoliberalism's focus on efficiency and individualism.

Within theme one I discussed how neoliberalism's "one size fits all" approach focuses on westernised approaches and doesn't allow for alternative, Kaupapa Māori informed practices. However, that is also arguably true for any alternative practice that doesn't fit in with the standardised biomedical model. Research clearly outlines that neoliberalism favours individualism in terms of self-interest, a lack of community emphasis, a minimised welfare state (Dawson et al., 2020; McGregor, 2008; Podsiadlowski & Fox, 2011; Poirier et al., 2022) and arguably concepts of meritocracy (Littler, 2013; Rottenberg, 2018; Young et al., 2017). However, it doesn't favour individualised care plans, tailored to the young person, that could include various clinical or non-clinical approaches that sit outside of the biomedical model. These individualised care plans, are shown to be beneficial for young people, as outlined in theme five and six. However, neoliberalism's understanding of individualism doesn't directly relate to individualised approaches, rather it favours more universal, homogenized methods that favour self-interest and monetary gain rather than mutual care or community concern. Dawson et al., (2020) states that while policies and procedures driven by neoliberalism and biomedical approaches remain dominant within the healthcare system, it will be challenging to adopt alternative approaches that are flexible to the needs of service users, such as tailored individualised care plans.

Participants #53, #11, #17 and #23 all highlighted examples of the pervasive nature of the biomedical model throughout the system, expressing that it is the primary, and sometimes only, approach used when caring for young people. We can also observe the medical model as a prevalent phenomenon, due to the lack of, or displacement of alternative models. Participant #17 stated that within the current system it is *"the DSM or nothing*". The DSM refers to the Diagnostic and Statistical Manual of Mental Disorders, currently in its 5th edition (American Psychiatric Association, 2022; Nelson, 2019). According to the participants I spoke to, my own experience working in the mental health system, and the existing literature, the Aotearoa New Zealand mental health system utilises medical diagnostic tools such as the DSM or the International Classification of Diseases, Eleventh Edition (ICD-11), to determine mental health conditions and the subsequent course of treatment (Brown et al., 2023; Otago University, 2010; World Health Organisation, 2023).

The reasons for the prevalence of the biomedical model within the current mental health system are clear, the biomedical model and its standardised approach reinforces ideas of efficiency. However, as many participants expressed frustrations and concerns due to the prevalence of the biomedical model, we must analyse what Nelson (2019) calls diagnostic dissonance and the impact that the biomedical model has on the care young people receive. Nelson (2019) defines diagnostic dissonance as a deep conflict between mental health professionals' theoretical orientations and the dominant presence of the biomedical model and the DSM. Participants in Nelson's (2019) study expressed similar concerns to the ones outlined in this research, "I hate the DSM……it limits and doesn't define the complexity of what I see in the room with me. Its labels and I hate doing that...It was meant to be a tool for clinicians, to have a language to describe symptoms and coordinate care. Now it's a labelling machine" (pp. 939).

That participant quote from Nelson (2019) describes a mental health professionals experience of diagnostic dissonance and arguably reflects what participants #17 and #11 are also expressing. *"You know, it's all too much about the DSM five now, not enough about real care, and what stuff does to you. What trauma does to you"* (Participant #17), *"the healthcare system is very diagnostic, its labels, its putting people in boxes. And if you don't fit into a box, you aren't getting guaranteed treatment"* (Participant #11). These quotes are clearly depicting a system where a diagnosis is the primary goal of mental health support and is sometimes a requirement to access further support. Under the operation of neoliberalism this biomedical approach is rationalised, due to its focus on standardisation and the encouragement of streamlined care plans rather approaches tailored to individual differences.

However, labelling or diagnosing individuals doesn't always directly contribute to improvements in mental wellbeing, often it can have the opposite consequence. Participant #17 outlines how *"the psych's and all those guys are very much diagnose and medicate. And I just don't believe that's necessary every time, certainly it's good sometimes, but not every time"*. Participant #17 echoes the claims of many other participants who highlight how the medical model may be necessary for some individuals, however, others may need a more holistic approach (Participant #17, #35, #53, #11), a Kaupapa Māori approach (Participant #53, #17), a transdiagnostic model approach (Participant #11), or other approaches that are explored in theme five and six. The message that all participants portrayed was that flexibility to provide the young person what they needed wasn't possible in a system that was focussed on standardisation, through using the DSM.

A focus on diagnosing and labelling individuals also has wider social ramifications. The medicalised process of diagnosing individuals with mental health challenges, indicates that an individual is flawed or diseased, further contributing to stigmatisation and misunderstanding (Boggs, 2014; Martin et al., 2000; Nelson, 2019; Thachuk, 2011). This medicalised process places emphasis on the label itself, often creating blind spots for mental health professionals, individuals, families, and society, who focus on the diagnosis instead of considering social, cultural or political influencing factors (Martin et al., 2000; Nelson, 2019; Thachuk, 2011). This preoccupation with disorders, conditions, intervention and medication, stigmatises behaviour that upon reflection might actually be considered 'normal' or 'common' (Boggs, 2014).

The neoliberal model of operation and its fixation on standardised practices, impacts the individuals seeking support from the system, and wider social perspectives concerning mental health in general. Alternatives to the medical model and its focus on diagnoses are explored in theme five and six when we analyse participant's suggestions for the mental health system moving forward and the sociological frameworks that deepen these understandings. Examples of this include the Transdiagnostic model (Frank et al., 2014), an increase in Kaupapa Māori approaches, an increased focus on collaborative care and the insights that disability scholars bring to understandings of regulatory and cultural norms and their connection to socially constructed labels (Brady & Franklin, 2023; McLaughlin et al., 2016).

4.3.3 A Fragmented System and the Impact on Young People – A suggested Move to Collaborative Care

Globally and here in New Zealand, the mental health system is a locus of rapidly escalating competition between different professionals or specialisms (Dermer &

Schwartz, 2014). Psychiatrists, psychologists, counsellors, mental health nurses, social workers and non-clinical staff alike are constantly competing to establish their identity within the system, fighting for the "largest slice of pie" (Dermer & Schwartz, 2014). While it must be acknowledged that fighting for the biggest slice of pie may be well intentioned as it is professionals seeking to help the most amount of people, we can draw parallels between the statements made by Dermer & Schwartz (2014) and the innate characteristics of neoliberalism, including competition and self-interest (Gane, 2014). Further parallels can be identified when Dermer & Schwartz (2014) state that within this competitive system, the DSM is treated as the "bible", furthering the significance placed on diagnosis and potentially stigmatising labels. An alternative to the competitive nature of a neoliberal model of operation, is a more integrated, collaborative, often coined holistic or wrap around approach, that encourages inter-professional harmony, rather than competition (Dermer & Schwartz, 2014; Huang et al., 2017; Mumba & Mugoya, 2022). The benefits of collaborative or holistic care are discussed in depth in theme five and six. However, what was made abundantly clear by participants, is the lack of collaborative or holistic care within the current system, and below I will explore the factors contributing to this.

Collaborative care is used effectively across a variety of health specialisms, including oncology, primary care, and mental health (Archer et al., 2012; Bower et al., 2006; Gilbody et al., 2003; Huang & Barkil-Oteo, 2015; Huang et al., 2017; Huffman et al., 2014; Irwin et al., 2019; Sharpe et al., 2014; Thota et al., 2012). While the exact definition and application of collaborative care may vary amongst different professions, core elements remain the same. Within the sector of mental health, and the context of this research study, collaborative care can be understood as way of supporting young people, utilising a multidisciplinary team, or professionals from varying services/agencies, working together to help a young person overcome mental health challenges (Archer et al., 2012; Shepard & Meehan, 2012). At its core, collaborative care requires and encourages professionals to see “our patient” rather than “your patient” or “my patient” (Fickel et al., 2007, pp. 208). Collaborative care occurs on a spectrum; it can something minimal such as regular communication, something more substantial like joint case reviews or shared activities towards common goals, or something even more significant like concurrent treatment and complete shared responsibility (Fickel et al., 2007).

Drawing on my own experience working in the New Zealand mental health system, the stories shared by participants and the Ministry of Health website (Ministry of Health, 2022), I can claim that the Aotearoa New Zealand mental health system consists of public mental health services, which have a variety of specialised teams, and community organisations, also staffed with a range of professionals. Currently the public mental health system (ICAMHS/CAMS) primarily deals with crisis management, and community organisations deal with mild to moderate mental health concerns. Collaborative care, in practice, can occur between professionals within the same team, within the same organisation or through interagency collaboration, for example ICAMS working with a community family support service. The degree of collaboration required is determined by the number of professionals/services involved in a young person’s care.

All of the participants I spoke to stated that young people were multifaceted and that caring for their mental health and wellbeing required a variety of different professionals, each catering to a different area of a young person’s life. Participant #53 gave an example of this - *“So they would have had involvement with police, social workers, icams, housing provider type people. You know, like budgeting finance that sort of thing, food supply from community organisations”.* This statement made by Participant #53 was echoed in stories told by many of the other participants, and they all expressed that the involvement of this many agencies, while it may be complicated at times, was necessary. When asked how those professionals worked together all participants stated that the process was not collaborative enough. *“Collaboration is the* *goal. But I don't…. So far, I've seen minimal of it in my line of work"* (Participant #76). *"**Researcher:** is it a collaborative process? **Participant:** No, not at all"* (Participant #23).

Instead of working collaboratively Participant #19 stated that *"everyone works in silos…. because ultimately, it's just how the bigger picture is, everyone wants to fight for contracts"*, reflecting the competitive nature of the neoliberal system (Dermer & Schwartz, 2014; Gane, 2014). Participant #23 elaborated on the nature of working in a system where services are unfortunately driven to compete with each other, stating that *"There's a lot of… and this comes back to like the politics of helping. Everyone's got their own idea of how it should be done. And there's a lot of biases and kind of hallway talk about other organisations […] so not a lot of collaboration".* This statement speaks to differing clinical decisions and that is bound to happen, due to the extensive variety of clinical and non-clinical approaches within mental health. However, this statement also arguably speaks to the general feelings or atmosphere between services who are working within a system based on competition rather than collaborative ideologies.

Services and professionals working in siloed or competitive environments are prevented from providing collaborative care, that is undeniable. However, an insufficiently resourced system with an extensive waiting list is also a significant contributing factor that is relevant when discussing the impact of neoliberalism and individualistic ideologies. Professionals who are feeling the pressure to move through a waiting list, due to a lack of staff or pressures to maintain efficiency, may be more likely to refer young people on to other services. The two quotes below highlight this from a participant perspective.

"They might get referred on to a service who just doesn't have the resources either. So it's going from one place to another place to just being bounced around and not actually getting the help that they sought in the first place" (Participant #76)

"People are overloaded, and they're just trying to find something or someone to support the person. And they're not building relationships with the young people because they're bouncing them around […] they're just palming people off as quickly as they can to reduce their workload". (Participant #35)

Drawing on the established understanding of organisational issues, caused by neoliberalism and individualism, and the statements made by participants, we can see that collaborative care is not conducive with a system driven by competition, efficiency, and self-interest. Professionals cannot prioritise collaborative care, or any alternative method outside the standardised practices, when they are focussed on triaging and moving through a waiting list due to insufficient resourcing. Participants I spoke to stated that the lack of collaborative care, especially when a young person is 'bounced' from service to service, has a detrimental impact on a young person's ability to develop trusting and therapeutic relationships. *"A young person I worked with said. I feel like I'm chucked around like a rugby ball, [...] the type of care that they are provided is get in, get out, get in, get out [...] What it seems like to me and the young people when they have been passed around the system, is that they feel like they haven't been prioritized".* (Participant #11).

The imagery of a rugby ball being passed around as a metaphor for a young person's experience within the mental health system, is saddening to read, yet also significant in terms of describing the nature of the neoliberal system that is focussed on inputs or outputs and how this doesn't allow for collaboration between professionals or services. Participant #11 outlines how this makes young people feel that they haven't been prioritised and are not valued. Participants #76 and #15 elaborate on this stating *"if they feel like they're just being bounced around to another service, it's going to be harder for them to want to engage with you"* (referring to future engagement with mental health services) (#76), *"the most important part is to have that strong therapeutic relationship and build that trust. However, that can be hard to get when they've already been disappointed by the service, you can kind of start on the back foot. But at the same time, you* *want to be cautious not to build too strong of a relationship in case you can't continue to provide that support"* (#15). Participant #15's description of 'starting on the back foot' and then being cautious when providing support, speaks to the lack of continuity of care, arguably due to the quick discharge process outlined above, or the pressure to refer young people on to other services, to maintain organisational efficiency.

First established in New Zealand in 1997, Strengthening Families is a programme set up for families/whānau and their children/tamariki, designed to assist in providing integrated, and collaborative care. The original premise outlined a need for support services to assist families who were engaging with multiple government agencies and needed 'one place to go' instead of approaching each service separately. Strengthening families employed coordinators who facilitated access to support services, adopting a wraparound approach. The programme was rolled out across the country, and still operates, in a limited capacity today (Strengthening Families, 2022). According to the Oranga Tamariki (2020) report on Strengthening Families, collaboration can be defined as the "means of producing something joined and new, from the interactions of people or organisations, their knowledge and resources". The integration of social services is not a new approach, however it is "increasingly being seen as key to addressing service fragmentation and inefficiencies" (Superu, 2015, as cited in Oranga Tamariki, 2020, p.1), and the literature continues to support the notion that "collaboration between agencies and disciplines is most effective and most appropriate for vulnerable and at-risk families…[as] these families often have multiple and complex problems that cannot be resolved by a single service provider" (McDonald & Rossier, 2011, as cited in Oranga Tamariki 2020, p. 6).

The Oranga Tamariki (2020) report goes on to define collaborative care further, providing examples of it within clinical practice such as frequent communication, tactical information sharing, collective resources, negotiated shared goals and long-term relational plans. All elements that resonate with the approach participants within this study were seeking, specifically the collaboration between agencies to provide care with the young person at the centre rather than quick discharges or referrals to other services. Unfortunately, Strengthening Families as an Oranga Tamariki funded service was reviewed and the original 38 coordinators has been reduced to 21 (Ridout, 2023; Strengthening Families, 2022). The Oranga Tamariki deputy chief executive of Māori partnerships made a statement on the reduction of coordinators after an outcry of community disappointment, stating that the funding cut "aligned with the agencies new strategic direction" (Ridout, 2023). When we analyse the rise of neoliberal policies throughout the 1990s and into the 21st century (Barnett & Bagshaw, 2020), we can infer that there is a link between reduced funding for welfare services, and subsequent reductions in services like Strengthening Families, and neoliberalism's focus on increased profit margins.

In conclusion, due to organisational challenges relating to staffing, funding and a focus on efficiency, the care that the Aotearoa New Zealand mental health system is providing is "quick fix" focussed rather than long term or continuous. This arguably presents as quick discharges and a lack of collaborative care, which despite its benefits, is not an approach adopted by a system focussing primarily on crisis management. All the participants I spoke to referred to the benefit of collaborative care, however they claimed that the system doesn't currently prioritise these practices. A more in-depth analysis into the impact that this has on a young person's experience and their ability to form trusting relationships will be outlined in theme four.

4.4 Theme Three: Experiences of Mental Health Professionals

The analysis so far suggests that the issues within the system are directly impacted by the organisational structure of the mental health system. In response to these issues theme five and six present alternatives practices and models. Before presenting the alternative models, I felt it necessary to highlight the participant's statements concerning mental health professional personal wellbeing and the wellbeing of the young people they care for, after inhabiting a system that may have impeded this. Themes one and two have outlined how the system is problematic and from that we can infer that it may be challenging to work within or receive care form. However, many participants shared specific stories and experiences that provide further insight, establishing just how problematic the system is, and providing a more emotive and relatable narrative.

Firstly, all participants I spoke to expressed that they work with a team of incredible colleagues - *"There's some really amazing professionals that work in the space. And there's a lot of experience, psychiatrists, psychologists, and other mental health professionals that want to encourage the development of new staff. And that do want to take on more of a mentoring approach, which, when that's done, it makes staff feel more supported [...] more able to work through sometimes quite traumatic and complex crisis situations"* (Participant #15). I would argue that the professional's participation within this project supports Participant #15's claim, showing their passion and drive to improve the system.

Despite participants feeling passionate about change and clearly wanting to positively regard their colleagues, most participants quickly reverted to discussions about how limiting the system has become, and how it prevents them and their colleagues from completing quality work. Participants stated that despite the amazing colleagues they may have, the lack of managerial support meant that professionals felt very isolated and unsupported, even when risk presented. *"You are just sort of left alone to try your best, and while they do have processes in place in terms of risk, it seems like everyone is just so busy […] Everyone seems very guarded and defensive, which makes it challenging […] And even if you raise something, some of the outcomes are pretty much 'you need to sort it out'* (Participant #15). This lack of support was arguably outlined when briefly discussing staff burn out in theme one, however what is important to recognise here is the impact it has on individual staff members and their wellbeing. As established by Luther et al., (2017), staff burn out can directly cause organisational issues such as high staff turnover, frequent absenteeism and diminished job engagement and a lack of quality care for young people. However, it is also important to recognise the detrimental impact it can have on a professional's personal mental wellbeing.

Devilly et al., (2009) state that engaging in an empathetic relationship with another person, has direct impacts on the therapist, both consciously and subconsciously, and can lead to burn out and secondary trauma related constructs such as compassion fatigue and secondary traumatic stress disorder (Devilly et al., 2009). The burden of tending to a suffering person is one complete with stressors (Figley, 2002). Observing or comprehending another's trauma or emotional distress can cause professionals to experience secondary traumatic systems such as recurrent and intrusive recollections of the client's experience, intense psychological distress when exposed to reminders of a client's trauma, efforts to avoid recalling information, activities or places that arouse recollections of a client's trauma and errors in clinical judgement when treating a traumatic case, among others (Figley, 2002). While not all professionals working within the system experience secondary post-traumatic stress to this extent, they may still experience other burnout symptoms such as extreme fatigue, and a decrease in personal wellbeing or perhaps the increase or causation of a mental health illness (Drayton, 2021). Recognising that their efficiency as a professional is dependent on their own physical and mental health, it is vital when encouraging professionals to seek support (Steele, 2019).

Unfortunately, as we can see from the participants answers above, gaining support while working through challenging tasks such as helping a young person with trauma, is not something that is prioritised, with Participant #15 expressing that they felt like they had to just *"sort it out"* on their own. Discussions with participants and my own experience working in the mental health system, can also illuminate the lack of support that is provided when a staff member is experiencing burn out or secondary post-traumatic stress disorder. Within the mental health system, professionals have access to 3 free EAP (employee assistance programme) counselling sessions for work related concerns or traumatic experiences. Some mental health services across the country offer more than 3 sessions, however overall long-term counselling or support for work related concerns must be personally funded. This draws on the concept of therapeutic relationships that is discussed at length in theme five. Limited sessions impede the ability to develop essential therapeutic relationships and therefore 3 EAP sessions do not cover what some individuals will require. Therefore, once again, we can see a system focused on short cuts, and profit margins, that is not providing quality support to its clients, or its staff that need support.

The second experience that made participants feel unsupported or depleted was the culture of 'all talk and no action'. According to Participant #19, Te Whatu Ora is "*notorious for promising funding and then it doesn't pop through*", with many promises such as pay rises, increased staffing or more funding for care packages never coming to fruition. The notion of unfulfilled promises, or 'all talk and no action', within the mental health system is also reflected in other areas such as the lack of genuinely implemented Kaupapa Māori approaches or alternative therapeutic models. Participants discussed and praised a variety of alternative models such as Kaupapa Māori informed models or collaborative models of care (which are discussed in theme five and six), however, they stated that similarly to the funding and staffing promises, they were talked about and then never implemented.

When referring to the implementation of Kaupapa Māori informed models and other alternative models of care, Participant #15 stated that "*It's talked about and kind of placed as like an ideal […] they're wanting to implement it, but it just isn't getting implemented […] There's a disconnect from upper management and the different levels of management, whether it's from the director to the team leader, teams are quite large so there's that disconnect, where people were just trying to survive with what they're doing*".

Participant #23 stated that *"there's lots of great models that exist, but how they're actually implemented. There's not always specific techniques associated with the model [...] So, I think it's all very well, it's great to have these models, but in terms of how they actually get implemented. There's a lack of professional development training as to how to implement the models"*.

Once again, this outlines how the neoliberal model of operation is focussed on quick fixes, profit margins and one-size-fits all approaches. While long term strategies or alternative models may be beneficial, they require time and effort outside of the standardised model. Participant #15's statement about professionals just trying to '*stay afloat'*, touches on the notion of a system reliant on the crisis management model and standardised biomedical approaches. Simply put, there is not enough time or space within the limitations of the system to explore alternative models, creating an internal conflict within professionals. These models are discussed, proven to be beneficial, presented as an "ideal" (Participant #15), and therefore professionals aim to use them. However, despite the advantages, they are not practical within the neoliberal system and therefore do not get implemented.

This example of 'all talk and no action', or the conflict between beneficial models and their lack of implementation, is not a problem unique to the Aotearoa New Zealand Mental Health system. It is arguably an issue across all health systems, globally. As outlined by Greaves & Bialystok (2011) governmental departments work in fragmented silos, with individual practices, goals, and budgets, working individually rather than collaboratively. Therefore, coming together to determine changes to standardised practices can be challenging. Greaves & Bialystok (2011) elaborate on this further, discussing yet another issue that was discussed in theme one, stating that general governmental and bureaucratic processes, make significant changes overwhelming and therefore often lengthy. This mirrors another statement made by Participant #19 who expressed that Te Whatu Ora is currently making changes to try remove unnecessary bureaucracy and the mismanagement of funding, however the process is so large and overwhelming that it is taking a significant amount of time. So even when some of the ‘talking’ turns into ‘actioning’ it is still an extremely lengthy process – *“because it’s long, big organization, it’s a slow, it’s a slow bureaucracy, we’re still quite slow to change”* (Participant #19). This not only has had impacts on the young people the system serves, it further contributes to the mental strain professionals experience working in a system of “all talk rather than action”.

In this theme we have seen how participants hold their colleagues in a high regard, respecting them as individuals and the work that they do, despite working within a system that is struggling to support its staff and meet the needs of young people. We have also seen participants demonstrate a passion for improving the system. However, it was clearly identified that despite the passion for change and respect for colleagues they may possess, professionals are negatively impacted by institutional challenges that contribute to fatigue and staff burn out. Professionals were also additionally impacted by the frustration of ‘all talk and no action’ and the slowness of organisational change.

4.5 Theme Four: How Professionals Perceive Young Peoples Experience in the Mental Health System

Theme four takes a more in-depth look into participants’ recounting of the experiences young people have while engaging with mental health services and the impacts on their mental wellbeing. When speaking about young people, participants emphasised how the system can diminish a young person’s already fragile self-worth and hope for the future. While discussing a young person’s negative reaction to meeting another mental health professional Participant #19 stated that *“Sometimes it just takes one person that you don’t like to put you off [...] given the fragility of opening up in the first place [...] if it’s somebody you don’t like then you’re not going to ask for help”.* It is important to recognise that not everybody will connect with the first therapist they meet, as outlined by Participant #23 *"you don't connect with every kid. But you give it a go. And if I can't, then I can hand them over to another counsellor".* That is simply the nature of human connections and while finding the right person may take some time, to ensure you get the most out of your therapy (Haupt, 2023), this process is vital. However, Participant #19's statement about the fragility of the young person is extremely significant.

Young people are in an existing state of fragility when they enter the mental health system, due to the mental health challenges that they are presenting with or the trauma they have experienced. Ensuring that young people receive care in a timely manner, in an environment and with a person that makes them feel safe, increases the chances of a young person having a positive experience within the system and subsequently feeling cared for (Edwards et al., 2023). Participants felt that young people who didn't experience quality care when they are in a fragile state, were at a high risk of feeling "*like they haven't been prioritized*" (Participant #11), like "*no one gives a dam about me. I'm just another number*" (Participant #76) or like they have to hurt themselves more to be taken seriously *"not being accepted into ICAMHS [...] having that person vent to me [...] do I have to be doing more to get to that stage [...] Should I just hurt myself even more*" (Participant #19). Analysing these experiences and investigating the impacts this has on a young person's mental wellbeing provides a deeper layer of understanding to the organisational challenges presented in theme two.

Reinforcing the statements made by participants in theme two, Brown et al., (2002) outlines the many costs associated with long waiting lists, including, the prolongation of extreme emotional distress, increased risk of danger to others and oneself, increased physical health risks, risk of further dangerous behaviours and subsequent incarceration, and an exacerbation of existing mental health conditions. The experiences of young people suffering the cost of a long waiting list, as told through participants, is one of hopelessness. The young people that are seeking support, have likely already experienced a form of trauma that impacts their ability to form attachments and maintain self-worth (Hong et al., 2012), or they are experiencing a mental health condition, such as depression, that directly impacts an individual's ability to maintain self-worth (Burwell & Shirk, 2006). Therefore, drawing on statements made in theme two regarding a young person's experiences engaged in the system as capital (Spark, 2016), we can see how this hierarchical process can reinforce their existing mental health condition or traumatic experience.

Prolonged wait times can also cause many young people or families to disengage completely, seeking support elsewhere, deciding they no longer need treatment, or feeling so dissatisfied with the quality of care that they choose not to return (Anderson et al., 1987; Westin et al., 2014). Experience with extended wait lists can decrease motivation to engage, a young person's mental health may have deteriorated further, or their engagement in risky behaviours may have increased and therefore their need for more extensive treatments (Brown et al., 2002; Westin et al., 2014) may be higher. This combination of elements is often referred to as a missed opportunity for effective treatment or intervention (Brown et al., 2002). Research indicated that the waiting lists which cause these experiences can range anywhere from 1 week to 6 months (Brown et al., 2002; Westin et al., 2014).

Drawing on the experiences of young people and their families here in New Zealand, as told by participants, we can see that the waitlists they experience are significantly longer than those outlined in the research above, with young people waiting between 1 to 2 years to be seen (Participant #11 and Participant #17). This indicates that the negative experiences associated with these wait times is likely to occur within the New Zealand System. Participants' statements about young people's experiences with wait times support this claim. Participant #53 stated that *"if the waiting list is six months long, then goodness knows what state the family is in six months down the track, the amount of family complexities [...] also a big stumbling block".* Participant #17 elaborates on statements made by the literature, *"Like, I'm not kidding* *our waitlist…over two years. [...] bringing people in here that are either worse, or we can't get hold of them, and they've actually gone out to the community or gone privately".*

Drawing on statements made within theme two, regarding quick discharges, limited sessions, staffing shortages and being 'bounced around the system' we can infer that when a young person finally enters the mental health system there is then no guarantee that they will gain long term care within the system or develop a therapeutic relationship. Participant #86 commented on this unfortunate reality stating that sometimes the system and by association professionals "do more harm than good". This is due to the feelings of distrust and abandonment that young people may feel after sharing their story to someone and then being discharged without developing a therapeutic relationship. Participant #86 commented on this stating, *"now, you don't care about me anymore. So you never did really care about me. It can be quite damaging when somebody has to finish when they're not ready to. I think potentially, it can leave them feeling like… well overall counselling no good"*. Participant #86 elaborated further on this claim stating that young people with a trauma background are more likely to feel further traumatised by the limited amount of sessions – *"Well, I think the difference between those who can manage three appointments and those who can't, is their level of self-development that they have already [...] But people who are really traumatized and they're just on the beginning of wanting to tell somebody their story, ya know it's really tough".*

The rising rates of mental health problems within New Zealand and the amount of young people who are experiencing serious mental health challenges, often linked to trauma, is significant, as outlined in the literature review. Participants explained that many of the young people entering the mental health system are *"really traumatised"* (Participant #86) and are often living without *"support, love and kindness"* (Participant #86). Therefore the organisational challenges that prevent young people from developing long term, therapeutic relationships with professionals, have the potential to negatively impact a young person perception of mental health services

(Brown et al., 2002), hindering their chances or seeking support in the future, and negatively impact their feelings of trust or self-worth, which are already fragile due to the experiences that prompted the mental health referral initially (Burwell & Shirk, 2006; Hong et al., 2012).

It is important to note here that participants also briefly discussed the impact that organisational challenges can have on families, as explained through Participant #53's statement about family circumstances changing while a young person is on the waiting list. Other familial factors such as transport issues, time off work to support young people to appointments, socioeconomic factors, and mental health complexities within the family, are all other factors that may also impact a young person's experience within the mental health system. Incorporating family within the therapeutic process and considering the elements that may prevent a family from supporting their young person, draws on understandings of holism, wrap around care and arguably Kaupapa Māori approaches as outlined in theme five. Therefore, it is an important element to discuss and consider when investigating a young person's experience within the system. However as outlined by Participant #17 sometimes families, especially parents are *"99.9% of the problem"*, causing the issues prompting mental health referrals or preventing the therapeutic process. The complex relationship between a young person's mental health and their family is a research project within itself. The parameters of this research project are focussed on the relationship between the system and the young person. However, when we are considering the impact that organisational challenges have on preventing quality care for young people, it is important to recognise that family play an important role in that.

Throughout excerpts of transcript that are presented in this theme we can observe the frustration and despair that young people can experience when interacting with the mental health system, as retold by participants. It was identified that young people are in an existing state of fragility when they enter the system, often due to trauma and mental health conditions. Utilising the perspectives of participants and the researcher's analysis we can interpret that this fragile state may be exacerbated by extensive waiting lists, a lack of therapeutic relationships or patient centred, tailored care plans, causing young people to feel unprioritized and further distressed.

4.6 Theme Five: Relational Thinking. Relational Models and Practices, An Alternative to the Current System

Earlier themes illustrated that Aotearoa New Zealand's mental health system is operating on a neoliberal model, which has deep roots in individualism. This may contribute to organisational issues such as incorrectly allocated funding and staffing shortages, subsequently creating a system reliant on crisis management, the biomedical model and individualised rather than collaborative care. This neoliberal model, and its connections to individualism, may also prevent the implementation of alternative approaches to mental health care, that sit outside the standardised biomedical approach such as Kaupapa Māori informed practices, creative therapies, collaborative, continuous or holistic care. However, each participant I spoke to highlighted the importance of these alternative methods and when employing 'blue sky thinking' and designing a model that they felt would truly care for young people in need, they drew on these alternative approaches, all arguably grounded in relational rather than individualistic thinking. In this section, I will explore each of these alternative approaches, investigating their connection to relational thinking.

When conducting thematic analysis on the transcripts one absolute contrast was apparent. The current model of operation draws on individualism, and all the approaches participants presented when discussing how the mental health system could, or should move forward, drew on relational thinking or collectivism. Collectivism, as defined by Triandis (1995), is a social pattern of closely interlinked individuals who see themselves as part of a collective, a community. These individuals are driven by the needs, goals and norms of the collective group rather than their own personal goals or needs (Triandis, 1995). Throughout this thesis, as outlined in the headings, I have compared individualism to relational thinking rather than collectivism. I intentionally used the term relational thinking as it draws attention to relational practices such as therapeutic and collaborative relationships, which participants presented as beneficial. However arguably, within the context of this research project the terms are used synonymously and synchronously.

Drawing on feminist ethics of care, was a significant element of this research project, deepening my understandings of relational thinking and connecting it to society's varying perceptions of the "self" and the importance of relationships. An explanation of feminist ethics of care, and how they relate to this research, can be found in the literature review. I argue that analysing the work of Virginia Held (2006), alongside various other works on feminist ethics of care (Johansson & Edwards, 2021; Johansson & Wickstrom, 2022; Lawrence & Maitlis, 2012; Machold et al., 2008; Nicholson & Kurucz, 2017; Phillips & Willatt, 2019; Pullen & Vachhani, 2021; Raghuram, 2019), provides a foundational understanding from which we can interpret the participants' alternative approaches and the significance these approaches place on relationships and viewing the self as part of a collective rather than a favouring self-sufficiency as advocated by individualism and subsequently neoliberalism (Barnett & Bagshaw, 2020; Brown et al., 2022; Dawson et al., 2020; Gane, 2014; McGregor, 2008; Podsiadlowski & Fox, 2011; Sparke, 2016).

4.6.1 Feminist Ethics of Care, a Sociological Inspired Way of Looking at Relational Thinking and Collectivism

As explained in the literature review one of the key elements outlined in the feminist ethics of care, was relational thinking and ways of being, stating that human beings are intrinsically driven to create and maintain caring relationships with one another (Larence & Maitlis, 2012; Phillips & Willatt, 2019), operating within community, rather than operating alone (Johansson & Wickstrom, 2022). This intrinsic drive within humans to connect and commune draws on the concept of solidarity, a "macro-level expression of collective caring" (Lynch & Kalaitzake, 2020). Lawrence & Maitlis (2012) outline how feminist ethics of care, and therefore concepts of collective caring, can be adopted by professionals. They state that people are innately relational, however just as a mother learns how to care for her child, so do organisations and professionals, learning how to become participatory individuals within caring relationships. Lawrence & Maitlis (2012) elaborate on this further discussing "compassion spirals", whereby individuals who receive compassion are more likely to enact caring behaviours towards others (pp. 655). For example, professionals who work within a supportive organisation are more likely to have capacity for caring relationships with their clients. The perspectives within feminist ethics of care, collective caring, or relational ways of being in general, both practically and in principle, are antithetical to individualism and neoliberalism, and therefore we can see why the system outlined in theme one and two, doesn't incorporate relational ways of thinking. However, all the participants I spoke to, despite working within a system that doesn't incorporate these ideologies, were extremely motivated to incorporate relational models and practices, an approach that is elevated through our understandings of feminist ethics of care, as a way of better serving the young people seeking support.

4.6.2 The Benefits of a Therapeutic Relationship

The first relational practice that participants outlined as lacking in the current system, yet beneficial for young people needing support, was therapeutic relationships. While we must never make the claim that there is one "right" way of treating an individual struggling with mental health (Duncan et al., 2022), to do so ignores cultural preferences and individual needs. We can make confident claims about therapeutic practices that have produced a high quantity of positive outcomes. A therapeutic relationship or alliance (the terms are used interchangeably) is one of, if not the strongest predictor of good treatment outcomes, no matter what intervention or modality a professional is utilising (Duncan et al., 2022; Hartley et al., 2022). A therapeutic relationship can be defined as "the feelings and attitudes that a therapist and client have toward one another, and the manner in which these are expressed" (Norcross & Lambert, 2011, p.5). These feelings and attitudes, often expressed first by the professional as a method of rapport and trust establishment, may include empathy, congruence, positive regard, honesty, warmth, attentiveness, and collaboration, among others (McCabe & Priebe, 2004; Noyce & Simpson, 2018), all arguably characteristics outlined within the feminist ethics of care. A therapeutic relationship is the 'key' ingredient to creating trusting relationships where clients, specifically child and adolescent clients, feel safe enough to openly communicate, be themselves, participant in therapeutic interventions and be emotionally vulnerable (Hartley et al., 2022; Horwitz, 1974, as cited in Noyce & Simpson, 2018; Matos & Dimaggio, 2023).

The participants I spoke to made similar claims to those outlined in the literature above. Participant #17 stated that a therapeutic relationship is the most important aspect of the work they complete – *"you need to build that relationship; you need to gain their trust. And quiet often, by the time they get to you here [mental health service], they've lost trust. And you know we've got kids coming into ED, having attempted suicide and stuff like that, they are coming from a really low place. And so, you've got a really short period of time to let them know that you're actually on their side. That's the single most important thing, building that relationship. Without it, you don't have a client".* Participant #76 stated that *"it's so important, especially with this age group, if you can get them to open up and trust you, you can make a world of difference".*

All eight of the participants who discussed therapeutic relationships identified elements of the system such as the limited number of sessions, the lack of collaboration between staff and the high turnover of staff (Participant #15, #35, #86, #53, #11, #23, #76, #17), as factors that prevent the development of in-depth relationships (as also outlined in theme one, two and four). Two additional key elements that participants touched upon were the expectation that young people should provide an intense reveal of personal information to a stranger, and how lacking therapeutic relationships impact a young person's fragile attachment style. These two elements will be briefly analysed below, showcasing the importance of increasing therapeutic relationships and relational ideologies within the mental health system moving forward.

Participant #35 stated that young people *"don't get any of the support they actually need, because they're not building relationships, they're not going to open up to somebody they see once or twice"*. Participant #15 elaborates on this stating that, *"they have to keep sharing the same information over and over again [...] They come to services [...] And then they are referred somewhere else. And then they have to re-share what they've told that person"*. This touches on the "fragility of the young person" that Participant #19 spoke about, explaining that when a young person is swapped around constantly and is not supported through the process, their ability to trust can be impeded. When discussing the limited number of sessions available within the public system and the impact this has on a therapeutic relationship, Participant #53 stated that *"for me, six sessions [...] you're not even beginning to really get to where you could get to in terms of a therapeutic relationship [...] Some of my clients, they're revealing their deepest stuff [...] only after they have known me for a couple of years, only then do they tell me that [person] used to lock me in [location] and leave me there overnight. Yeah, say that in the first few sessions to someone new […] the organisations they're getting all, you know, time scrunchie and becoming more robotic, and that's the opposite of what the kids actually want…. usually their greatest need is to feel understood, loved"*.

This part of the interview was told with such emotion that as a researcher I could feel the frustration and hurt that this professional felt on behalf of the young person they were discussing. Multiple other participants shared similar stories, where young people felt they could not share their information to mental health professionals, who were essentially strangers, within the limited amount of sessions they were provided within the mental health system. This draws heavily on some of the characteristics of caring as described within feminist ethics of care, such as love, empathy, nurture, and concern (Held, 2006; Johansson & Wickstrom, 2022; Machold et al., 2008; Nicholson & Kurucz, 2017; Phillips & Willatt, 2019). While these terms do not fit into a clinical diagnostic model, which is the preferred approach within the biomedicine and therefore the mental health system (Brown et al., 2023), participants clearly state that they are essential aspects of relationship building and subsequently required to support a young person through trauma and mental health challenges.

I asked participants what skills they needed to employ to develop therapeutic relationships and they said, *"a lot of kind of soft skills, so just conveying genuine empathy, warmth, really following their lead, giving them options…. It's really hard to describe but a lot of its just kind of authenticity and trying to connect"* (Participant #23). Once again, these traits and skills, particularly those, or those with synonymous meanings to warm, gentle and nurturing, are characteristics often associated with motherhood and various expressions of femininity (Di Battista, 2023; Donnelly & Twenge, 2017). This is not to exclude men from the conversation or claim that men cannot possess these characteristics. This research project, and its male participants prove otherwise. However, through elevating the lived experiences of those who express traits traditionally characterised as feminine, we can observe how, when applied to mental health specialisms, they can enable the development of therapeutic relationships, enhancing the care that young people in New Zealand receive.

A few participants also touched on a young person's attachment style and how a therapeutic relationship, or lack thereof, can reinforce issues from childhood. When discussing the limited number of sessions, a young person has access to, and therefore the diminished ability to develop a therapeutic relationship, Participant #86 stated that *"I think its potentially catastrophic. We can see that potentially the therapeutic relationship is mirroring the behaviour that happened in their attachment style with their primary parent.*

And it can feel like you've been abandoned all over again, it can make them feel like nobody cares about me […] you know, I've told you my whole life story, and now you don't care about me anymore […] that is unfortunately the nature of a low-cost system".

Attachment, developed within childhood is one of the earliest ways that we learn how to survive and connect with our primary caregiver. Originally outlined by John Bowlby and Mary Ainsworth, attachment theory describes how the strength of our relationships as infants and young children, directly influence our ability to interact with the world as older children and adults (Holmes & Farnfield, 2014; Mamis, 2020; O'Shaughnessy et al., 2023). Attachment patterns or styles have subsequently been developed and scholars within psychology and human development have produced significant research on how these styles impact a variety of adult relationships (Holmes & Farnfield, 2014; Mamis, 2020; O'Shaughnessy et al., 2023; Talia et al., 2019). Analysing how a therapeutic relationship, or the lack thereof, reinforces, or mirrors experience we had as infants, and the impact this has on the therapeutic process, is a separate research project within itself (Mamis, 2020; Talia et al., 2019). However, within the context of this research project, we can see how neoliberalism and its focus on a low-cost system, has directly influenced the number of sessions a young person has access to, and therefore has limited the potential for a quality therapeutic relationship. For individuals with insecure attachment styles this has the potential to be, as participant #86 stated, '*catastrophic*'. This is something to consider when presenting alternative relational approaches, that prioritise relationships, as this may prevent this 'catastrophic experience' from being sustained throughout the system.

Participants, and the supporting literature clearly stated how significant the therapeutic relationship is, despite its limited presence within the current system. Arguably, the feminist ethics of care and its statements about the relevance of caring relationships and carting traits such as love, nurture, and empathy, supports the implementation of therapeutic relationships. However therapeutic relationships are a practice based on relational ideologies and collectivism, subsequently in tension with neoliberalism and individualism. Therefore, we can understand why they are hard to implement in a system that is focussed on short term strategies and efficiency.

4.6.3 The Importance of Collaborative Care. A Brief Analysis

As defined in the literature review, collaborative care is multi-professional approach, that supports the patient holistically (Archer et al., 2012; Lake & Turner, 2017; Reist et al., 2022; Thota et al., 2012). Lake and Turner (2017) also outline that collaborative care, as a long-term strategy is efficient and cost-effective, after the initial upfront costs associated with the implementation of a new system. While I will predominantly be focussing on the therapeutic benefits of collaborative care within this section, it is important to make note of Lake and Turners (2017) claim here, due to the value neoliberalism places on efficiency and increased profit margins. Within theme two participants stated that collaborative care doesn't occur frequently due to the time and effort it requires, which professionals cannot prioritise when they have high caseloads within an under resourced system. Therefore, despite the potential long term economic benefits, we can see that the cost, time, and effort it would take to implement collaborative care as an enforced practice, is a hindrance, explaining participant's comments about the present lack of collaboration.

As outlined within theme two collaborative care is used effectively across a variety of health specialities, and is recognised as a valuable practice that encourages interprofessional harmony (Archer et al., 2012; Bower et al., 2006; Dermer & Schwartz, 2014; Gilbody et al., 2003; Huang & Barkil-Oteo, 2015; Huang et al., 2017; Huffman et al., 2014; Irwin et al., 2019; Mumba & Mugoya, 2022; Sharpe et al., 2014; Thota et al., 2012), enabling professionals to work for the good of their shared patient. Within theme two, a comprehensive analysis of collaborative care and the factors causing its minimal implementation within the system was presented. During the interviews participants did not specifically outline the benefits of collaborative care, instead participants often became visibly frustrated, primarily focussing on the negative implications associated with the lack of collaborative care. From these complaints, I suggest that increased collaborative care was something that participants wanted to see within the system. Furthermore, collaborative care was the key model or practice described within the 'blue skies thinking' and ideal mental health systems that participants designed, as outlined in theme six.

Collaborative care is a model of practice that is practically applied in various ways, across many specialisms. Within Aotearoa New Zealand's mental health system, participants suggested that collaborative care was a more holistic approach, especially in comparison to the current model of operation. Holism is the care and treatment of the 'whole' person, a model of care that western medicine has unfortunately lost (Margereson & Trenworth, 2009). Within the context of health care holism can be understood as an approach or ideology that embraces the whole person, and all aspects of their functioning, including "physical, psychological, emotional and social aspects of self and the personal meaning that is attached to their experiences of health and illness" (Margereson & Trenworth, 2009, p, 3).

Clinical understandings of collaborative care outline an approach that incorporates multiple health professionals, all responsible for differing aspects of a person's physical or mental wellbeing (Archer et al., 2012; Lake & Turner, 2017; Reist et al., 2022; Thomas & Hargett, 1999; Thota et al., 2012). However, outside the clinical sector understandings of collaborative care can also be expanded to include other individuals such as the family, the administrators, the therapists (Thomas & Hargett, 1999), the teachers, and the community among others (Garrett et al., 2019; Settipani et al., 2019), Therefore, drawing on understandings of holism, and how this approach caters to all elements of a individuals wellbeing (Margereson & Trenworth, 2009), we can understand collaborative care as a holistic approach. Healing a patient requires incorporating all aspects of a person's wellbeing, not just their physical or psychological health as cared for by clinical professionals (Thomas & Hargett, 1999).

Within the context of this research project, we can therefore understand collaborative care as a multidisciplinary team of professionals, family, and community members, working together to ensure the 'whole' young person, and all aspects of their wellbeing are taken care of.

Literature outlining models such as Youth One Stop Shops and other integrated, community led programmes, as outlined in theme six, discuss collaborative care and holistic care as interlinked concepts, and the innate properties of these models utilise a range of individuals, not just clinical health professionals. The Whanau Ora approach, and arguably other Kaupapa Māori informed health models, as outlined below, also discuss collaboration between professionals, family, and community as a relational method of holistically caring for young people (Levy & Waitoki, 2016; Macfarlane, 2016; Whānau Ora, 2023). The concept of holism or collaborative care is not new, communities, as outlined below, have been doing this for many years. The voices of Participants, specifically their frustrations expressed on behalf of young people who get passed from service to service, reiterate claims made in the literature, presenting collaborative care as a vital therapeutic practice. However, as established in earlier themes, this is not a dominant application within the current mental health system, as it contradicts the individualistic, standardised, one-size-fits all treatment practices that are dominant in the neoliberal model of operation.

4.6.4 The Benefits of Kaupapa Māori Informed Practices and Models

Another relational model that participants presented as a beneficial alternative to the current system, was an increase in Kaupapa Māori informed models and practices. As outlined in theme one, there are relatively few Kaupapa Māori informed mental health services and this should be remedied in accordance with The Treaty of Waitangi/Te Tiriti o Waitangi (Beutow & Coster, 2001; Te Ara, 2016), The New Zealand Public Health and Disability Act 2000 (New Zealand Legislation, 2022), and the United Nations Declaration on the Rights of Indigenous Peoples (United Nations, 2007). However, an increase in Kaupapa Māori approaches also aligns with the collective and relational practices that participants presented as a suggested improvement strategy for the system moving forward.

According to Waitoki (2016) Mātauranga Māori is a "unique way of viewing the relational phenomena of the world, taking into account Māori methods of comprehending, observing, experiencing, studying and understanding ***everything***" (pp. 284). Durie (2012) encourages the realisation that Mātauranga Māori is not an ancient form of knowledge that is static, and in the past. Instead, it is a knowledge that is always changing and evolving, designed to guide people. Mātauranga Māori, as a framework of knowledge, can be applied to all traditional and contemporary aspects of society, including education, science, technology (Waitoki, 2016), and arguably the mental health system. A Mātauranga Māori approach to the mental health system is not a new idea or implementation, several Māori informed health models based in holistic understandings such as Te Whare Tapa Wha (Durie, 1985) or Te Wheke (Pere, 1997) are implemented across the health sector presently, informing professional training and development (Levy & Waitoki, 2016). These models of health, comparative to the standardised biomedical model, intrinsically rely on holistic understandings, incorporating physical health *(Taha Tinana),* mental health *(Taha Hinengaro),* spiritual health *(Taha Wairua),* the immediate and extended Whānau and other relational aspects *(Taha* Whānau */Hononga),* an individual's connection to their ancestral land *(Whenua)* and their pride, cultural identity, attitude, and self-potential *(Mana Motuhake)* (Levy & Waitoki, 2016; Macfarlane, 2016; Mental Health Foundation, 2023). However, as outlined by the participants in theme one, these models are often only discussed within training and then inadequately implemented into practice.

The study of these models in relation to decolonisation and Māori experiences within the mental health system is valuable work that is already being researched, arguably by Māori for Māori. As a Pākehā woman, especially without the regular guidance of a cultural supervisor, it is vital that I unequivocally state that the intention of this research project is not to replicate or provide additional research within this field. Instead, the purpose of this section is to draw on participants who stated that while Kaupapa Māori informed models, such as Te Whare Tapa Wha (Durie, 1985) or Te Wheke (Pere, 1997) are discussed as an "ideal", they are not adequately implemented in a genuine way. These models, draw on ideologies that vary significantly from the standardised biomedical model which may ignore elements of wellbeing due to its reliance on the diagnostic approach.

Participant #35 outlined the importance of incorporating a holistic wrap around approach, such as the Kaupapa Māori informed model stating, *"you've got to take a holistic approach [...] you can't just look at one aspect, especially with youth. [...] Because it's always inter- linked".* Other participants echoed this statement referring the holistic, Kaupapa Māori informed models as an *"obvious"* approach (#11), allowing for *"care continuity and significant relationship building"* (#53), both elements missing within the current system. Participant #53 stated that a mental health system that truly incorporated *"Kaupapa Māori would be the opposite of the chop, change, take you here there and everywhere. That's the antithesis of Te Ao Māori",* highlighting the lack of collaborative care in the current system and how this might be mitigated with the introduction of Kaupapa Māori informed practices. Participant #53 then stated that a system truly incorporating Te Ao Māori would *"utilise the community to surround that person, rather than take the person to a whole lot of different places". Participant #53* elaborated, stating that this approach mirrored many of the principles discussed earlier in the interview in relation to collaborative, holistic care. The comments made by these participants, and supporting literature, suggest that a system based on Kaupapa Māori informed practices, would be intrinsically collaborative, would cater to all elements of wellbeing holistically (Levy & Waitoki, 2016; Macfarlane, 2016; Mental Health Foundation, 2023), and would utilise the community to provide care

(Whānau Ora, 2023), rather than expecting a young person to travel to various clinical settings. This paints a picture that contradicts the individualistic nature of the current system. A system that prioritises standardised treatment often focussing on one element of wellbeing such as diagnosis and encouraging the 'chop and change' between services and locations.

A model that incorporates the Kaupapa Māori informed practices outlined above, is the Whānau Ora framework, as defined and explained in the literature review. This approach benefits Māori due to its ability to closely reflect the nature of the treaty partnership (Taskforce on Whānau-centred Interventions, 2010); its ability to consider and elevate the Māori culture, focussing on continuous, holistic, Whānau oriented cultural practices, avoiding the "patch and dispatch" quick fix, quick discharge culture (Moyle, 2014); and it considers the symbiotic relationship between Whānau and the individual, creating strategies that maximise positive outcomes for the Whānau as a whole (McLachlan et al., 2014). However, this approach also positively impacts non-Māori (Taskforce on Whānau-centred Interventions, 2010). Drawing on the importance of caring relationships through the feminist ethics of care and the analysis of collaborative care and holism, we can see that relational approaches have benefits for individuals, irrelevant of culture or ethnicity. This wrap around, holistic approach outlined through the Whānau Ora framework or Māori informed health models such as Te Whare Tapa Wha (Durie, 1985) or Te Wheke (Pere, 1997), incorporates and celebrates the importance of relationships and collaboration. As outlined by Participant #53 earlier in this section of the chapter, ideologies and practices outlined within Mātauranga Māori approaches to mental health, reflect many of the ideologies and practices discussed in non-Māori literature on collaborative care and therapeutic relationships. Therefore, the genuine and widespread incorporation of these practices within the mental health system, would have a twofold impact. The incorporation of these practices would benefit Māori and therefore upholds The Treaty of Waitangi/Te Tiriti o Waitangi and may address the concerning statistics of youth Māori mental health concerns across the country (Ministry of Health, 2022). Whilst also benefiting other cultures across New Zealand through the incorporation of more collective, relational approaches, as an alternative to the individualistic nature of the neoliberal model of operation.

A Kaupapa Māori approach to mental health, such as the Whānau Ora framework, aims to provide quality rather than quantity, focussing on the results of the intervention, rather than simply recording the inputs and outputs (Taskforce on Whānau-centred Interventions, 2010). This is a direct contrast to the quick fix culture discussed in theme one. It also values collectivism, Whānau, and being interdependent with one another, rather than self-sufficient as encouraged by the neoliberal model of operation (Podsiadlowski & Fox, 2011; Poirier et al., 2022). It also views the individual as a whole, focusing on holistic, mana enhancing therapeutic practices (Levy & Waitoki, 2016), rather than a deficit focussed diagnostic model (Boggs, 2014; Martin et al., 2000; Nelson, 2019; Thachuk, 2011). Overall, we can claim that the Whānau Ora approach, and the Kaupapa Māori informed health models outlined above, draw on relational approaches, contrast to neoliberalism and individualism. While the literature and participants have highlighted the benefits of this model, both for Māori and non-Māori, we can see a lack of widespread implementation across the mental health sector, arguably due to the contradictions between individualistic and collective approaches.

4.6.5 Other Alternative Approaches to Mental Health: Sociological Understandings and Alternative Therapeutic Approaches

Elaborating on Levy and Waitoki's (2016) statement about deficiency focussed models of care, I briefly draw the reader's attention back to the literature review where research completed by critical disability studies scholars was analysed, specifically understandings of labels, diagnoses, and society's role in constructing norms and the subsequent deficiencies or deviancies from these norms (Brady &

Franklin, 2023; Garland-Thompson, 1997; Mac Carthaigh, 2020; McLaughlin et al., 2016). This analysis provides an alternative approach to the deficit focused biomedical model and supports claims made specifically by Participant #11, alongside Participant #17.

As outlined within theme two, the current focus of the mental health system is the biomedical model, centring on diagnosis. Participants perspectives on the relevance of the biomedical model varied. Many participants expressed concerns about the model, due to its inability to provide flexible, tailored care plans for young people who may require a therapeutic approach outside of the biomedical mode. However, some also outlined that it beneficial in some circumstances – "*if it's high needs, nothing wrong with that, you know, mental health is an extreme from the medical to the philosophical […] there needs to be something for everyone*" (Participant #23). However, other participants decidedly claimed that it served no purpose within the system, "*in my opinion, the diagnostic model isn't the best way to practice, chuck that away*" (Participant #11).

Applying the understandings that disability scholars and Foucault's concept of the medical gaze contribute to this section of analysis, highlights the potential harms associated with the systems reliance on the biomedical model. This reinforces participant's suggestions for alternative approaches that celebrate individual differences rather than placing them on a socially constructed hierarchy. Adopting an alternative perspective may elevate some of the stigmatisation that is placed on 'othered', 'disabled' or 'mentally unwell' children/youth. As outlined by Participant #23 the biomedical perspective and subsequent diagnoses have been beneficial for some young people, enhancing their lives and providing them with opportunities previously denied. For others however, it has been an experience of stigmatisation and exclusion (Brady & Franklin, 2023). The key message here is that a flexible approach, that considers the individual young person and their needs, is vital. Unfortunately, as outlined above, the current mental health system, operating on neoliberalism, is focussed on standardisation and efficiency, and therefore the flexibility to choose between the diagnostic model or an alternative model is limited, if not completely unobtainable. These statements, particularly Participant 11's claim about removing the diagnostic model from the system entirely, raise questions about what alternative approaches would be used instead. Kaupapa Māori approaches, understandings of holism and insights shared by disability scholars all present beneficial options. Participant #11's suggestion, the transdiagnostic model, is outlined below.

Participant #11 presented the transdiagnostic model as an alternative to the DSM-5 as it allows "clinicians to choose from available psychological theories and empirically supported treatments when attempting to understand patient's problems and individualising treatment to solve them" (Frank et al., 2014, p. 3). Participant #11 outlined how this may look in practice stating *"If we worked on a transdiagnostic model, I believe care would be so much easier to provide, you wouldn't have to put people in boxes, you can identify the vulnerability mechanisms that they have…And then with the transdiagnostic model, there's response mechanisms. [...] And then from that, the model then shows different treatment plans".* The alternative model presents an approach that values tailored and individualised care plans, based on the needs of the young person, not based on a predetermined care plan associated with a diagnosis. This allows for a level of flexibility, something that has been alluded to throughout this chapter, as a missing element of the current system that is focussed on standardisation and efficiency. However, it is important to recognise that this model is still relatively diagnostic, relying on clinical modalities. It doesn't incorporate Kaupapa Māori approaches as it is still a westernised approach, utilising traditional psychological therapies such as ACT (Acceptance and commitment theory), CBT (cognitive behavioural therapy) and DBT (Dialectical Behaviour therapy), among others (Frank et al., 2014).

Overall, what I inferred from Participant #11's statement about "*chucking out the diagnostic model*" and the subsequent analysis into alternative approaches such as the transdiagnostic model and the understandings that disability scholars can bring to the mental health space, was that, despite the current system's attempt to utilise efficient, standardised practices, there is no one-size-fits all approach. As Duncan et al., (2022), stated, there is no one 'right' therapy for everyone and to believe so shows a misunderstanding of the complex nature of mental illness and disregards individual and cultural differences. Participant #11's opinion regarding the diagnostic model holds merit, and the insights that the disability scholars provide concerning social norms and stigmatising labels, supports Participant #11's claim. However, Participant #23 stated that the diagnostic, biomedical model also holds merit within the right circumstances, stating that mental health is a spectrum from the medical to the philosophical, and that *"there needs to be something for everyone".*

Participants within this research project were somewhat divided on the modalities or practices, they believed were best. For example, not all participants placed value on Kaupapa Māori Informed practices. One participant chose not to answer questions about Kaupapa Maori informed practices all together, and others explained that there was a lack of Kaupapa Māori informed practices within the system, yet they provided no elucidation as to their importance moving forward. It is important to note that the discrepancies between participant answers was very minimal with all participants sharing similar opinions across almost all areas of questioning. What was clear, was the emphasis placed on relational practices. All the alternative practices or models that were presented in this section of the chapter drew on relational thinking. That includes collaborative care, therapeutic relationships, increased Kaupapa Māori approaches or the transdiagnostic model, alongside sociological perspectives, such as feminist ethics of care and the insights of the disability sector, that I drew connections to. The dominance of relational thinking, that was presented by participants throughout all alternative suggestions and 'blue skies thinking' outlined in theme six, presents a direct contrast to the individualistic nature of the current model. Therefore, despite the participants differing opinions on the modalities they believed were best for the system, one thing was clear and agreed upon by all participants. The current system and its reliance on individualistic, neoliberally informed practices, are problematic, and moving forward the implementation of relational practices that can be tailored to meet the holistic needs of the young person, would be highly beneficial.

4.7 Theme Six: Relational Thinking. Participant Proposals, Designing a New System.

At the end of each interview participants were asked to describe what the mental health system would look like in an ideal world. They were encouraged to utilise 'blue skies thinking', implementing their preferred therapeutic practices and making suggestions regarding the organisational structure. All participants described their ideal system as an organisation that would address the staffing and funding concerns outlined in theme one and two and would implement the alternative relational practices outlined in theme five. Most participants then described specific structural models or approaches that they would like the system to implement, with the hope that they would transform the systems current limitations. Most of these structural models were elaborations of elements that have been discussed within theme five, and some of the others are outlined below. Two participants were more creative when answering this question, designing an entirely new structural approach to the mental health system.

When describing the ideal system, all participants drew on similar approaches, themes, and strategies. Some described it in more detail, some were briefer, and there were elements of difference, however overall, all 11 participants described a more collaborative, wrap-around, holistic, community focussed system. Participant #15 and Participant #11 had both spent time prior to the interview, designing a new system. These new designs, and the time these specific participants dedicated to their creation prior to the interview, was unprovoked, and not something I had suggested as a researcher. I have named these new approaches the "Umbrella approach" and the "Micro teams approach", entitled as such after the descriptive terms used by each participant. Both approaches draw heavily on collaboration between individual professionals and amongst services.

4.7.1 The Umbrella Approach and Youth One Stop Shops

Directly contrasting the current system which operates as a collection of Non-Governmental Organisations and Charities, alongside the public health system, which itself is divided into different specialist teams. Participant #11 described a system where every service operates under the same 'umbrella', the same overarching structural organisation. Participant #11 began by stating that "*obviously, it would definitely have a holistic view […] one umbrella, and one model of care [....] everyone has the same values, [...] They have the same processes [...] Everyone in this umbrella then goes through compulsory education… on the term collaboration, or collaborative care, and what that actually looks like. So, everyone then is on the same page, the same model of care. Then that would include effective communication, shared decision making between all levels, there's no hierarchy like yes, there is the people that run it. But like in terms of like an AOD service, a mental health service, psychiatry services, psychological services, occupational services, they all run under the same umbrella [...] when it comes to the needs of the clients, they have those shared decision-making meetings. There's mutual respect, there's mutual trust…A model of care or like a system, like the youth one stop shops, that everyone's under one roof. So, everyone practices by the same model of care*".

Participant #11 elaborates on the practical elements of their newly designed system stating that the model of care would be reviewed every 3 or 5 years to ensure that it is informed by up-to-date best practice models of care. Bureaucracy and multiple layers of management, as seen in the current system, would be eliminated and instead Participant #11 suggested that managers of each mental health specialism meet regularly and form a board of directors. This suggestion addresses some of the comments made by participants within theme one who stated that often the funding is incorrectly allocated when decision makers are not informed about or considerate of the needs identified by those working on the front line. The reduction of middle management and bureaucracy also addresses concerns expressed by participants within theme one who identified that funding often is allocated to paying the wages of these managers and therefore doesn't increase FTE or care packages for young people.

Participant #11 then discussed how this newly designed model of care would address current issues with interagency or interprofessional collaboration stating that within this umbrella system *"those relationships would be tighter, and you guys are under the same umbrella, you have the same values [...] when you make those referrals, you're like, oh, hey, how's it going over there, and not having to build on those external relationships at the same time as referring my client".* Participant #11 stated that this system would be extremely large, incorporating all mental health services under one umbrella, or even one roof, and that has its impracticalities. They also acknowledged that interprofessional care would still have its challenges due to the size of the organisation. However, they believed that these issues would be mitigated through the implementation of collaborative care training, companywide core values and aligned goals, rather than separate organisations operating upon varying agendas and policies.

Participant #11's design is not fully formed, and it is not without space for critique. However, it reflects the concerns and subsequent suggestions of many participants. Participant #11's design identifies key challenges associated with the lack of collaborative care, specifically in relation to young people being referred between services and the communication between professionals. In response, Participant #11 designs an organisational structure that removes elements of bureaucracy, elevates the voices of professionals who work on the front line, and is intrinsically holistic and collaborative. I am not presenting this model as the solution to the challenges identified earlier in this chapter. I am presenting this model as an example of participant initiative and advocacy, designing a new system, based on the identified needs of young people, which when unpacked, makes claims that are supported by other participants and external literature.

Participant #11's claims about the importance of collaborative care have been addressed in theme five. However, their reference to Youth One Stop Shops, presents collaborative care within a more applicable rather than a uniquely theoretical light. A Youth One Stop Shop, often referred to as YOSS (also known as ICYSHs, Integrated Community Based Youth Service Hubs), "is a youth focussed community-based centre providing a range of primary healthcare and social/development services at little or no direct cost for 10- to 25-year-olds" (Ministry of Health, 2009, as cited in Garrett et al., 2019). A Youth One Stop Shop adopts a holistic, multidisciplinary, collaborative approach, providing a variety of supports that young people may need such as education, mental health, physical health, addiction concerns, sexual health and family planning, employment services, social services and culturally specific services targeted at Māori, Pacific, migrant or refugee youth (Garrett et al., 2019; Hetrick et al., 2017; Settipani et al., 2019). Each of these services occur at a youth friendly, accessible location, with professionals coordinating regularly to lift professional standards, providing truly wrap around care, enabling the positive health development of young people (Garrett et al., 2019). Evidence suggests that youth benefit from this collaborative, multidisciplinary care that caters to all elements of their wellbeing (Garrett et al., 2019; Hickie et al., 2019; Hetrick et al., 2017; Lake & Turner, 2017; Settipani et al., 2019), and that they prefer to have all their needs met in one physical location (Hetrick et al., 2017).

Within New Zealand, there are a variety of Youth One Stop Shops, all acting independently from one another, usually community grown and operated (Settipani et al., 2019). Youth One Stop Shops are few in quantity and are sparsely located across the country, with many major cities lacking the implementation of the model (Healthify He Puna Waiora, 2022; Ministry of Health, 2009). The sparsity of Youth One Stop Shops, despite their clear therapeutic benefits, in alignment with holism and collaborative care, is arguably due to funding restraints and government support (Garrett et al., 2019; Lee & Murphy, 2013). A government document of note is the 'Under one Umbrella. Integrated Mental Health, Alcohol and Other Drug Use Care for Young People in New Zealand' commissioned by the Aotearoa New Zealand government to address some of the challenges in the mental health system (Cross-Party Mental Health and Addiction Wellbeing Group, 2023). This document was published after interviews with participants were completed, however it supports many of the claims made in this research, bereft the sociological perspective. This document is briefly outlined in the literature review.

Participant #11's "umbrella approach", reflects a lot of the principles that a Youth One Stop Shop embodies. Specifically, the incorporation of a variety of services, under one system, or even one roof (in the case of many One Stop Shops), all working together, implementing the same values through a holistic, multidisciplinary approach for the benefit of the young person. Other participants also stated that extensive implementation of Youth One Stop Shops, through their hypothetical incorporation into the reimagined public system, was something they would like to see. Participant #35 stated that they would like to see "*everybody working collaboratively together, getting other services so that you kind of get a hub of services all working together to support whanau and the youth*". Upon discussing Youth One Stop Shops and their hypothetical expansion Participant #76 stated that "*I think that would be amazing. Because one thing I've noticed in this line of work that holds you back from working collaboratively with other services, is privacy…. confidentiality, you* *cannot information share. So if there was a way that we could all come together, where you can freely share information to get them the services….And it would also help the young people because they wouldn't feel like they're getting bounced around from service to service, it would be under one umbrella and encompassed with everything. Yeah, just a collaborative way to support them".* One important note to make here is the privacy and confidentiality laws that are in place, specifically the Health Information Privacy Code 2020, and the parameters around sharing information (Privacy Commissioner, 2020).

Participant #23 elaborated on the concept of Youth One Stop Shops, and arguably Participant #11's 'umbrella approach' design, stating that the decentralisation of funding, directly contributes to what Participant #19 referred to in as '*fragmented silos*' (within theme two), where funding is allocated to a variety of non-government organizations, and this results in competition for funding and contracts. Participant #11's design, incorporates all non-government and government organisations into one system, combating the notion of competitive fragmented services. Participant #23 supports this claim stating that *"I think how you do that is by having a more centralised funding, rather than funding like a gazillion NGOs, to just have the DHBs (public system) do everything…. have them be aspects of one thing, rather than sending money in all these directions and hoping that stuff gets done".*

Drawing on the concept of Youth One Stop Shops, or the "umbrella approach", we can see the benefit of centralised funding and services and how one larger organisation, incorporating multidisciplinary teams, would facilitate collaboration and mitigate some of the fragmentation that occurs within the current system. Therefore, a reimagined system, may benefit from incorporating all service into one system, or implementing more Youth One Stop Shops that act as "umbrella services" on a slightly smaller scale, within each town.

4.7.2 The Micro Teams Approach

Described in slightly less detail, Participant #15 also presented a well thought out, newly designed system, that also drew significantly on the importance of collaboration. Differing from Participant #11's wide scale, systematic approach, Participant #15 was more concerned with the collaboration between professionals within organisations. *"Yes, it's good for collaboration with outside services, as well. But also, inside the services between different professionals and different disciplines [...] What I always thought would be helpful was if they instead of having one large team, they had a micro team that had a psychologist, psychiatrists, social worker [...] they all hold the same caseload so that different disciplines can focus on what their core expertise or knowledge is [...] not that all of them need to be actively working with them at the same time. But all of that expertise can be shared more regularly [...] and also having a closer working relationship with other colleagues.*

When asked how these micro teams might be practically applied within the mental health system Participant #15 stated that *"ideally, it would be nice to have like a one, one stop shop [...] under the same roof, so that when someone comes in and they've got a particular difficulty, and you can walk them next door to get that support. And be able to have that relationship with other professionals because you see them often [...] if everything was under the same roof, people aren't having to be redirected and re referred [...] we have got positive outcomes when we have had a team wrapping around it, and we are all working closely on several cases"*. Participant #15 provides similar suggestions to Participant #11, especially in relation to collaboration, however Participant #15 arguably provides an extra dimension to the "umbrella approach" explaining the need for a micro team within large organisations, to ensure that professionals form connections and work collaboratively with one another. Pairing the 'umbrella approach' and the "micro teams" approach, highlights the need for collaborative, multidisciplinary care while providing practical applications.

The data suggest that the participants I spoke to, and by association other professionals and the young people they care for, are in desperate need of systemic change. This analysis suggests that the challenges related to the neoliberal model of operation, as outlined in themes one and two are preventing quality care, negatively impacting the wellbeing of staff and in some instances impeding a young person's ability to trust in the system and maintain self-worth. The Government Inquiry into Mental Health and Addiction (2018) states that "If our treatments work shouldn't we have fewer people presenting in crisis, [fewer] people on a disability benefit due to mental illness, a reduction in community measures of psychological distress and a decrease in the suicide rate? Despite access to costly biomedical treatment, something central to recovery appears to be missing in the social fabric of developed countries" (pp. 65). Drawing on the literature, and the voices of all eleven participants, I believe that the missing element, is relational ideologies, practices, and models of care, drawing significantly on collectivism, community, collaboration, and the importance of a caring relationship.

CHAPTER FIVE: CONCLUSION

5.1 Overview of Thesis

The number of young people experiencing a form of mental distress, locally and internationally is steadily rising (Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2021; Unicef, 2021; WHO, 2021). Concerns regarding the mental health systems response, specifically here in Aotearoa New Zealand, inspired and informed this research thesis. International and local responses to the increasing number of referrals have been critically analysed by many academic scholars, and it has been widely determined that systems are inadequately meeting the needs of young people. Literature highlights prominent issues preventing care such as insufficient resources, specifically funding and staffing (Baker et al., 2019; Cranage & Foster, 2022; Dawson et al., 2020; Government Inquiry into Mental Health and Addiction, 2018; Huxley et al., 2005; McMillan, 2002; Oxtoby, 2023; Parish, 2018; Rimmer, 2021; Sprinks, 2016; Triliva et al., 2020; World Health Organisation, 2020); increasingly large waitlists (Adams, 2023; Brown et al., 2002; Government Inquiry into Mental Health and Addiction, 2018; Mulraney et al., 2020; Puton et al., 2022; Sacco et al., 2022; Westin et al., 2014) and a need for more patient centered care (Jørgensen & Rendtorff, 2018; Lempp et al., 2018; Paton et al., 2021; Triliva et al., 2020). Within Aotearoa New Zealand the mental health systems response has become a 'hot topic' addressed by various media outlets (Almeida, 2023; Hendry-Tennent, 2022; NZ Herald, 2023; RNZ, 2023; Roberts, 2023; Trigger, 2023), government reports (Cross-Party Mental health and Addiction Wellbeing Group, 2023; Government Inquiry into Mental Health and Addiction, 2018; Ministry of Health, 2021; Te Hiringa Hauora, 2020) and concerned fuelled community discussions.

When reviewing the literature, many challenges within the mental health system were illuminated, and their impact on young people seeking care was carefully depicted. However, I believed that there was a significant gap within this field of research and this thesis intended to begin resolving that knowledge gap. An extensive pool of literature discussed the challenges within the mental health system from a clinical perspective, with many articles originating from mental health nursing, psychiatry, psychology, and social work specialisms, each utilising the perspectives of mental health professionals and previous or current patients (Baker et al., 2019; Brooker & Coid, 2019; Cranage & Foster, 2022; Gulland, 2016; Lacobucci, 2022; McMillan, 2002; Mojtabai & Olfson, 2020; Mulraney et al., 2020; Rimmer, 2021; Sacco et al., 2022; Triliva et al., 2020; Westin et al., 2014). There were also various articles that addressed mental health concerns, or provided relevant insight, from a sociological perspective, drawing significantly on feminist theory (Cohen & Hartmann, 2023; Marecek & Gavey, 2013; Payne, 1991), critical disability studies (Brady & Franklin, 2023; Mac Carthaigh, 2020; McLaughlin et al., 2016), the potentiality of mental illness as a socially constructed phenomenon (Bowers, 1998; Cohen, 2016) and the implications of neoliberalism within healthcare settings (Barnett & Bagshaw, 2020; Brown et al., 2022; Cohen, 2019; Dawson et al., 2020; McGregor, 2008; Moncrieff, 2018; Rizq, 2014; Zeira, 2022). However, very few articles paired the clinical perspectives and utilisation of professional voice with the sociological perspective. Furthermore, there were no articles that utilised these two perspectives in collaboration, while also presenting a unique Aotearoa New Zealand-informed viewpoint. Therefore, to resolve this knowledge gap, this research thesis, intended to explore current challenges within the Aotearoa New Zealand mental health system, utilising the perspectives of mental health professionals, while drawing significantly on sociological frameworks of understanding.

Findings from this research depicted challenges within the Aotearoa New Zealand Mental Health system that professionals felt were preventing them from providing quality care to young people. Analysis identified that these challenges could be linked to phenomena such as neoliberalism, its associated models of operation, and individualistic thinking. This research suggests that ideologies associated with neoliberalism and individualism, specifically a focus on efficiency and profit margins, may be implicated in the current situation of insufficient resourcing; the reliance on crisis management and long waiting lists; the pressure to quickly discharge young people rather than form continuous therapeutic relationships and professionals subsequent inability to explore therapeutic approaches that lie outside of standardised biomedical models. While some of these challenges, specifically the reliance on crisis management can be understood, due to the increasing number of complex mental health referrals, as outlined in the literature review, participants and Brown et al., (2022) draw connections between crisis management and the system's reliance on profit margins and efficiency. The reliance on the biomedical model, echoes similar claims to those above, due to the standardised, efficient nature of biomedicine (Nelson, 2019).

Staff burnout and the impact of caring for others without adequate support was also an identified concern, further illuminating issues such as diminished staff morale and subsequent challenges with staff retention, this was also reflected in previous research (Devilly et al., 2009; Figley, 2002). Research findings suggest that the lack of therapeutic relationships, which are considered a key ingredient to supporting young people (Hartley et al., 2022; Horwitz, 1974, as cited in Noyce & Simpson, 2018; Matos & Dimaggio, 2023), made professionals feel like the system was doing more harm than good by reinforcing insecure attachment styles (Lim et al., 2012) and negatively impacting the fragility of a young person who felt they had not been prioritized or adequately cared for.

The later section of the research focussed on what approaches could be beneficial for the system moving forward. Findings identified alternative approaches to mental health care which drew significantly on relational ideologies and phenomena such as collaboration, therapeutic relationships, patient-centred care, and holism. These alternative, relational approaches directly challenge the individualistic, neoliberal ideologies that appear to be dominant within the mental health system's current model of operation. Findings from this section of the research encourage practices that foster therapeutic relationships (Duncan et al., 2022; Hartley et al., 2022); an increase in interprofessional collaboration, and care plans that incorporate holism (Garrett et al., 2019; Settipani et al., 2019; Thomas & Hargett, 1999); an increase in Kaupapa Māori informed practices (Beutow & Coster, 2001; Levey & Waitoki, 2016; Taskforce on Whānau-Centered Initiatives, 2010; Te Ara, 2016); approaches that move away from the diagnostic model and its perpetuation of discourses of personal tragedy (Brady & Franklin, 2023; Garland-Thompson, 1997; Mac Carthaigh, 2020; McLaughlin et al., 2016) and an increase in mental health care systems that are integrated and based on collaborative care models (Cross-Party Mental Health and Addiction Wellbeing Group, 2023) such as youth one stop shops.

The findings in this research suggest that neoliberalism, traditionally understood as a political or economic business strategy, is influencing the Aotearoa New Zealand health system (Dawson et al., 2020; Gane, 2014; Sparke, 2016). Applying a sociological lens, a perspective that critically analyses systemic issues successfully (McManus et al., 2019; Pescosolido, 2010; Rodriguez et al., 2019), demonstrates how individualism and neoliberalism, specifically the standarised and efficient approaches to mental health, alongside the dominant western biomedical model, are significantly contributing to the issues currently presenting within the Aotearoa New Zealand Mental Health system. Comparatively, relational, community-focused, and flexible approaches to mental health, are presented as beneficial and encouraged. This research outlines why a critical analysis of approaches based on individualism and neoliberalism, in comparison to relational, community-focused approaches is significant when attempting to understand the root causes behind the inadequacies of the mental health system. An analysis of the impact that neoliberalism is currently having, followed by a presentation of alternative approaches, that can also be further understood through sociological frameworks such as feminist ethics of care and the understandings shared by disability scholars, illuminates processes through which the mental health system can transform, to better service our communities, specifically young people struggling with mental health concerns.

5.2 Limitations and Strengths of the Research

This research was completed, almost in its entirety, by me, a New Zealand European/ Pākehā woman in her early 20s. While I was supported by my supervisor, an experienced researcher and professor, it must be acknowledged that my personal identity, demographic background, and limited experience as a researcher, will have impacted the quality of the collected data and subsequent findings (Davies, 2010). My age, sex, ethnic origin, social status, academic background, appearance, how I phrased questions during the interviews and within the context of this research, and my current role within the mental health system, are all elements of my personal identity, that may have influenced the information that participants were willing to share (Davies, 2010). I believe that my role within the mental health system was a strength of this research. It helped develop rapport, encouraged in-depth discussions due to shared experiences, and helped me to ask relevant follow-up questions. However, due to my age, I have limited experience within the system, and therefore cannot fully understand the complexity of working as a mental health professional. Therefore, this may have been a limitation. As a Pākehā woman, I did not possess the cultural expertise to delve fully into conversations connected to Kaupapa Māori informed practices, nor did I feel it was appropriate to engage in research that is already being completed by experts in the field. Therefore, the data collected within this realm of questioning was limited. This research was completed for a master's thesis, and this was my first experience conducting interviews or data analysis. Therefore, as it is with all research projects, the findings will be influenced by the perspective, skills, and interpretations of the researcher (Yin, 2011), and within this research, the interviewer's skills and analytical interpretations were developed throughout the process.

A strength of this research was the quality of the data collected. Participants were willing to share in-depth stories of their own experiences and share on behalf of young people, arguably this presented comprehensible and quality findings. Participants identified and shared overarching, systemic challenges, the direct impact on young people, and their experiences as professionals. They shared emotive narratives that provided a layer of depth, and they described alternative solutions that posed a direct contrast to the current system. However, within the time limitations of this research, one year, I was only able to complete 11 interviews, in part due to the time dedication in-depth interviews require. This sample size was also determined by the number of mental health professionals who were willing to complete an interview. Many mental health professionals were intrigued by the research proposal and recruitment occurred across many services throughout the north island, however, many mental health professionals stated that they simply didn't have the time to complete an interview, due to the high caseload they were working with. This speaks to many of the issues outlined in the findings, regarding staff who are overworked within the system. Therefore, the sample size for this project was relatively small, which can be a limitation when making generalised conclusions regarding a large system.

Of the 11 participants, only two currently worked within ICAMHS or CAMS, and three had previously worked within the public system. The remaining participants predominantly worked within community-based or private mental health programs which were often funded by the public system yet managed separately. Participants originated from a range of specialisms including social work, psychology, mental health nursing, counselling, addiction counselling, and youth work. The range of specialties and services was a strength, providing a wide range of perspectives. However, this can also be a limitation, as it can be challenging to make conclusions when you don’t have a participant group that is concentrated in one area. Participants were recruited from the North Island/ Te Ika-a-Māui exclusively, and it cannot be assumed that individuals in the South Island/ Te Waipounamu would share the same insights. However, country-wide government reports and news articles outlined in the literature review would suggest that some of the issues are nationwide.

Despite the limitations outlined above, this research has many strengths. Through a sociologically informed lens, this research highlights challenges within the Aotearoa New Zealand mental health system, while providing alternative approaches that could be significantly beneficial if implemented. As established throughout the research, the sociological perspective and the clinical perspectives shared through the participant's voice is a unique paring, specifically within an Aotearoa New Zealand. I believe that this is the most significant strength of this research, due to its ability to elevate the voices of professionals who have ‘boots on the ground’ and are able to share relevant experiences, whilst utilising sociological frameworks of understanding to investigate the influence of social structures, ideologies, power dynamics and systems of inequality that are influencing, and arguably giving rise to the insights shared by participants.

5.3 Suggestions for Future Research

A larger research project, with the capacity to survey or interview young people on their experiences, would be extremely beneficial. The incorporation of patient/client/youth voice was not possible within the current research project, and instead, we gained insight into youth experiences through the voices of professionals. Extensive literature searching for this research project, identified that the use of youth voice, when discussing the systems impact upon them, is somewhat limited and this is a knowledge gap that should be filled. Completing a similar research project to this one, on a much larger, national scale, with mental health professionals, young people, or a combination of both, would enable researchers to make concrete claims regarding the state of the mental health system and the impact it has on young people. While I am confident in the findings of this research, a much larger sample size would be beneficial for future research.

One area of research that was illuminated within this study, that future research should analyse further, was the impact that the system has on a young person's insecure attachment style. This was mentioned by 3 participants, and there is a vast pool of international literature on the significance of attachment styles. However, the claims made by participants regarding the system's potential to reinforce insecure parental attachment styles through quick discharge or transfer of care is a significant area of research that may illuminate the continuation of insecure attachment styles. Participants also briefly touched on some alternative models of care such as creative therapies, the transdiagnostic model and Kaupapa Māori informed practices, which each hold merit as a therapeutic approach. Further exploration of their therapeutic benefit and how the system inhibits or enables their application would be beneficial.

5.4 Implications of the Research

This research project has reiterated many of the concerns others share about the mental health system, specifically the insufficient resourcing, focus on crisis management, impact of waiting lists, and how this influences the care young people receive. However, the points this research made regarding individualism, neoliberalism, and relational ideologies moving forward, is a relatively new space of research within Aotearoa New Zealand. It is hoped that this area of research will be expanded upon significantly and that the concerns and suggested alternative approaches will be considered by high-ranking professionals within the mental health system when making decisions regarding the future of the system.

When describing what their ideal mental health system would look like many participants touched on collaborative or integrated care, multidisciplinary teams, and the incorporation of all mental health services under one system. Youth one-stop shops were discussed at length and the recent cross-party mental health and addiction wellbeing group report, coincidentally coined “under one umbrella” reiterates many of the claims made by participants. This research study identified that, Whānau focussed, holistic ideologies they youth one-stop stops, or other collaborative models are formed upon, are extremely beneficial for all people seeking support, specifically young people with mental health concerns. Research into the practicality of these models, and how they might be implemented for the benefit of young people seeking mental health care, would be a positive step forward for this field of research.

The findings from the current data analysis and literature review, alongside my own personal experience working within the mental health system, lead me to claim that the current model and ideologies that the mental health system is operating upon are not supporting young people. This is extremely concerning when we consider the increasing number of people suffering from some form of mental distress, and the increasing complexity of young people’s trauma and mental health conditions. I believe that adapting the mental health system to incorporate the alternative approaches suggested by participants, specifically the concept of youth one stops and integrated, holistic care, is the best way to improve the care our young people receive. Further research into the practical application of these ideas, and the impact they might have on young people is, in my opinion, desperately required. Listening to the voices of the participants in this study, and the emotive stories they shared about the young people they care for, is a striking aspect of this research. There are many young people suffering from mental health conditions, and we have some of the highest rates of suicide in the OECD (Mental Health Foundation New Zealand, 2023). This makes it especially important for ongoing research to investigate the systems supporting young people and critically analyse how youth mental health systems could better serve our communities.

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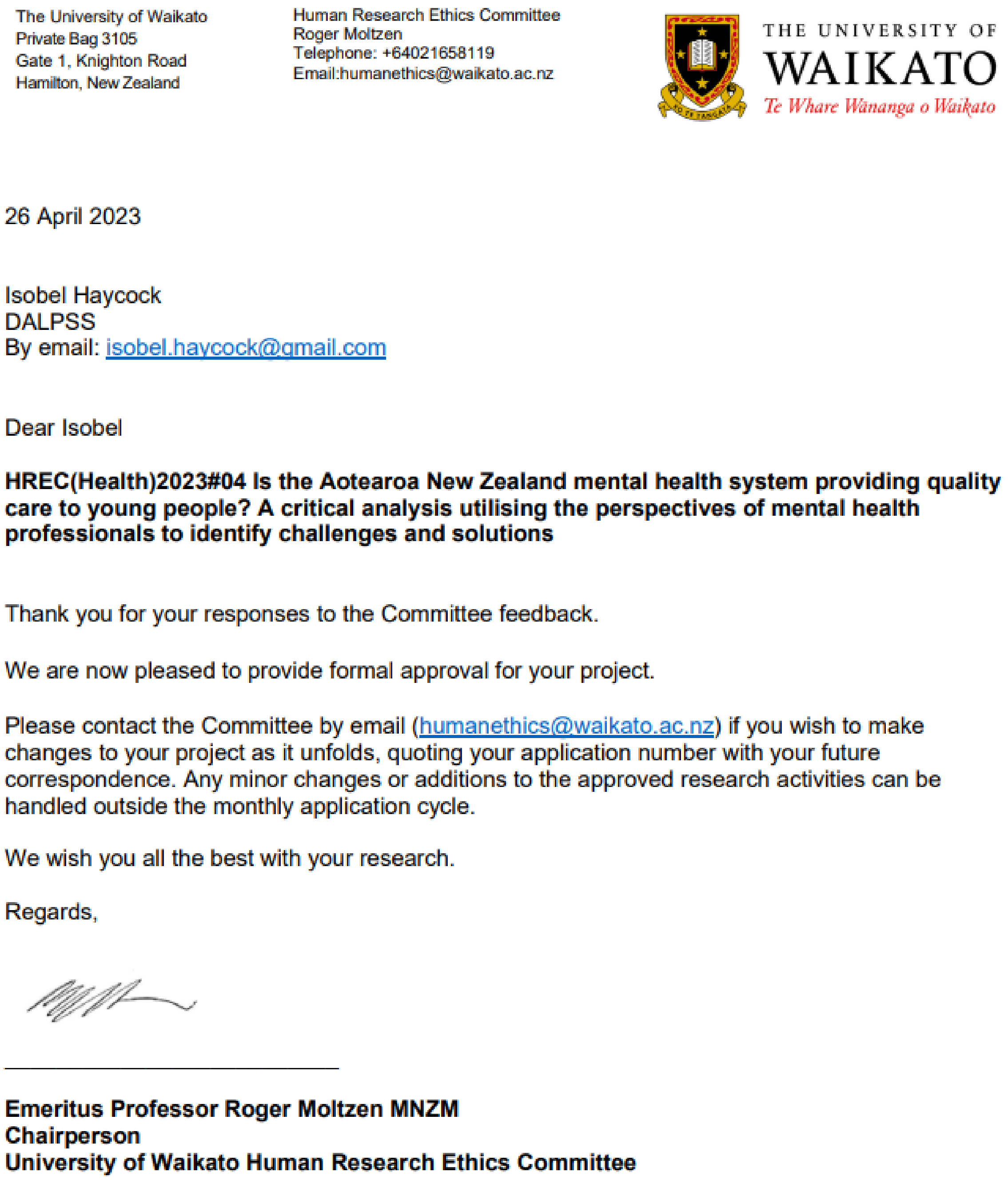
APPENDICES

Appendix A: Ethics Committee Formal Approval Letter



The University of Waikato
Private Bag 3105
Gate 1, Knighton Road
Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

26 April 2023

Isobel Haycock
DALPSS
By email: isobel.haycock@gmail.com

Dear Isobel

HREC(Health)2023#04 Is the Aotearoa New Zealand mental health system providing quality care to young people? A critical analysis utilising the perspectives of mental health professionals to identify challenges and solutions

Thank you for your responses to the Committee feedback.

We are now pleased to provide formal approval for your project.

Please contact the Committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,

Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee

Appendix B: Recruitment Poster

Participants wanted for Master's Research Project

Seeking clinical and non-clinical staff who want to participate in an interview about working in Aotearoa New Zealand's mental health system.

This is an invitation to participate in research, specifically for staff who are currently in Infant, Child and Adolescent mental health services or those who have worked in this area in the past 10 years.

Contact the researcher.

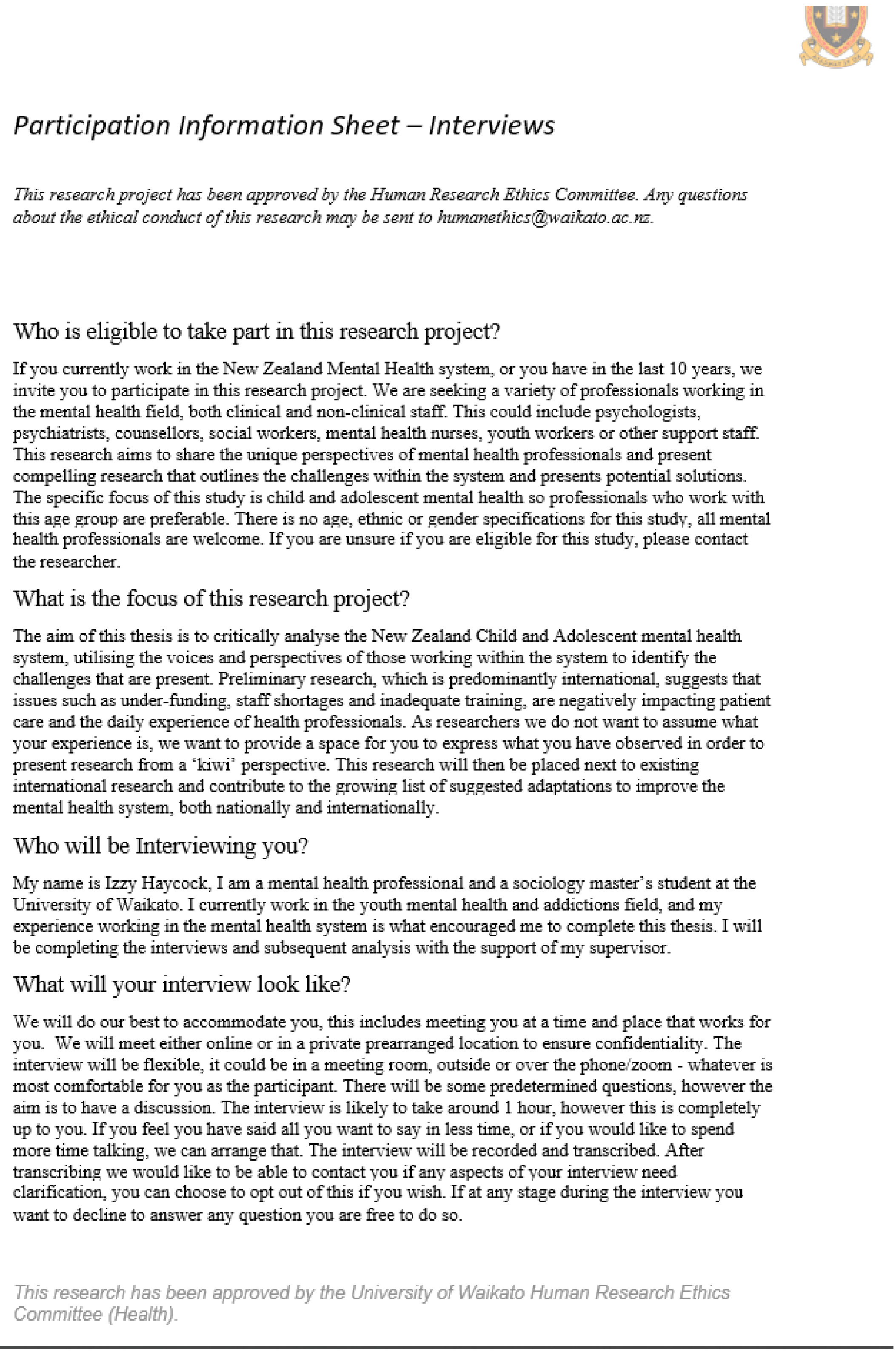
0221629497

ic40@students.waikato.ac.nz

KO TE TANGATA

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Appendix C: Participant Information Sheet



Participation Information Sheet – Interviews

This research project has been approved by the Human Research Ethics Committee. Any questions about the ethical conduct of this research may be sent to humanethics@waikato.ac.nz.

Who is eligible to take part in this research project?

If you currently work in the New Zealand Mental Health system, or you have in the last 10 years, we invite you to participate in this research project. We are seeking a variety of professionals working in the mental health field, both clinical and non-clinical staff. This could include psychologists, psychiatrists, counsellors, social workers, mental health nurses, youth workers or other support staff. This research aims to share the unique perspectives of mental health professionals and present compelling research that outlines the challenges within the system and presents potential solutions. The specific focus of this study is child and adolescent mental health so professionals who work with this age group are preferable. There is no age, ethnic or gender specifications for this study, all mental health professionals are welcome. If you are unsure if you are eligible for this study, please contact the researcher.

What is the focus of this research project?

The aim of this thesis is to critically analyse the New Zealand Child and Adolescent mental health system, utilising the voices and perspectives of those working within the system to identify the challenges that are present. Preliminary research, which is predominantly international, suggests that issues such as under-funding, staff shortages and inadequate training, are negatively impacting patient care and the daily experience of health professionals. As researchers we do not want to assume what your experience is, we want to provide a space for you to express what you have observed in order to present research from a 'kiwi' perspective. This research will then be placed next to existing international research and contribute to the growing list of suggested adaptations to improve the mental health system, both nationally and internationally.

Who will be Interviewing you?

My name is Izzy Haycock, I am a mental health professional and a sociology master's student at the University of Waikato. I currently work in the youth mental health and addictions field, and my experience working in the mental health system is what encouraged me to complete this thesis. I will be completing the interviews and subsequent analysis with the support of my supervisor.

What will your interview look like?

We will do our best to accommodate you, this includes meeting you at a time and place that works for you. We will meet either online or in a private prearranged location to ensure confidentiality. The interview will be flexible, it could be in a meeting room, outside or over the phone/zoom - whatever is most comfortable for you as the participant. There will be some predetermined questions, however the aim is to have a discussion. The interview is likely to take around 1 hour, however this is completely up to you. If you feel you have said all you want to say in less time, or if you would like to spend more time talking, we can arrange that. The interview will be recorded and transcribed. After transcribing we would like to be able to contact you if any aspects of your interview need clarification, you can choose to opt out of this if you wish. If at any stage during the interview you want to decline to answer any question you are free to do so.

This research has been approved by the University of Waikato Human Research Ethics Committee (Health).

What will we do with the data we collect from you?

Once the interviews are transcribed, they will be analysed and sections of them will be used within the thesis, both as direct quotes and as summaries. You will be sent a copy of your transcript for review (3 weeks after your interview), and you can request that amendments be made to the transcript with a view to optimising anonymisation and correcting any material that is no longer accurate.

The analysis of the interviews will contribute to a report on the current challenges in the mental health system. If you would like to view the thesis once it has been completed, you are welcome to ask for this. Your interview transcript will be kept securely until the research has been completed. Excerpts from participant transcripts will appear anonymously in the published master's thesis which will be available online. Once the thesis has been completed the remaining data (your anonymised transcript) will be kept for up to five years to allow academic examination, challenge or peer review. All personal details that may identify you will be destroyed once your interview and transcript are complete and from that point onwards you will be assigned a number to ensure anonymity.

Confidentiality

Once your interview is completed you will be assigned a number. Only the researcher and the research supervisor will have access to the raw data. All other presentations of this data, including the final thesis will not include any identifying information. All data will be stored securely.

Withdrawing from the Research

If at any stage during the research process (until 6 weeks after the interview) you would like to withdraw, you may do that, and we will remove and dispose of any information you may have already given us. Once 6 weeks have passed it is likely that the data will already be included in the research process and therefore, we cannot remove it.

Gaining support

If during the interview, or afterwards, you feel upset, we encourage you to seek support. This may be through prearranged professional supervision or with private counselling. If you need help accessing these supports, we encourage participants to reach out to us and we can put you in contact with the appropriate services.

Questions and Concerns

If for any reason you would like to make a complaint, if you have any questions or concerns about the research, we suggest you contact the research supervisor. If you have concerns or complaints of an ethical nature, please contact the Human research Ethics Committee.

Contact Information

Researcher:

Email: ic40@students.waikato.ac.nz

Phone: 022 162 9497

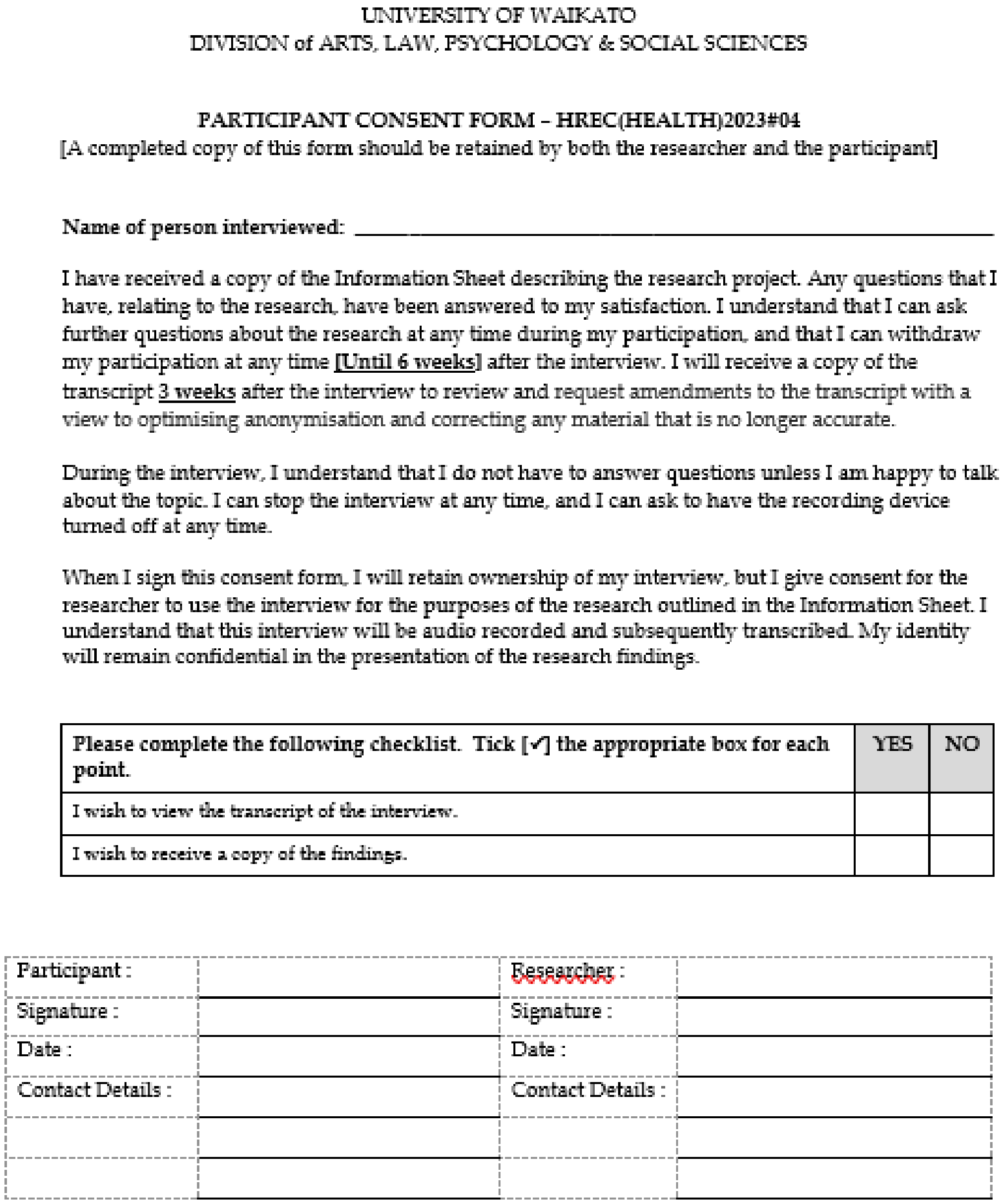
Research Supervisor: Katrina Roen – Professor of Sociology, University of Waikato

Email: katrina.roen@waikato.ac.nz

University of Waikato Human Research Ethics Committee:

humanethics@waikato.ac.nz.

Appendix D: Participant Consent Form



UNIVERSITY OF WAIKATO
DIVISION of ARTS, LAW, PSYCHOLOGY & SOCIAL SCIENCES

PARTICIPANT CONSENT FORM – HREC(HEALTH)2023#04
[A completed copy of this form should be retained by both the researcher and the participant]

Name of person interviewed: ______________________________

I have received a copy of the Information Sheet describing the research project. Any questions that I have, relating to the research, have been answered to my satisfaction. I understand that I can ask further questions about the research at any time during my participation, and that I can withdraw my participation at any time **[Until 6 weeks]** after the interview. I will receive a copy of the transcript **3 weeks** after the interview to review and request amendments to the transcript with a view to optimising anonymisation and correcting any material that is no longer accurate.

During the interview, I understand that I do not have to answer questions unless I am happy to talk about the topic. I can stop the interview at any time, and I can ask to have the recording device turned off at any time.

When I sign this consent form, I will retain ownership of my interview, but I give consent for the researcher to use the interview for the purposes of the research outlined in the Information Sheet. I understand that this interview will be audio recorded and subsequently transcribed. My identity will remain confidential in the presentation of the research findings.

Please complete the following checklist. Tick [✓] the appropriate box for each point.	**YES**	**NO**
I wish to view the transcript of the interview.		
I wish to receive a copy of the findings.		

Participant :		Researcher :	
Signature :		Signature :	
Date :		Date :	
Contact Details :		Contact Details :	

Appendix E: Interview Question Guide

Interview Guide – Including Interview Questions.

Interview length: 45 minutes - 1-hour minutes (estimate)

Interview Space: Private room or zoom call. Interviewer will accommodate the interviewee and meet them at a convenient location.

Type of Interview Participant: Professional working in the Mental Health system, specifically with children and/or Adolescents (public or private). Examples could include mental health nurse, psychologist, social worker, counsellor, psychiatrist, youth worker or support worker.

Type of Questions/Interview: Semi-structured interview. Lots of follow up questions based on what the participant responds.

- Interviewer to explain any unknown terms before interview commencement.
- Interviewer will take notes and conduct audio recordings for each interview.
- Interviewer may exclude some questions when they appear to not be relevant or when considering time restraints.

Research Questions:

• What understandings do mental health care staff across specialisms bring to systemic issues in youth mental health care?

• How do mental health care staff across specialisms think systems could better serve young people and what can a sociological lens contribute to this thinking?

• What models of care and sociological understandings can guide improvements to youth mental health care in Aotearoa New Zealand?

Interview Questions:

Introduction questions:

Question 1: Please tell me about the role you play in the mental health system, briefly tell me what does your role include and how long you have worked in the system?

Interview Questions based on research Question One: Systemic issues in youth mental health care:

Question 2: A lot of preliminary research suggests that mental health systems across the globe are severely flawed and are not meeting the needs of their patients. Briefly tell me about your experience working in the New Zealand Mental Health system and how you believe it is, or isn't, meeting the needs of patients.

Question 3: What do you think are the main issues or flaws within the system that are currently preventing quality patient care?

- Summarize it for me
- New Zealand Perspective

Question 3A: Is underfunding one of these issues, if so, how does it impact patient care?

Question 3B: How does staffing issues such as training or shortages impact the mental health system?

Question 4: What is your experience with long waiting lists and staff shortages, and how does this impact the strain on other services and the referral process?

Question 5: How do services within the New Zealand Mental Health System work together?

- Is it a collaborative process?
- What are some of the issues you have identified?
- What is the referral process like? Is it positive or negative? Both for the young person and the professional.

Question 6: What impact, if any, do you believe that the transference between services has on a young person's mental health?

- Does transference have a positive or negative impact on young people's treatment?
- What role does a therapeutic relationship/connection between patient and professional play in this?

Question 7: In the current mental health system, are professionals able to form quality connections with their patients?

- Does the current level of connection between staff and patient increase patient wellbeing, or could it be improved?

- How does the system impact this?

Question 8: In your opinion how are therapeutic relationships/connections between patient and professional formed and what strategies need to be employed to develop and maintain them?

- What are the barriers and enablers?
- What are the benefits of these relationships?

Interview Questions Based on Research Question Two: How could our system better serve young people?

Question 9: In your experience, here in New Zealand or overseas, what are the positive elements of the system that should be recognised/encouraged?

Question 10: When discussing suggestions for improved care within the mental health system many research projects suggested integrated care. The collaboration of services (physical health, mental health and social care) all under one roof, or under one system. These have been referred to as youth one stop shops, among many other names but the general premise is that families have one place to go, where they can access wrap-around support. What are your thoughts on models like these and how do you see these working in New Zealand? – *Note for interviewer to explain we do have some one stop shops in New Zealand, however they are primarily charitable organisations separate from each other and from the national health system.*

Question 11: What elements, models, strategies or personal practices do you think should be considered and implemented in the New Zealand Mental Health system?

- Implementation of integrated care, what needs to be considered?
- Continuous and collaborative care, what needs to be considered?
- Under funding, staff shortages, what needs to be considered?

Question 12: Considering all we have discussed today, both positive and negative, I want you to think of a very hypothetical, blue skies, ideal world approach. What would you like the Mental Health System in New Zealand to look like?

Interview Questions Based on Research Question Three: What models of care could or should guide mental health support in New Zealand?

Question 13: In your professional opinion, are there any specific models of care that work really well in the mental health system? - *only applicable for some applicants who have a background in clinical models of care.*

- models that are currently implemented in the mental health system.
- models that are implemented overseas.
- models that are culturally responsive.
- models that are not yet implemented.

Appendix F: Table of Preliminary Codes

Code	**Colour and Associated Potential Theme**
1. Increasing Level of Complexity.	Increasing Mental Health in Society/Social Politics.
2. Increasing Numbers/High Case Loads	Increasing Mental Health in Society/Social Politics.
3. Having to Prioritise One Young Person Over Another	System Limitations/Overwhelmed
4. Lack of Availability in the Public System/Long Waiting Lists	System Limitations/Overwhelmed
5. Public System only Dealing with Crisis Management	System Limitations/Overwhelmed
6. Family Involvement (As a barrier or enabler)	Public Health/Preventative Care/Barriers to Care
7. Physical Barriers (Travel, cost, timing, etc.....)	Public Health/Preventative Care/Barriers to Care
8. Quick Discharge From Public System	System Limitations/Overwhelmed
9. Young People Not Wanting to Go into the Public System	Youth and/or Community Lack of Trust in the System
10. Importance of Therapeutic Relationships/Attachment Styles	Importance of Therapeutic Relationships
11. Lack of Funding/Funding Criteria	Funding Mismanagement, Bureaucracy, Corporatization

12. Funding in Incorrect Places/Beuacracry/Mismanagement	Funding Mismanagement, Bureaucracy, Corporatization
13. Needing Decentralised Support- In the Community Rather than a Centralised Public System.	Decentralized System (Communities/Schools).
14. Lack of Collaborative Care/No Continuity of Care	Collaborative Care and Everything that Comes with it.
15. Lots of Services Involved/Bounced from one to another	Collaborative Care and Everything that Comes with it.
16. Lack of Therapeutic Relationships/Expected to Reveal Personal Information to a Stranger	Importance of Therapeutic Relationships
17. Pressure to Move Through Lots of Patients Due to Waitlists/Limited Sessions	System Limitations/Overwhelmed
18. Need for/Importance of Hubs, Youth One Stop Shops/Community Centres, Centralised Systems, Microteams, Blue Skies Thinking.	Collaborative Care and Everything that Comes with It.
19. Staff Shortages	Staffing Issues
20. Staff Burn Out/High Turnover/Losing Staff	Staffing Issues
21. Lack of Kaupapa Māori Approaches in Current System	Alternative Therapies

22. Importance of/Need for a Kaupapa Māori Informed System	Alternative Therapies
23. Collaborative/Collective Approaches/Link to Kaupapa Māori Approaches	Alternative Therapies
24. System Impact on Māori Young People	Alternative Therapies
25. Holistic Approach	Holism and its connections to collaboration, collectivism, and centralization.
26. Other Physical Barriers Such as Poverty	Public Health/Preventative Care/Barriers to Care
27. Need for Preventative Care Rather than Reactive Crisis Management	Public Health/Preventative Care/Barriers to Care
28. Distrust in the System/Service Providers	Youth and/or Community Lack of Trust in the System
29. Staff Not Adequately Trained	Staffing Issues
30. Need for More Health Promotion/De-stigmatisation	Public Health/Preventative Care/Barriers to Care
31. Fragility of Young People	Importance of Therapeutic Relationships
32. No Smooth Transition Between Services (Lack of Collaborative Care)	Collaborative Care and Everything that Comes with It.
33. Staff Becoming Robotic, Not Forming Relationship.	System Limitations/Overwhelmed

34. Individual Staff Are/Can Be Really Good	Positive System Changes/Positive Individuals
35. Community Connectors - A Positive	Positive System Changes/Positive Individuals
36. Talk and No Action	Youth and/or Community Lack of Trust in the System
37. Collaboration can Happen, Often within Services but not externally (in the MDT space)	Collaborative Care, and Everything that Comes with It.
38. Young People feel like they have to hurt themselves more to get help	System Limitations/Overwhelmed
39. Some Professionals can form good relationships with young people and advocate beyond systemic limitations.	Positive System Changes/Positive Individuals
40. Confidentiality - Sharing of Information Between Services.	Collaborative Care and Everything that Comes with It.
41. Individual clinicians feel they have to break the rules to provide care within the system.	Positive System Changes/Positive Individuals
42. People within the system attempt to make changes within the system.	Positive System Changes/Positive Individuals
43. System Changes, Introduction of Te Whatu Ora, Māori health Authority, increase in public health funding.	Positive System Changes/Positive Individuals

44. Biculturalism as Tick Box Approach/ Tokanistic	Alternative Therapies
45. Increasing Mental Health within Society	Increasing Mental Health in Society/Social Politics.
46. Staff Outside the Public System have to Hold on to People Longer than they Should.	System Limitations/Overwhelmed
47. Passed from Professional to Professional within one Service	Collaborative Care and Everything that Comes with It.
48. Focus on Diagnosis/Medical Model	System Limitations/Overwhelmed
49. Does the System Actually Help?	System Limitations/Overwhelmed
50. Limited Sessions in the Public System, no time to develop a relationship.	Importance of Therapeutic Relationships
51. Staff Having to Personally Upskill Due to High Demand.	Staffing Issues
52. Staff Doing the Work of Other Staff	Staffing Issues
53. Staff not Trained in Kaupapa Māori Principles - it is very tick box	Alternative Therapies
54. Creative/Alternative Methods of Therapy	Alternative Therapies
55. A better Communication network is Needed Between Services, A Call Log of Who Does What.	Collaborative Care and Everything that Comes with It.

56. Lack of Resources, Programmes, Groups, Packages of care, Financial support.	System Limitations/Overwhelmed
57. Becoming a Mental Health Professional is Hard; Training, University, Registration, Profession is Not Attractive.	Staffing Issues
58. No Time to Build a Therapeutic Relationship Because of System Limitations.	System Limitations/Overwhelmed
59. Making Sessions Casual/Youth Focussed - Needed but Often Not Able To.	System Limitations/Overwhelmed
60. Different Models of Care, Different Opinions on How to Help - Social Politics.	Increasing Mental Health in Society/Social Politics.
61. Reputation of Mental Health Services (Often Bad).	Youth and/or Community Lack of Trust in the System
62. Maintaining or Developing Therapeutic Relationships, what is required, and Why is this Difficult?	Importance of Therapeutic Relationships
63. An alternative of Specific Models of Care. E.g.: Person Centred, Cultural, and Transdiagnostic.	Alternative Therapies
64. Social Stigma/Destigmatisation	Public Health/Preventative Care/Barriers to Care

65. Harm Reduction/Minimisation/Solution Focussed	Holism and its connections to collaboration, collectivism, and centralization.
66. Services Not Being Published.	Public Health/Preventative Care/Barriers to Care
67. Benefits of Fragmented, Decentralised, Self-Governing Services.	Collaborative Care and Everything that Comes with It.
68. Legislation (Issues with, Benefits of)	System Limitations/Overwhelmed
69. Quick Fix Culture	System Limitations/Overwhelmed
70. Lack of Therapeutic Relationships Mirroring Childhood Attachment.	Importance of Therapeutic Relationships
71. Individual Clinicians Struggling to Provide in a Broken System	Staffing Issues
72. Services Outside the Public System Getting Referrals Not Meant for Them.	System Limitations/Overwhelmed
73. Non-Clinical Staff Members Forming More of a Relationship	Importance of Therapeutic Relationships
74. Time/Resource Constraints Means Alternative Models or Anything Extra are not a Priority	System Limitations/Overwhelmed
75. Impact on Family/Parents/Community	Youth and/or Community Lack of Trust in the System
76. Long-Term Care within the Public System	Positive System Changes/Positive Individuals

77. Respite in the Public System- Beneficial When Used and Available	Positive System Changes/Positive Individuals
78. Staff Not Supported within the Public System	Staffing Issues
79. Taught to Reach Out, Then Sit on a Wait List, Negative Impact on Youth Self Worth	Importance of Therapeutic Relationships