

RESEARCH

Two Decades After Siaan Nathan's (1999) Study: Revisiting the Responsiveness of Professional Clinical Psychology Programmes

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Clinical psychology training programmes in Aotearoa New Zealand are predominantly monocultural and centred on perspectives from Western Europe and North America. Several initiatives have sought to address the monocultural dominance of Western psychology in training programmes, with limited sustainability. We surveyed clinical psychology programme directors (N=6) to assess the progress of programmes towards meeting Te Tiriti o Waitangi obligations across five key domains (Māori representation across programme staff and students, advisory group, admissions process and programme content). Promisingly, progress regarding the inclusion of Māori-focused content and faculty representation was identified. However, all directors reported that the increase in Māori student representation was slow, with half (n=3) reporting the number of taura Māori applicants to programmes was an ongoing concern. The limited progress towards ensuring increased Māori representation was thought to reflect system constraints. The findings highlight the pressing need for clinical psychology training to fulfil Te Tiriti o Waitangi obligations to support tino rangatiratanga for Māori that leads to transformative change. Notably, equity for Māori was identified as a priority through the provision of sufficient and sustainable resourcing for kaupapa Māori psychologies.

In settler-colonial nations such as Te Whenua Moemoeā (Australia), Turtle Island (Canada and North America), and Aotearoa (New Zealand), the monocultural dominance of Western epistemologies (i.e. systems of knowledge and ways of knowing) in the clinical psychology discipline has been criticised for the exclusion of Indigenous epistemologies and practice. The failure to recognise the culturally bound nature of Western knowledge and distinct epistemologies of Indigenous worldviews has contributed to

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calls to advance Indigenous education in clinical psychology that addresses disparities, promotes reconciliation and strengthens Indigenous education (Ansloos et al., 2019; Cullen et al., 2020; Dudgeon & Pickett, 2000; Durie, 2004; Fellner, 2018; Groot et al., 2018).

In Aotearoa, the clinical psychology discipline holds ethical responsibilities under Te Tiriti o Waitangi (Te Tiriti) to ensure that research, training and practice are responsive to tangata whenua Māori (the Indigenous peoples of Aotearoa New Zealand). As a constitutional framework, Te Tiriti obligations are recognised by the clinical psychology discipline as the foundation for ethical and competent training and practice, as outlined in the *Code of Ethics for Psychologists Working in Aotearoa/New Zealand 2002* (New Zealand Psychological Society, 2002) and the *Core Competencies for the Practice of Psychology in Aotearoa New Zealand* (New Zealand Psychologists Board, 2018). The four key principles outlined in the Code of Ethics make explicit references to Te Tiriti as the framework for ethical practice, and core competencies require that the worldviews and paradigms of both Te Tiriti partners are reflected in clinical training and practice, including a working knowledge of Te Tiriti (New Zealand Psychological Society, 2002; New Zealand Psychologists Board, 2018).

Four decades ago, Abbott and Durie (1987) surveyed directors of psychology training programmes (including clinical, educational and community; $N=9$) and found the discipline fell behind in the incorporation of Māori-focused content (e.g. Māori health models) relative to other professional programmes. A decade later, a replicated study (Nathan, 1999) found most clinical psychology training programmes ($n=5$) had minimal improvement in increasing Māori-focused content. Despite Māori representation in psychology having gradually improved, numbers are still well below population figures. For clarity, 17.3% of the New Zealand population identify as Māori, whereas less than 6% of the psychology workforce identify as Māori (Levy & Waitoki, 2015; Scarf et al., 2019; Statistics New Zealand, 2023). University academic staff and student numbers are also under-represented in psychology. No Māori staff were noted by Abbott and Durie (1987), and one staff member was noted by Nathan (1999). The number of taura Māori (Māori students) increased from zero to 24 after a decade. As expected, the lack of Māori representation also affected curriculum content. A recent review of 48 clinical psychology course outlines (Waitoki et al., 2023) found that mātauranga Māori (knowledge systems) content was embedded in 6% of courses, and 33% integrated some aspects of Māori-focused content. Regarding curriculum content, clinical psychology students have expressed the need for a bicultural curriculum that reflects responsibilities to Te Tiriti, increased visibility and respect for mātauranga Māori in training and increased emphasis on cultural awareness and cultural safety (Johnson et al., 2021; NZCCP Students, 2019).

The structural discrimination and continued privileging of Pākehā (New Zealand European) worldviews and the exclusion of Māori worldviews in institutions and practices remains largely invisible to those embedded within the context of Western psychology, hindering the contribution of mātauranga Māori to ensuring ethical and culturally safe psychological practice (Black & Huygens, 2016; Groot et al., 2018). Decades of insufficient actions to facilitate the adequate inclusion of Māori in psychology and breaches of Te Tiriti by the Crown and its agencies (e.g. New Zealand Psychologists Board, Ministry of Health, Department of Corrections) led to the lodging of a Waitangi Tribunal claim (Levy, 2018) detailing the manifestations of racism across systems and agents responsible for the regulation, training and employment of psychologists.

Expanding on a previous study that examined the responsiveness of psychology training in honouring Te Tiriti (Waitoki et al., 2024), this study examined the responses of clinical psychology programme directors who participated in the Kia Whakapapa Pounamu survey. Given that clinical psychology is the largest branch of psychology in Aotearoa, particular attention and scrutiny is warranted. We identified changes in clinical psychology training programmes after two decades through comparison with previous research (Nathan, 1999) across five domains: programme staff, Māori advisory group, admissions process, programme students and programme content.

Method

Procedure

This study is part of a larger project, WERO Working to End Racial Oppression, which examined systemic racism in psychology training. Purposive sampling was used to invite all clinical psychology programme directors ($N=6$) to participate in the Kia Whakapapa Pounamu Survey. Initially, a collective hui (meeting) was held to establish relationships and provide information regarding the research objectives and approach (e.g. highlight the research focus on the identification of institutional constraints in embedding Te Tiriti among programmes). All directors were sent a personalised email with an invitation to complete the survey via Qualtrics in September 2022. All directors completed the survey before February 2023. Ethics approval for this study was granted by the Human Ethics Committee at the University of Otago (D21/199). Further details about the survey methods are outlined in Waitoki et al. (2024).

Analysis

Descriptive analyses were performed using IBM SPSS version 29. Comparative analyses of statistics drawn from Nathan (1999) involved chi-squared comparisons of proportion tests using MedCalc (MedCalc Software Ltd., 2023). Open-text responses were analysed using inductive content

Table 1.

Comparison of five domains after two decades

	Nathan (1999) n (%) ^a	Present study (2023) n (%) ^b
Programme staff		
Involve Māori clinical staff	1 (20.0)	6 (100.0)
Staff pre-requisites re Māori issues and Te Tiriti	3 (60.0)	4 (66.7)
Staff prerequisite: knowledge of tikanga	0	3 (50.0)
Staff training in tikanga Māori	5 (100.0)	6 (100.0)
Shortage of Māori staff of concern	5 (100.0)	6 (100.0)
Steps taken to address imbalance of Māori staff	2 (40.0)	6 (100.0)
Māori advisory group		
Links to Māori advisory body	4 (80.0)	5 (83.3)
Programme students		
Māori representation on panel	3 (60.0)	5 (83.3)
Prerequisites on Māori culture ^c	0	4 (66.7)
Interview questions relevant to Māori culture ^c	3 (60.0)	3 (50.0)
Opportunity for applicants to bring whānau support	4 (80.0)	6 (100.0)
Number of Māori applicants perceived as inadequate	4 (80.0)	3 (50.0)
Number of Māori graduates perceived as inadequate	4 (80.0)	2 (33.3)
Steps taken to address imbalance of taura Māori	3 (60.0)	3 (50.0)
Programme content		
Kaupapa Māori psychology integrated into content		6 (X=20%)
None	0	0
Some	3 (60.0)	2 (10–15)
Substantial	2 (40.0)	4 (20–35)

Note: ^an=5; ^bn=6; ^cMāori culture was described in a broad way, including tikanga (protocols and processes that guide appropriate and ethical behaviour), te reo Māori (language) and Māori health models.

analysis (Vears & Gillam, 2022) when sufficient details were available. The directors' identities were anonymised to protect the interests of the programmes.

Participants

Representatives from each programme completed the survey, including five directors who identified as Pākehā (European). One survey was completed collaboratively by an immediate past director (Māori) and current director (Pākehā). On average, directors of clinical psychology programmes had been appointed to the role for 4.33 years (range 1–10 years). Most directors had completed their training at a university in Aotearoa (66.7%, $n=4$). Two directors had completed training in the United States and spent an average of 12 years involved in clinical psychology training in Aotearoa.

Results

The findings are reported across five domains and compared with statistics from Nathan (1999) as applicable ([Table 1](#)).

1. Programme Staff

Prerequisites on Māori perspectives. Two-thirds of the programmes (66.7%, $n=4$) required knowledge of Te Tiriti, and half (50%, $n=3$) required knowledge of tikanga Māori during staff appointments. Director 1 emphasised that knowledge of Te Tiriti was essential during staff selection and appointment, including an '*understanding and/or willingness to learn about bicultural matters including tikanga Māori, te reo Māori, and Kaupapa Māori and Indigenous Psychologies*'. Two programmes (Directors 2 and 6) did not have formal prerequisites on Māori perspectives; however, they expected staff to have sufficient knowledge or commitment to developing bicultural knowledge.

Māori teaching staff. All directors reported concern about the shortage of Māori staff and had taken steps to address this, including the active recruitment of Māori staff (100%, $n=6$), implementing culturally responsive recruitment processes (83.3%, $n=5$) and supporting the development of current Māori staff (e.g. promotion, external funding applications, permanent positions for those on temporary contracts) (50.0%, $n=3$). Compared with Nathan (1999), there was a significant increase in directors taking positive steps towards addressing the low numbers of Māori staff (100% vs. 40%, $\chi^2(1)=4.50$, $p<.05$). Across programmes, positive outcomes reported by directors included the retention of current Māori staff (Director 1), the recruitment of Māori staff into programmes (Directors 2, 4 and 6), input from external clinical psychologists (Director 5), partnership with Māori treatment providers (Director 5), increased pathways for a sustainable Māori workforce (e.g. increased paid hours for Māori staff and clinical educator positions, establishing permanent positions for staff on temporary contracts) (Directors 1 and 3); and establishment of new Kaupapa Māori academic positions (Director 3).

However, 50% of directors ($n=3$) reported difficulties in Māori staff recruitment. Reasons cited included Māori applicants not applying for roles, limited candidates in the academic pipeline with clinical qualifications (Director 2), limited Māori practitioners with availability to apply for roles and hesitancy among potential applicants because of past institutional experiences (Director 3). Director 3 also highlighted the need for the discipline to increase the number of Māori in the workforce and '*inspire Māori with clinical qualifications to seek academic appointments*'.

2. Māori Advisory Boards

Five directors (83.3%) reported links to a Māori advisory body for consultation and training purposes. Contribution to programmes involved providing training and supervision for students (83.3%, $n=5$), research consultation (50.0%, $n=3$) and input into the selection interview process (50.0%, $n=3$). Three directors (50.0%) highlighted that Māori advisory bodies contributed to programmes through consultation and guidance around the

incorporation of Kaupapa Māori into programmes, and support for staff/students related to bicultural practice. Director 4 also acknowledged that formalisation of these relationships was an area of development for their programme. Director 2 did not have an existing link to a Māori advisory body; however, they reported '*an active working relationship*' with the Divisional Associate Dean Māori involving consultation '*on a number of ongoing issues, including hiring, selection into the clinical programme etc.*', and seeking contacts with Māori organisations outside the university. Relative to Nathan (1999), little appeared to have changed regarding programme links to Māori advisory boards (83.3% vs. 80.0%, $\chi^2(1)=0.02$, $p=0.89$).

3. Student Admissions Process

Regarding student evaluation and selection into programmes, four directors (66.7%) reported assessment of bicultural knowledge and practice, Te Tiriti and cultural competency/engagement through case scenarios or interview questions. For example, Director 3 emphasised '*looking for acknowledgment of the Treaty, commitment to social justice, equity, values congruent with the course, personal qualities, inclusion of whānau, the presentation, service-user experience*'. Director 4 added that interviews were '*conducted with appropriate consideration to Māori tikanga, manaakitanga and whakawhanaungatanga*'; however, they acknowledged '*room for improvement in our current interview protocol and are working toward establishing a selection process tikanga that is more resonant with Māori values*'.

There was a significant increase in programmes requiring applicants to demonstrate prior engagement with Māori culture compared with Nathan (1999) (66.7% vs. 0%, $\chi^2(1)=4.77$, $p<.05$). Two programmes (33.5%) did not explicitly require evidence of Māori perspectives but noted that '*diversity and cultural competency were valued in the evaluation of applications*' (Director 2), or '*we do not have a particular requirement regarding te reo or other classes, but we encourage that*' (Director 3).

Factors that contributed to the decision-making process, which were ranked by directors on a scale from 1 (highest influence) to 5 (lowest influence), included: commitment to Te Tiriti ($\bar{X}=2.33$), academic performance (e.g. grade point average, quality of thesis) ($\bar{X}=2.83$), interview performance ($\bar{X}=3.17$), previous work experience and community engagement ($\bar{X}=3.33$) and whakapapa Māori identification ($\bar{X}=3.33$).

Selection interviews. Three programme directors (50%) reported specific questions related to tikanga and mātauranga Māori, including: the relevance of Te Tiriti to psychological practice; distinctions between Māori and Pākehā approaches to mental health; knowledge of working with Māori; knowledge of te reo Māori; and knowledge of Māori health models. All directors reported that all Māori applicants were informed of the eligibility to bring whānau support to interviews. Four directors (66.7%) reported that

applicants were informed in advance via phone/mail/email, and two directors (33.3%) clarified that all applicants were offered the option of whānau support, irrespective of ethnicity. The proportion of programmes encouraging Māori applicants to bring whānau support to the interview had not changed significantly from 1999 (100% vs. 80.0%, $\chi^2(1)=1.20$, $p=.27$).

The findings indicated there was improvement in the importance placed on Māori perspectives in the student selection process. Four directors (66.7%) reported that evidence of knowledge of mātauranga Māori and cultural diversity was required, with specific assessment of Te Tiriti, bicultural knowledge and practice, and cultural competency or awareness. In addition, three directors (50%) explicitly reported the incorporation of tikanga Māori in the interview process (e.g. mihi whakatau, karakia), and all six directors acknowledged the importance of cultural diversity. Furthermore, all directors reported that the opportunity to bring whānau support to the interview was offered to applicants. Relative to previous studies, the findings from the present study indicated increased recognition of the value of Māori perspectives in clinical psychology training.

Representation on selection panel. Relative to Nathan (1999), where 60.0% of clinical programmes were reported to have Māori representation on the selection panel, five directors (83.3%) in the present study explicitly stated they ‘always’ ensured Māori representation on the selection panel, irrespective of applicant ethnicity ($\chi^2(1)=0.678$, $p=.41$). Although Director 2 did not explicitly state ‘always’ having Māori representation on the panel, they noted that consultation ‘*with the Associate Dean Māori on every Māori application and a Māori clinical psychology academic staff member is also involved in the discussion of each applicant and meets with them even if this person is not on the selection panel that particular year*’.

4. Programme Students

Tauira Māori. [Table 2](#) compares enrolment and completion numbers of tauira Māori in clinical psychology training between the two timepoints (1995–1999 and 2020–2021). Although a direct comparison was hindered by the different timeframes, it is reasonable to infer that the enrolment of tauira Māori in clinical psychology increased since 1999. However, the completion rate among tauira Māori in 2021 remained relatively low, which raises concerns about supporting the needs and aspirations of tauira Māori and meeting the mental healthcare needs of Māori clients (NSCBI et al., 2018).

Directors were asked whether the annual intake of Māori clinical psychology students was adequate in terms of application to programmes, acceptance into programmes and graduation from programmes. The annual number of Māori applicants was considered adequate ‘to some extent’ by 50% of directors ($n=3$), and 50% of directors ($n=3$) indicated that it was ‘not at all’

Table 2.

Number of taurira Māori in clinical psychology training

	1995–1999 (Nathan, 1999)	2020–2021 (Ministry of Education) ^a
Number of taurira Māori enrolled	24	80
Number of taurira Māori completed	15	20

Note: ^aData obtained through an official information request from the Ministry of Education.

adequate. The annual number of taurira Māori accepted into programmes was considered adequate 'to some extent' by 66.7% of directors ($n=4$), and 'not at all' adequate by 33.3% of directors ($n=2$). The annual number of Māori graduates from programmes was considered 'absolutely' adequate by 16.7% of directors ($n=1$), adequate 'to some extent' by 50% of directors ($n=3$) and 'not at all' adequate by 33.3% of directors ($n=2$). There was no statistically significant difference when comparing the proportion of directors expressing concerns for the number of taurira Māori in the programme between the two time points (50% vs. 80%, $\chi^2(1)=0.96$, $p=.33$).

All directors were asked to elaborate on answers given regarding the annual intake of taurira Māori. Among directors who indicated that intake numbers were adequate (i.e. 50%, $n=3$), reasons given included: being content with the increasing number of taurira Māori; current numbers of taurira Māori being representative of the university and region; and having a higher proportion of taurira Māori in recent cohorts than in the general population. However, the need for Māori representation in psychology was acknowledged. Director 1 noted an '*aspiration for half our taurira to be Māori*', and Director 2 noted that '*there are decades of neglect of Māori representation in the workforce that we need to combat, so even higher proportion than what is population representative will take a long time before we have an acceptable representation of Māori in clinical psychology practice*'.

Directors who indicated that the annual intake of taurira Māori was 'not at all adequate' (i.e. 50%, $n=3$) attributed this to the low number of Māori applicants and subsequent intake into programmes. However, these directors highlighted that Māori applicants were prioritised for selection given acceptance thresholds were met. All three directors reported steps taken (or that could be taken) to address the low numbers of taurira Māori in programmes. Actions included: active recruitment of Māori staff; active promotion of psychology training programmes for Māori students; attempts to make selection process culturally responsive for Māori students; scholarship programmes; and incorporation of Māori-focused content into psychology papers. Director 4 also highlighted policy development to formalise commitment to biculturalism and supportive environments for taurira Māori.

5. Programme Content

Incorporation of Kaupapa Māori content. Kaupapa Māori psychology is grounded in Māori philosophies and epistemologies. Participating directors were asked to rate the extent Kaupapa Māori was required in clinical practice on a scale from 1 (not important at all) to 5 (extremely important). The mean score across programmes was 4.17 ± 0.75 , with 33% ($n=2$) of programme directors rating this as extremely important, 50% ($n=3$) as very important and 16.7% ($n=1$) as moderately important. All programme directors (100%, $n=6$) reported that content related to Kaupapa Māori psychology was incorporated through Māori input into the delivery of training programmes, guest lecturers and workshops. Other modes included consultation with Māori staff or Māori departments in the university (83.3%, $n=5$), visits to Māori health services (66.7%, $n=4$), visits to marae (66.7%, $n=4$), consultation with Māori advisory boards (50.0%, $n=3$) and consultation with kaumatua (33.3%, $n=2$). Directors elaborated on initiatives taken to incorporate Māori perspectives, which included Māori health frameworks and models (83.3%, $n=5$), tikanga Māori embedded in programme processes such as staff hui, student selection interviews (66.7%, $n=4$), staff professional development and training (50%, $n=3$), placement or internship opportunity at Kaupapa Māori mental health services (33.3%, $n=2$), monthly Kaupapa Māori cultural supervision for interns (16.7%, $n=1$), specific examination focused on working with Māori (16.7%, $n=1$) and a space for tauira Māori (16.7%, $n=1$). Across the programmes, directors indicated that 10%–35% of the curriculum comprised content related to Kaupapa Māori psychology (*mode* = 20%). Directors rated how much more or less time should be dedicated to Kaupapa Māori content within training on a scale from 1 (much more) to 5 (much less). The mean score across programmes was 1.83 ± 0.75 , with 33.3% ($n=2$) indicating much more content related to Kaupapa Māori psychology was needed, 50% ($n=3$) indicating slightly more and 16.7% ($n=1$) indicating about the same. Three programme directors (50%) reported that Kaupapa Māori psychology content was not incorporated well into the training curriculum. Reasons provided included: no funding support (Director 6); no support from school/department/faculty on new teaching endeavours (Director 5); and student workload being full of other clinical training requirements, limited Māori staff available for consultation, and not having relationships with Māori organisations (Director 2).

Facilitators and barriers to incorporating Māori perspectives into programmes. Participating directors were surveyed on factors influencing the incorporation of Māori perspectives into programmes. Support was identified as the most prominent facilitator, which included institutional support from the wider department/faculty and university, support from both Māori staff and graduates of the programme and collaboration with other clinical training programmes. Policies and initiatives were also identified to facilitate this process. For example, Director 4 highlighted that it was important ‘for

all staff to be committed to bicultural practice and we are in the process of developing a strategic plan to formalise that commitment and expectation', whereas Director 1 noted initiatives to increase staffing and incorporate tikanga into the wider department. The normalisation of Māori perspectives was identified, including marae on campus, noho marae and wānanga, and incorporating tikanga and reo into the faculty. For example, Director 4 noted, *'staff are important models for students. Incorporating tikanga and te reo means it is a core part of our usual business that students become familiar with and competent in'*.

The two most prominent barriers highlighted by directors were the lack of funding and organisational constraints. Financial restrictions were reported to limit funding available for new positions and Māori involvement in programmes, and impede programme growth and progress. Organisational constraints identified as barriers included poor decision-making models, online teaching because of COVID-19 and cultural labour placed on the limited Māori staff available. As Director 4 noted, *'university structures require cultural consultation on all ethics applications which puts a lot of pressure on Māori staff, often to work within very tight timeframes and juggle their existing significant workloads'*.

External contracts with Māori educational organisations. Directors were asked about their views on the possibility of contracting out parts of their programme to Māori educational organisations, such as Te Wānanga o Aotearoa or other Māori institutes of learning. All directors appeared to be open to contracting out aspects of the programme, citing support for pathways that would improve cultural competencies of students and programmes, and seeing the benefits to the contributions by Māori institutes of learning. However, some directors cited caveats such as funding and structural constraints within universities, the need to build capacity within the institutions and suitability of external programmes.

Discussion

Our findings highlighted the increased recognition of the value Māori perspectives contribute to clinical psychology relative to two decades ago, as evidenced by actions taken to increase Māori staff and student numbers, and Māori-focused content. However, given that only 20% of Kaupapa Māori content (on average) was integrated into the curriculum and the insufficient representation of Māori staff and students, there are concerns about the cultural competency of the clinical psychology workforce and whether the workforce is equipped to adequately meet the mental health aspirations of Māori.

The present findings indicated that despite being expected across all programmes, knowledge and understanding of Te Tiriti were not explicit requirements for staff recruitment or actively included in staff development across some programmes. The minimal expectation that programme staff

have an 'openness to learning' mātauranga Māori remains insufficient to address the Eurocentric dominance in clinical psychology and the critical awareness needed to understand the culturally bound nature of the discipline and historical positioning within colonial ideologies (Cullen et al., 2020; Pomare et al., 2021). Meeting Te Tiriti aspirations requires collective responsibility and effort from Pākehā and tauīwi (non-Māori) in programmes. Consistent with previous research (Abbott & Durie, 1987; Levy, 2002; Nathan, 1999; Waitoki et al., 2024), the limited capacity of programmes to be responsive to Māori is perpetuated by the continual cycle of insufficient representation of Māori. The bicultural requirements of programmes were reported to fall disproportionately to Māori staff, placing pressure on the small pool of Māori staff to fulfil multiple roles, including cultural advisors and teachers, leading cultural education, supervision, mentorship, creating and maintaining safe environments and advocating for structural change. The additional demands and cultural labour placed on Māori diverts time spent progressing the development of Kaupapa Māori psychologies and the professional development of Māori staff (Levy, 2002; Nathan, 1999). As not all programmes required prerequisite knowledge of Te Tiriti and Kaupapa Māori psychology before programme entry, the burden of cultural labour may also fall on tauira Māori to educate classmates (Johnson et al., 2021), highlighting the need for Pākehā and tauīwi to take responsibility for their learning and engagement in culturally responsive practice.

Although some directors acknowledged the increased demands placed on existing Māori staff, such as educating Pākehā and tauīwi staff regarding Māori perspectives and acting as cultural advisors for tauira Māori, there was a noticeable absence of concerted efforts and initiatives aimed to address the uncritical imposition of Western assumptions and epistemologies. Nathan (1999) noted that prerequisite knowledge of non-clinical mātauranga Māori before clinical psychology training could alleviate the pressure placed on programmes and reduce the cultural labour placed on Māori staff and students, allowing for the development of foundational knowledge with specific relevance to clinical practice and working with whaiora Māori, while also addressing challenges in determining the appropriate level at which to convey information to students. The engagement and retention of Māori staff and tauira is crucial given the demands placed on Māori staff because of insufficient representation of Māori clinical psychologists.

Programme directors reported varying degrees of links to a Māori advisory body, with one programme lacking formal relationships. Little change had occurred over the past two decades relative to Nathan's (1999) study, raising concerns regarding the meaningful commitment of programmes to pursue Māori-led solutions for addressing the Eurocentric dominance and need for culturally responsive training. Additional concerns arose regarding the tokenistic inclusion of Māori staff to fulfil bicultural programme

requirements and the extent of Māori participation and exercising tino rangatiratanga (Levy, 2002; Nathan, 1999). When outsourcing programme components to Māori organisations or institutions of learning, it is imperative that relationships are guided by Te Tiriti and facilitate meaningful participation of Māori with respect to kāwanatanga, tino rangatiratanga and mana ōrite (Jackson & Mutu, 2016). However, the option to outsource should not replace active efforts to advance the growth of the Māori clinical psychology workforce.

Structural changes informed by Te Tiriti are crucial to address concerns outlined in this paper. Immediate actions to increase the meaningful participation of tauira Māori and staff include addressing the academic pipeline and representation of Māori staff (Naepi et al., 2019), increasing Māori-focused content and employing Māori with expertise in mātauranga Māori (Waitoki et al., 2023), normalising tikanga Māori and values (Johnson et al., 2021) and implementing affirmative action policies (Barham et al., 2023). Adopting He Awa Whiria can create a culturally informed approach to clinical psychology by combining the strengths of Western and Kaupapa Māori knowledge streams (Macfarlane & Macfarlane, 2018). Compulsory training in Kaupapa Māori approaches, such as the Hui Process/Meihana model (Pitama et al., 2017), Pae Tata Pae Tawhiti (McLachlan & Waitoki, 2024), Mahi a Atua (Rangihuna et al., 2018) and Te Tiriti-informed training are essential for programme staff and key stakeholders (e.g. New Zealand Psychology Board members) as active leadership can better support the collective effort required to meet Te Tiriti obligations.

Promisingly, recent findings indicate increased importance placed on Māori perspectives and increased efforts to address the insufficient representation of staff, students and content in programmes relative to Nathan (1999). Increasing visibility through Māori-focused content, student representation and employment of Māori with expertise in mātauranga Māori can contribute to creating culturally safe and responsive learning environments that Māori are more inclined to engage with (Levy, 2002; Waitoki et al., 2023). Positive attitudes towards the value Māori perspectives contribute to the discipline and the steps taken to reflect this provide hope that Te Tiriti aspirations can be achieved.

Conclusion

Cultural responsiveness towards Māori in clinical psychology programmes has improved relative to two decades ago, indicated by actions taken to increase Māori staff and student numbers and Māori-focused content. However, a shortage of Māori staff persists, despite efforts made to address this through the active recruitment of Māori staff, culturally responsive recruitment processes and pathways to support the development of Māori staff. Most programmes also reported established links to a Māori advisory body. These findings highlight persistent concerns regarding ethnocentrism,

and the insufficient representation of Māori in clinical psychology remains a pressing issue. Collective responsibility is required from programme staff and wider faculty to facilitate the growth of the Māori psychology workforce, including measures to support culturally responsive training that upholds Te Tiriti obligations, amplifies Māori perspectives and creates an educational environment that supports the retention (and completion) rate of Māori staff and students.

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