Show: Health Decoded: Complex Research Simple Explanations
Hosts: Olivia and Elijah

Episode: Bridging Cultures in Mental Health Access

INTRODUCTION

Elijah: Hey, everyone. Welcome to Health Decoded, where we take complex health research and try to make it... not so complicated. I'm Elijah, speaking from Atlanta, and as always, I'm joined by my co-host, Olivia.

Olivia: Hey y'all! I'm Olivia, coming to you from Miami. We're here to dig into how language and culture really shape who gets access to care and services—and who ends up left out.

Elijah: That's right. Today we're exploring an article with quite a title—it's called "Hopefully You've Landed the Waka on the Shore." It's all about the negotiated spaces in New Zealand's so-called bicultural mental health system. We'll break down what's working or not, and see what lessons cross over to the US.

Olivia: Yeah, and for those listening who are like, "what's a waka?"—think of it as this symbol of journey and arrival, but, you know, it's also this metaphor for how different cultures are trying to land together in the same health system.

Elijah: We're gonna unpack barriers and talk real-world impact. Alright, let's push off, shall we?

BEYOND MONOCULTURALISM: BICULTURAL MENTAL HEALTH IN NEW ZEALAND

Olivia: So, Elijah, I love how this article dives right into what it means for a country to try and actually structure its mental health system around two cultures instead of one. In New Zealand, that's Māori—the Indigenous people—and Pākehā, or people of European descent.

Elijah: Yeah, and they're not just saying, "Let's respect both heritages." There's this whole legal and ethical framework because of the Treaty of Waitangi, which, in theory, makes Māori and Pākehā partners. The reality, though? Still a lot of dominance from Western—basically mainstream Euro-American—models. Māori perspectives often get lip service, but not real power.

Olivia: Exactly, it's like, on the surface, there are cultural symbols, some language use, but when you scratch beneath, mental health care is still mostly designed for white, Western views of what health even looks like. Real Māori approaches? Barely get space beyond token gestures.

Elijah: It reminds me of this phrase the article uses: "superficial engagement." It's like having Indigenous symbolism with no real shift in how care is done. That's a problem if you want a system that's genuinely

just and effective for everyone. I mean, if the system never changes its foundation, it's always going to be more comfortable for one group over the other, right?

Olivia: And that's the heart of it—if you only "include" Indigenous ways at the surface, you're not actually addressing power or making space for different forms of healing or justice. So, these negotiated spaces are where the real work has to happen. Should we talk about what the researchers actually did in the study?

Olivia: Alright, let's break down their approach. The lead author, Jordan, spent a year working with Māori and Pasifika health orgs. She started with a qualitative framework... appropriate given the depth and subjectivity of the topic. Specifically, Jordan employed a critical-interactionist ethnography. This is a methodology that explicitly sets out to critique the asymmetrical power relations that exist within cultural and social arenas.

Elijah: Yeah, and instead of just interviews, she used what's called "korero mai"—these unstructured, really relational narrative interviews, which are super important in Māori research ethics. She interviewed 30 mental health providers: Māori, Pākehā, Samoan, Tauiwi—so a lot of different worldviews. With all that data, she did this "situational mapping"—basically, it's like creating a visual map of all the ways people negotiate or push back in the mental health system.

Olivia: Right, and what she came up with was five strategies, or positions, of negotiation. They sound kinda abstract, but actually, you see these everywhere. So, first, opposition—where the Western frameworks undermine or outright dismiss Indigenous healing methods, saying "that's not real science." Essentially, it's that 'we know better' attitude.

Elijah: Then there's resistance— this is about pushing back against the dominance of Western frameworks. It's standing firm in the face of pressure and advocating for Indigenous methods of healing. Many Māori practitioners take on this role as kaitiaki—guardians, claiming space in the system.

Elijah: Assimilation is another one: Indigenous workers and practices kind of get swallowed up by the mainstream system, so even when someone's Māori, they end up doing things the "Western" way just to survive in the job. It's like they're working with their hands tied. It sounds frustrating and, honestly, isolating for many practitioners.

Olivia: Yeah... and it sounds like maneuvering can actually be just as insidious. It often involves tokenizing Indigenous practices. You know, surface-level gestures—like using Māori language or rituals—not to create meaningful change but to tick a box or meet funding criteria. One participant in the study described it as "window dressing."

Olivia: And finally, actual collaboration, where the hard work of truly sharing power happens. People build those bridges, translate not just language but meaning, develop mutual respect. But, as the article notes, that's pretty rare and comes with a lot of discomfort for everyone involved.

Elijah: Yeah, it sounds like most negotiation sits closer to Western comfort zones. The waka faces a tough journey.

Elijah: And honestly, while the context is different, there are striking similarities. In the U.S., we may not have formal bicultural policies like Aotearoa does, but many of the challenges we face in mental health care—especially for marginalized communities—exist here too.

CONNECTING TO A US AUDIENCE

Elijah: And reading this made me think about my own work trying to diversify the mental health workforce here. We talk about inclusion a lot. But, often, it's more about appearances, hiring people from different backgrounds but expecting them to fit the same old mold.

Olivia: Yeah...It reminds me of something you've spoken about before—tokenism.

Elijah: Exactly. Both groups are often hired to check a diversity box, Olivia. My research shows parallels—like how Black therapists might feel pressured to assimilate into White systems. The same is true for Māori practitioners, who are pushed into roles that dilute their significance.

Ah, I see. And surely that kills authenticity for both, right? They're not there just to fill quotas. It feels like a move toward "integration," but all it does is diminish participation, create friction, and honestly, make people feel like their identities don't count.

Elijah: It plays out across systems—not just hospitals, but courts, schools, voting booths. And just like in New Zealand, this kind of exclusion disproportionately affects communities already facing health disparities.

Olivia: So, if we know these obstacles, what do we actually do to move toward real inclusivity, beyond just having a diverse staff on paper?

TOWARDS CULTURALLY COMPETENT AND INCLUSIVE CARE

I think, for me, one thing that comes up is the actual recommendations from organizations like NAMI. It's stuff like following national CLAS standards for language access, so people understand their care—all documents and services in a patient's language, not just English. It's about recruiting and retaining diverse, bilingual staff who don't just match the population, but actually stick around long enough to change the climate.

Elijah: And there's the cultural competence piece—where everyone from the front desk to the therapists has ongoing training, not just a one-off workshop. It helps with trust. Studies show—well, the APA and the US Surgeon General have both pointed out—when you don't address cultural factors, not only do people avoid seeking help, but when they do, they might not even get the right diagnosis. Folks might say, "my heart hurts," or talk about dizziness instead of "depression." Clinicians can miss the root cause completely if they're not tuned in.

Olivia: Exactly. There's also how stigma operates—it's more than just social embarrassment. For some Latino and African American communities, there's this added layer: mental health is "private family business" or "potentially very socially damaging," so people might go to clergy, family, or friends before ever considering a mental health clinic. That means clinics can't just sit back waiting; they've got to partner with community leaders and meet folks where they're actually comfortable.

Elijah: That's similar to resistance and collaboration from the New Zealand study, right? Where community empowerment and self-determination are front and center. We need more of that—supporting peer-led groups, building real partnerships, making sure resources reflect cultural needs, not just translation but meaningful context.

Olivia: I totally agree. And honestly, living abroad made me appreciate that this isn't out of reach. In Amsterdam, for instance, language access is just standard—you can walk into a clinic and get help in Turkish, Arabic, whatever. It helps immigrants feel like they belong, instead of being outsiders just because they can't fill out a form. I wonder if places like New Zealand and the U.S. might be able to take a lesson from Amsterdam, it feels like they are getting it right.

Elijah: If we could build in those supports here, not as an add-on, but as a core part of care, we'd see much more trust—and better outcomes. It shifts from checking a box to actually creating equity. That's what I hope we take away from both these cases.

CONCLUSION

Olivia: So, we covered a lot—everything from bicultural negotiation in New Zealand to language and inclusion battles here in the US. For me, the big takeaway is that it isn't enough to just say we value different cultures. We need real, deep, sometimes uncomfortable change—in ourselves, our organizations, and in the systems around us.

Elijah: Yeah, and if you're listening, we hope you'll think on how you can invite more biculturalism or multiculturalism into your day-to-day, whether that's asking for those language services, seeking out providers who get your experience, or advocating for change where you see gaps.

Olivia: Thanks for being on this journey with us—whether your waka's already landed or you're still paddling, we're glad you're here. Elijah, as always, it's a pleasure.

Elijah: Always a pleasure, Olivia. Take care, everyone. Catch us next time on Health Decoded, where we'll break down more research you can actually use. Bye!

Olivia: See y'all next episode. Stay curious!