TE TIRITI PARTNERSHIP: ON THE GROUND ACTIONS FOR CLINICIANS

Te Ao Marama Apiata

Cate Grace

Rachelle Martin

Ha-I-Mano

Whakarongo, whakarongo, whakarongo

Whakarongo ki te Ha-I-Mano e karanga nei

Tui, tui, tui, tuia

Tuia ki runga, tuia ki raro, tuia ki waho, tuia ki roto

Tuia ki te here tangata

Tīhei uriui, tīhei nakonako, tīhei mauri ora

Tūturu whakamaua ki tina. Tina!

Haumi e, hui e, Tāki e.

Te Tiriti Partnership: On the ground Actions for Clinicians

What is an Alliedship statement, What is yours?

What is partnership from a clinical perspective, what is froma tāngata whaikaha perspective?

Who's table are we sitting at?

What might cultural competency mean to the system, to you or your tangata whaikaha?

What is you responsibility to Te Tiriti o Waitangi, what is the role of Tāngata / Mana whenua?

What is your understanding of the why?

What has been the outcome of Te Tiriti o Waitangi

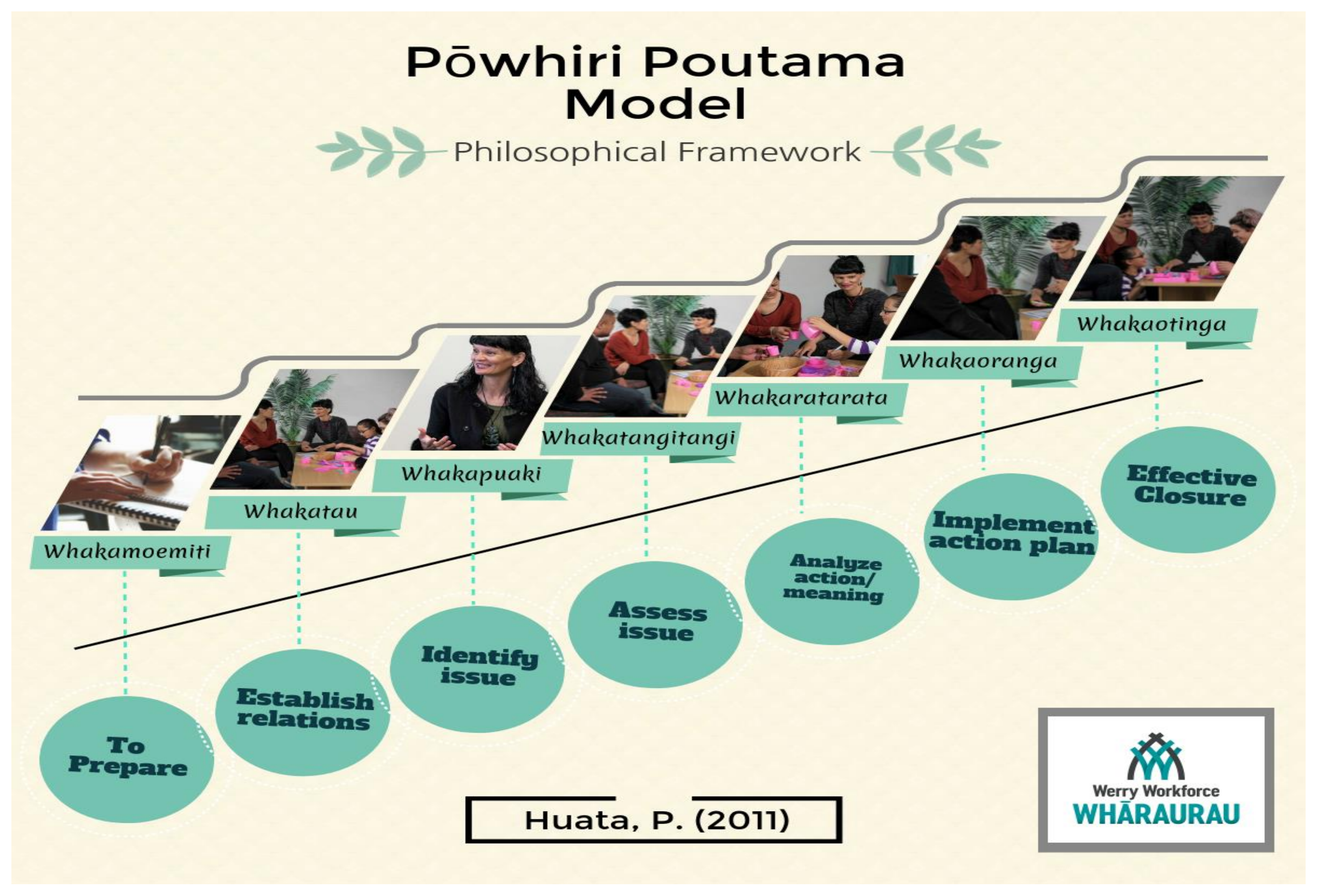
What tools have we at hand that supports Mana Motuhake?

How do you apply them?

Tirohanga Māori ways of being

- Powhiri Model
- Meihana Model
- Te Wheke
- Te Whare Tapa Wha
- Hui Process
- Manaakitanga
- Whakawhanaungatanga
- Whakapapa
- Whānau
- Kawa & Tikanga

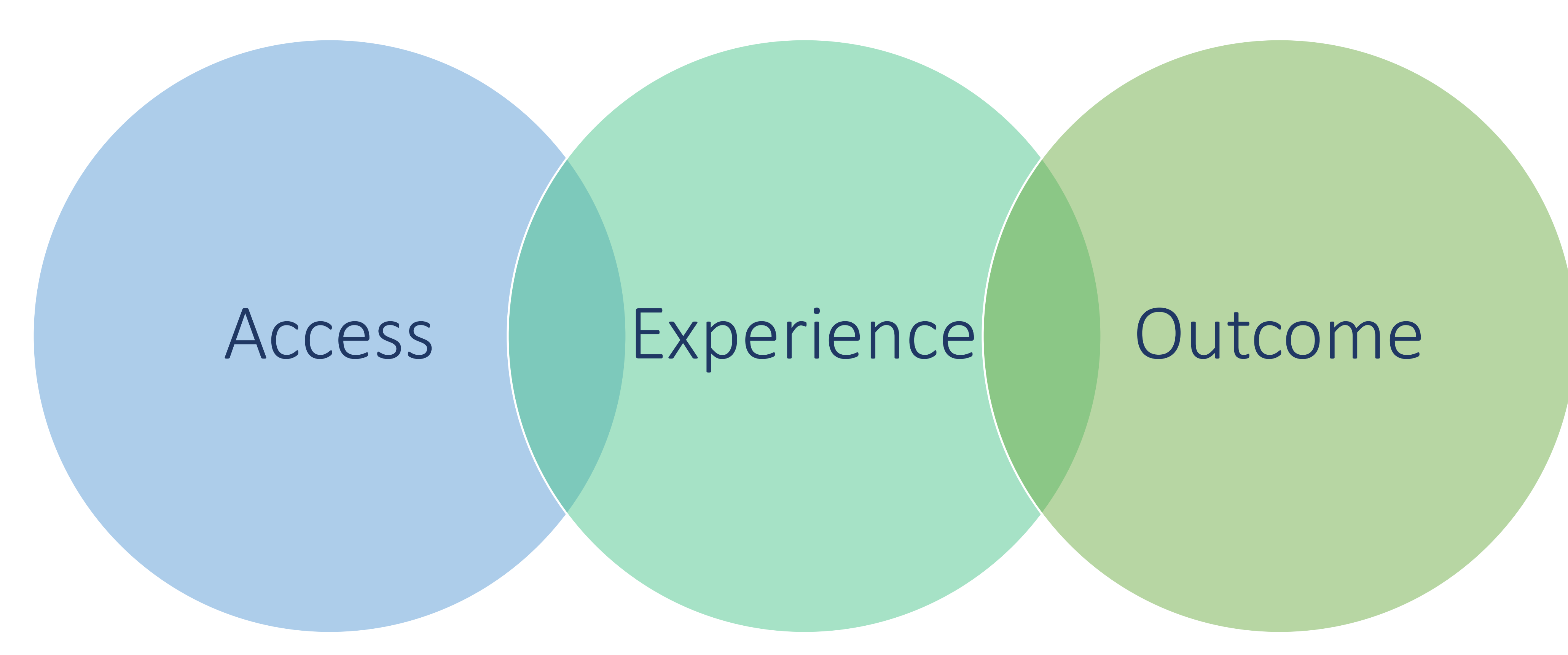
Powhiri Model of engagement



He waka
eke noa

ACHIEVING EQUITY IN HEALTH
A Pākehā health care providers perspective
RACHELLE MARTIN

ACHIEVING EQUITY IN….



QUESTIONS TO CONSIDER

HOW BIG IS THE GAP?

WHAT IS CONTRIBUTING TO THE GAP?

WHAT STEPS CAN I TAKE TO REDUCE THE GAP?

HOW BIG IS THE GAP?

The degree of inequity of access, experience or outcome

THE GENERAL

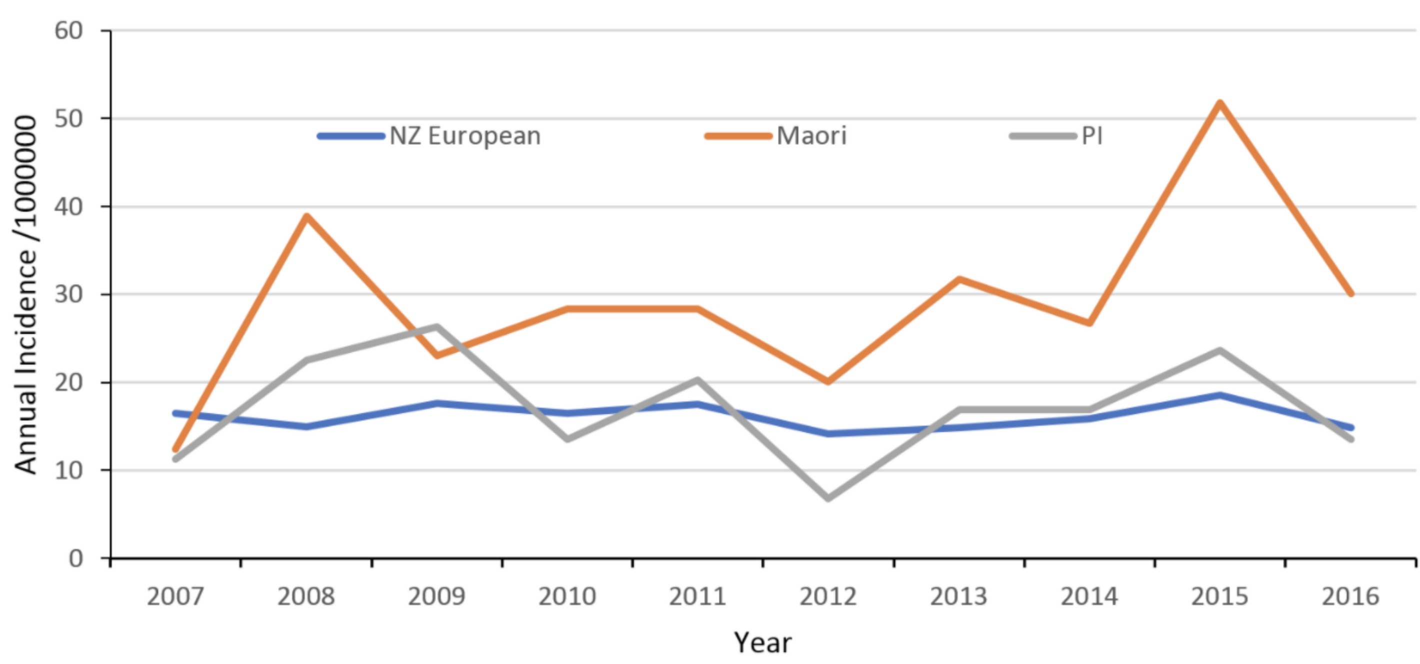
In 2013, an estimated 24% of New Zealanders reported experiencing disability > increase to 27% by 2038.

Māori have higher age-adjusted rates of disability (32%) than non-Maori (24%).

Strong evidence demonstrating inequity of outcome, unmet need and difficulty accessing health-optimising systems and services for tāngata whaikaha, and particularly Māori, within NZ.

THE SPECIFIC

Figure 4: Traumatic spinal cord injury (TSCI) rates by ethnicity.



https://www.nzma.org.nz/journal-articles/epidemiology-of-traumatic-spinal-cord-injury-in-new-zealand-2007-2016

Prevalence and predictors of disability for Māori 24 months after injury

Emma H. Wyeth,[1] Ari Samaranayaka,[2] Gabrielle Davie,[3] Sarah Derrett[3]

Māori (New Zealand's indigenous population) make up 15% of the New Zealand (NZ) population.[1] As with other indigenous populations, Māori experience considerable health disparities compared to non-indigenous populations.[2-6] Injury and disability for Māori are no exceptions.[7-10] For example, Māori aged 15–64 years have more than double the mortality risk and more than 1.5 times the risk of hospitalisation due to unintentional injuries, compared to non-Māori the same age.[7] Additionally, Māori experience at least twice the rate of estimated health-related loss (measured in disability-adjusted life years; DALYs) due to injury compared to non-Māori.[8]

After adjusting for age, Māori have higher rates of disability (32%) than NZ Europeans (24%).[9,10] Māori aged 15 years and over experience higher rates of disability after injury than non-Māori. For Māori aged 15–64 years, injury is the second leading cause of disability[11] and is responsible for disability for ~33% of disabled Māori.[10] Despite these considerable disparities, there is little published research specifically investigating

Abstract

Objective: To investigate post-injury disability prevalence and identify pre-injury and injury-related predictors 24 months post-injury among Māori Prospective Outcomes of Injury Study participants.

Methods: Participants were recruited from New Zealand's no-fault injury insurer. Pre-injury and injury-related characteristic information was obtained from participants at three and 24 months post-injury. The World Health Organization Disability Assessment Schedule was used to measure disability. Multivariable models were developed to estimate relative risks of post-injury disability.

Results: Of 2,856 participants, 566 were Māori. Analyses were restricted to 374 Māori with pre-injury and 24-month post-injury disability data available. Pre-injury, 9% reported disability compared to 19% 24 months post-injury. Strong predictors of increased risk of disability 24 months post-injury were having ≥2 chronic conditions pre-injury and having trouble accessing healthcare services after injury. Hospitalisation for injury and having inadequate pre-injury household income were other predictors.

Conclusions: Māori experience considerable disability 24 months post-injury. Pre-injury socio-demographic, health and psychosocial, and injury-related characteristics independently predict post-injury disability and provide focus for future research and interventions to improve Māori post-injury outcomes.

Implications for public health: Despite having had access to services, injured Māori experienced considerable long-term disability. Pre-injury and injury-related factors predict long-term disability and should be the focus to reduce the post-injury disability burden for Māori.

Key words: Māori, injury outcomes, disability

- Hospitalised groups experiencing disability at 24 months
  - 26% of Māori
  - 10% of non- Māori.

WHY IS THERE A GAP?

Our study found cervical injuries were more common in Pacific Islanders (76%) and Māori (61%) compared to New Zealand Europeans (50%). The higher incidence of cervical TSCI may be due to anatomical differences in the spine, with Māori having 1mm and Pacific Islanders having 2mm smaller cervical canal than New Zealand Europeans.[20]

One key finding of the study was that rates of TSCI in Māori were 1.8 times greater than New Zealand Europeans and increasing at a faster rate than both New Zealand Europeans and Pacific Islanders. Further work is needed to understand the basis for this disproportionate representation in Māori, given Pacific Islanders have a lower rate of injury despite also having smaller cervical canals than New Zealand Europeans.

PUBLIC HEALTH 176 (2019) 118–127

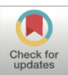
Available online at www.sciencedirect.com

Public Health

journal homepage: www.elsevier.com/puhe

Themed Paper – Original Research

Understanding longer-term disability outcomes for Māori and non-Māori after hospitalisation for injury: results from a longitudinal cohort study



E.H. Wyeth [a,*], A. Samaranayaka [b], M. Lambert [a], M. Tapsell [a], D. Anselm [c], P. Ellison [d], M. Harwood [e], B. Metzger [f], T. Wright-Tawha [f], S. Derrett [g]

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Predictors of disability 24 months after injury:

- not working for pay (pre-injury socio-economic),
- experiencing disability before injury (pre-injury health-related)
- having trouble accessing healthcare services (health services-related) for injury.

NEW ZEALAND SPINAL CORD IMPAIRMENT ACTION PLAN (2014-2019)

FINAL EVALUATION REPORT

26 MARCH 2020

AUTHORS:

- DR RACHELLE MARTIN
- DR JO NUNNERLEY
- MATT ALDRIDGE
- DR JOHNNY BOURKE

FUTURE STRATEGIC DIRECTIONS

Equitable access to services

Inequity of access to SCI services is a key issue identified across all objectives and from all stakeholders.

- A strong reliance on self-advocacy following discharge from supra-regional services, and the 'hit and miss' presence of a navigator to support the persons/whānau journey through the systems over time (i.e. over the years) appears to be contributing to inequity of outcome. Establishing mechanisms to improve access to and navigation through services for those most at risk of poor health outcomes (i.e., those on MOH funding, Māori and those with dual-diagnoses) is recommended.
- It is recommended that consideration be given to developing resources and/or tools to empower the person with SCI (and their family/whānau) to more effectively advocate for themselves. The focus should be on facilitating communication (i.e., targeted to the specific needs of the person and provided at the right time) and increased transparency of information related to processes of care (i.e. at what point modifications are at, when assessments are due, who to contact for what issues) for the person with SCI.
- SCI service delivery organisations should consider service design adaptations they could make to ensure more equitable outcomes for individual people with SCI.

Palmer et al. International Journal for Equity in Health (2019) 18:163
https://doi.org/10.1186/s12939-019-1057-4

International Journal for Equity in Health

RESEARCH **Open Access**

Reported Māori consumer experiences of health systems and programs in qualitative research: a systematic review with meta-synthesis

Suetonia C. Palmer[1], Harriet Gray[2], Tania Huria[2], Cameron Lacey[2], Lutz Beckert[1] and Suzanne G. Pitama[2*]

Experiences of Māori of Aotearoa New Zealand's public health system: a systematic review of two decades of published qualitative research

Rebekah Graham,[1] Bridgette Masters-Awatere[1]

Abstract

Objective: This paper aims to synthesise the broader perspectives of Māori patients and their whānau (extended family, family group) of their treatment within the public health system. Our research question was 'What are the experiences of Māori in the public health and/or hospital system in Aotearoa New Zealand?'

Methods: A systematic search using PRISMA protocols and reflexive typology organised around the categories of Māori, public healthcare and qualitative research identified 14 papers that covered all three categories. We undertook a qualitative metasynthesis on these papers using a critical community psychology approach.

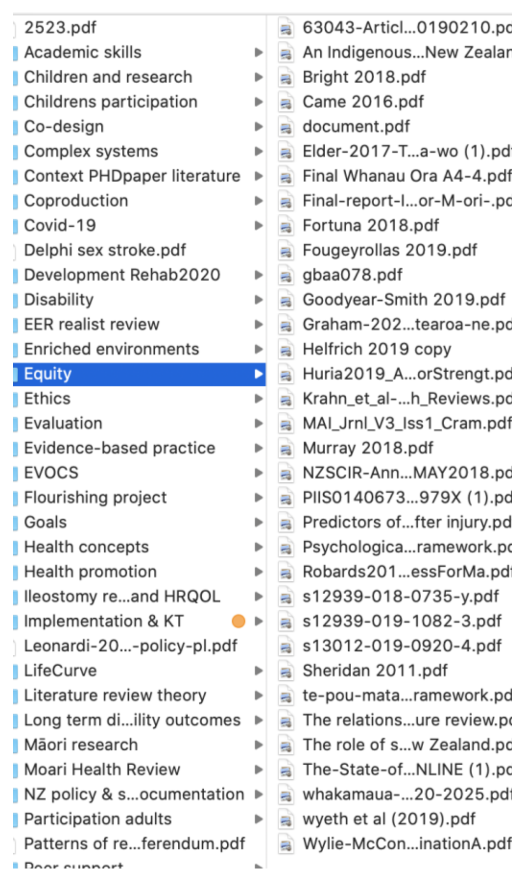
Results: Māori patients and whānau from the included papers mention both barriers and facilitators to health. We categorised barriers as organisational structures, staff interactions and practical considerations. Facilitators were categorised as the provision of whānau support in the form of practical assistance, emotional care and health system navigation.

Conclusions: For many Māori, the existing public health system is experienced as hostile and alienating. Whānau members provide support to mitigate this, but it comes as a cost to whānau.

Implications for public health: Public health providers must find ways to ensure that Māori consistently experience positive, high-quality healthcare interactions that support Māori ways of being.

Key words: Indigenous health, healthcare barriers, inequities, whānau, institutional racism

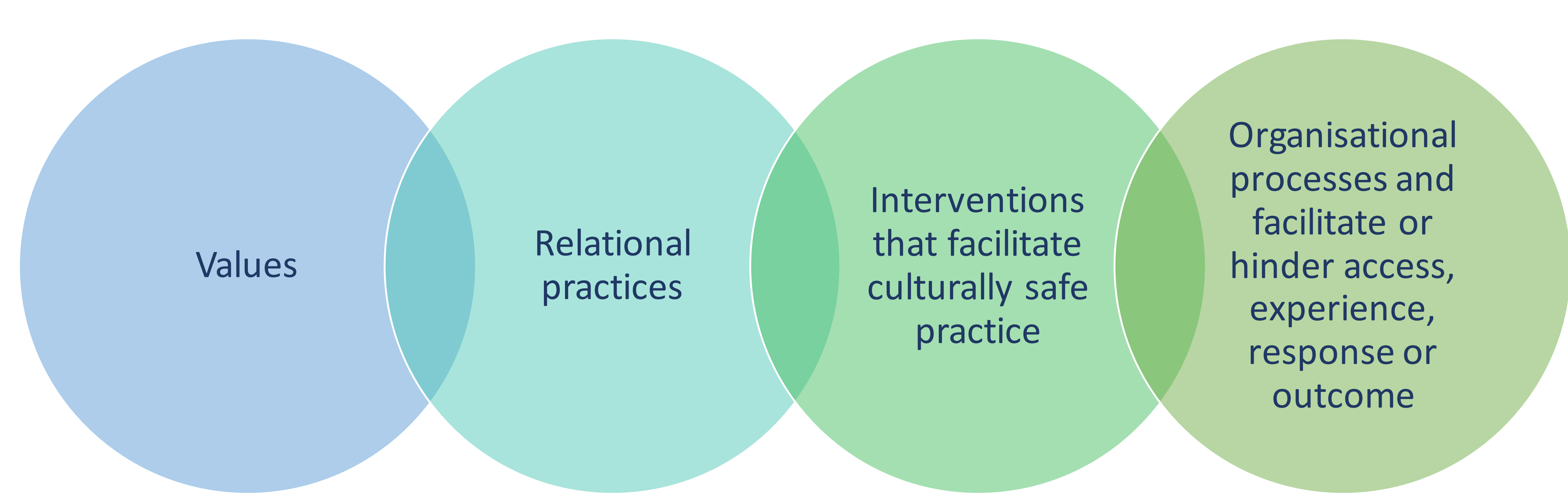
Aotearoa New Zealand's publicly funded, universal health system incorporates free inpatient and outpatient public hospital services, subsidies on prescription items, subsidised primary healthcare and a range of support services for people with disabilities in the community. However, this publicly funded health service is designed to privilege individualistic approaches, clinical discourses and acute need.[1] This form of service provision disadvantages Māori, the Indigenous people of Aotearoa New Zealand. Prior to colonisation, Māori had developed health structures and systems tailored to themselves, their environment and collective concepts of health.[2] Colonisation fundamentally disrupted these systems, with newly imposed health systems (including hospitals) configured primarily to serve Pākehā (New Zealanders of European descent).[3] Inequitable Māori healthcare outcomes are consistent with broader Indigenous



KEEPING TABS ON THE SIZE OF, AND CONTRIBUTORS TO, EQUITY GAPS THAT ARE RELEVANT TO MY PRACTICE

WHAT CAN I DO ABOUT THE GAP?

SYSTEM LEVELS TO CONSIDER

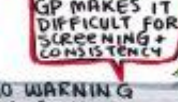


LISTEN
&
LEARN

The Power of Traditional Wellness: Indigenous Cancer Mapping

Legend: GAP =

Pre-Diagnosis



This is a Journey. Some people do it multiple times.

Fear of going to hospital prevents seeking care

Awareness of early screening is essential!

I had a gut feeling something was wrong

I had a dream I had cancer

Traditional Medicine: People in community provided immediate support

Not having a GP makes it difficult for screening + consistency

No walk-in clinics up north: have to use the ER

No warning signs: went to hospital for other issues — Discover cancer

Routine testing revealed cancer — Wait for Biopsy:

Initial assessment: "It's probably nothing." – Mis-diagnosis — Some have short wait... ...others have 2 month wait.

Sometimes takes multiple visits to GP before more tests ordered!

Fear: I didn't want to call

I had to call to complain about the wait!

Diagnosis

Trauma of diagnosis

How do I tell my family? They'll be upset!

Is this a death sentence?

What next?

Medical terms are hard to understand!

Waiting for next steps was difficult

No treatment other than Western medicine

BC Cancer is fragmented across rural BC

FNHA has a book on the journey

No info: Who are my doctors? Who is my team? No one could tell me!

Overarching Themes:

Power of prayer, traditional medicines, connection to land

We are strong warriors, and positive thinking is key

Maintain cultural sovereignty of clients you're serving

Family supports are essential: consistent person to attend appointments

"I'm sorry that's our policy" is frustrating

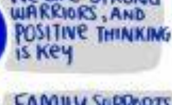
Nurse practitioner can fill the GP role

Our cultures aren't all the same

Aboriginal patient navigator

Resistance from Dr-s and specialists

The Power of Traditional Medicine



Ancestors, Sweats, Cold water, Prayer, The Land, Smudging, Food

Aboriginal nurse navigator helped bridge gap in nurses' awareness

Healing Room at Prince George used for smudging, drumming, gatherings

"I hid my traditional medicine from my doctors."

Treatment

Staff in hospital not always culturally aware...

...Better awareness in smaller communities

Support: There are no rural supports

Family, Online forums, Church

In BC it's hard to find support in general

Not all communities have internet

I had to go on E.I.

Financial: Family, Local fundraisers, Tight budget, Some nations have funds, Had to sell possessions

Generosity of community

Barriers to care cause stress

Non-insured health benefits: No support for traditional medicine

Not always clear how to access funds, especially between provinces!

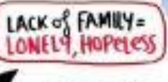
Travel

Being without family was hard when travelling for care

The challenge of weather + travel isn't always considered!

Canadian Cancer Society: cancer lodges have food (no traditional) and good access but no privacy

Nothing is sanitized on planes, ambulances – can make you sick!



We weren't fully informed about treatments, surgeries, options, or why things were happening

"I wasn't given a choice in treatment: 'You're having a masectamy'"

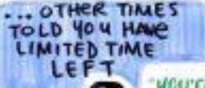
"You're having chemo"

Chemo was toxic and had terrible side effects

Sometimes treatments work...

...Other times told you have limited time left

"You're wrong – I'm not going anywhere!"



Telehealth allows you to see expressions

"Follow-up calls were so appreciated"

"Experienced positive care throughout my journey"

Pharmacists: source of info, often know funding available for medication

Next Chapter

Treatment has side-effects: physical, emotional; take time to heal

After care doesn't exist – have to support yourself

Lack of family = lonely, hopeless

I still don't fully understand my cancer

You'll be ok mom

Family is essential

No access to: counsellors, physio, group support in community

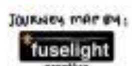
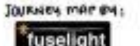
Churches can be a support

We need Indigenous groups

Recognize the burden they bear

The Journey continues... ...it never ends!

Communities are providing end-of-life care – they need support!

Journey map by: fuselight creative

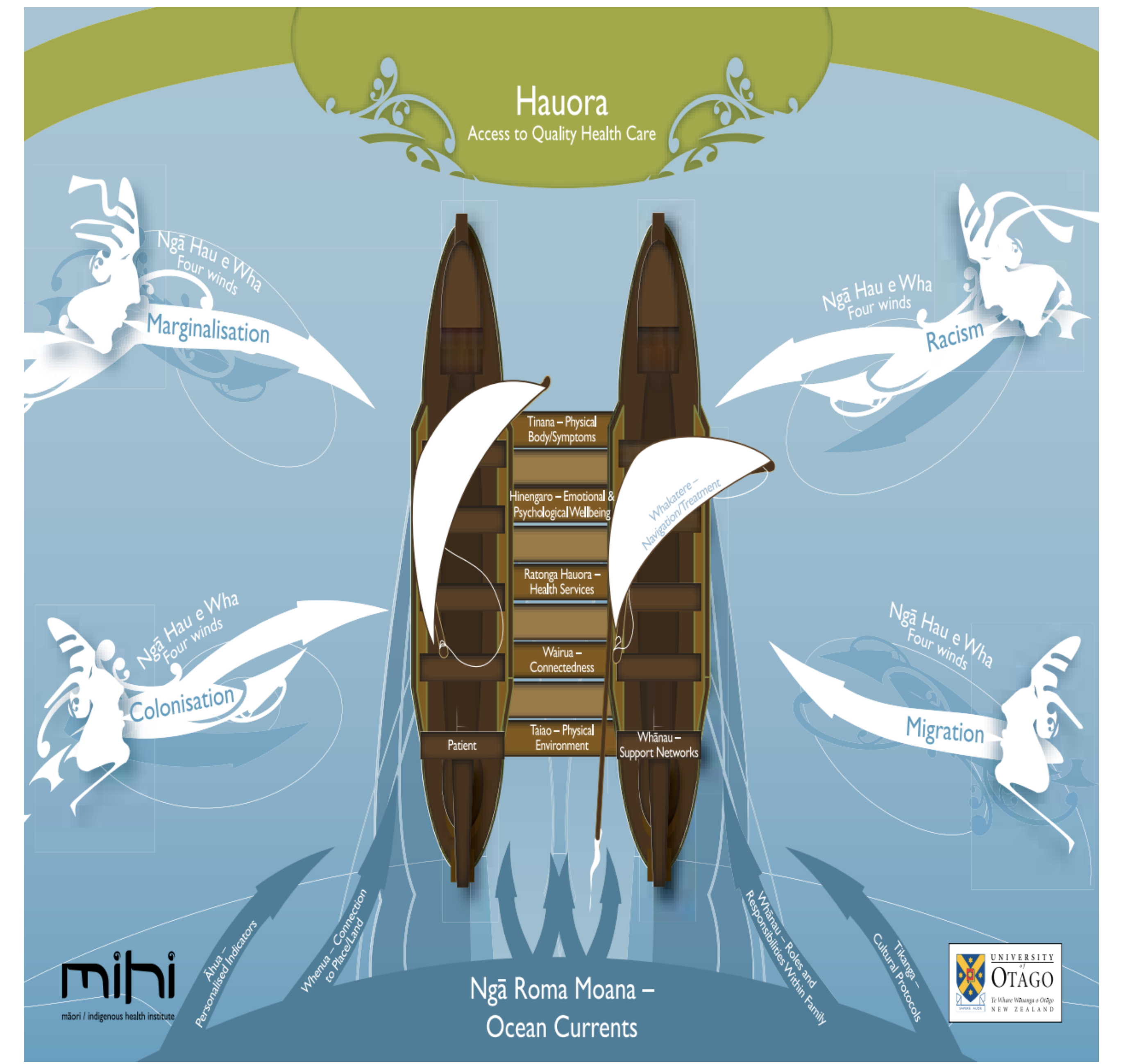
MANATŪ HAUORA
MINISTRY OF HEALTH

He Korowai Oranga

Whakamaua

Māori Health Action Plan

2020–2025


Hauora
Access to Quality Health Care
Ngā Hau e Wha
Four winds
Marginalisation
Ngā Hau e Wha
Four winds
Racism
Ngā Hau e Wha
Four winds
Colonisation
Ngā Hau e Wha
Four winds
Migration
Tinana – Physical Body/Symptoms
Hinengaro – Emotional & Psychological Wellbeing
Ratonga Hauora – Health Services
Wairua – Connectedness
Taiao – Physical Environment
Patient
Whānau – Support Networks
Whakatere – Navigation/Treatment
Āhua – Personalised Indicators
Whenua – Connection to Place/Land
Whānau – Roles and Responsibilities Within Family
Tikanga – Cultural Protocols
Ngā Roma Moana – Ocean Currents
mihi
māori / indigenous health institute
UNIVERSITY of OTAGO
Te Whare Wānanga o Otāgo
NEW ZEALAND

A proposed hauora Māori clinical guide for psychologists: Using the hui process and meihana model in clinical assessment and formulation

Suzanne G. Pitama[1], Simon T. Bennett[2], Waikaremoana Waitoki[3], Tracy N. Haitana[1], Hukarere Valentine[2], John Pahina[2], Joanne E. Taylor[2], Natasha Tassell-Matamua[2], Luke Rowe[2], Lutz Beckert[1], Suetonia C. Palmer[1], Tania M. Huria[1], Cameron J. Lacey[1] & Andre McLachlan[4]

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[3] *Waikato University,* [4] *Waikato Institute of Technology*
New Zealand

This paper documents a joint initiative of clinical practice educators from four tertiary institutions and their engagement in the design and development of a proposed Hauora Māori Clinical Guide for Psychologists, which outlines how to apply the Hui Process and Meihana Model to applied psychology. It describes the ability for this proposed Hauora Maori Clinical Guide for Psychologists to assist clinicians, professional psychology training programmes and institutions in meeting the expectations of the Health Practitioners Act and The New Zealand Psychologists Board's (NZPB) Standards and Procedures document. It presents how this proposed guide can support the implementation of clinical and cultural competence and the Code of Ethics for Psychologists Working in New Zealand. It also provides an opportunity for the psychology profession to demonstrate responsivity to Te Tiriti o Waitangi obligations.

Keywords: Māori, clinical assessment, clinical practice, formulation

Background

Māori mental health inequities are well documented (Baxter, Kingi, Tapsell, Durie, & McGee, 2006; Baxter, Kokaua, Wells, McGee, & Oakley Browne, 2006a; Harris, Tobias, Jeffreys, Waldegrave, Karlsen, & Nazroo, 2006; Baxter, 2008; Newton-Howes, Lacey, & Banks, 2014; McLeod, King, Stanley, Lacey, & Cunningham, 2017). Despite this, universities and professional bodies have demonstrated marked variation in the way professional psychology training programmes prepare students and clinicians to work with Māori clients and whānau. Because of this it is difficult to ascertain the profession's ability to contribute to the reduction of mental health inequities (Levy & Waitoki, 2016; Masters, Nikora, Waitoki, Valentine, Macfarlane, & Gibson, 2016; Waitoki, 2016; Bennett, 2016).

The introduction of The Health Practitioners Competence Assurance Act in 2003 (HPCA, 2003) was designed to provide governance of clinical training programmes. The HPCA 2003 signaled a departure from the Psychologist's Act 1981 through increased scrutiny of professional training programmes. Public protection is the primary purpose of the HPCA, with section 118(i) of the Act mandated cultural competency through *"setting standards of clinical and cultural competence, and ethical conduct to be observed by health practitioners of the profession"* (HPCAA, 2003, p. 87). Although there is no specific mention of the Treaty of Waitangi, or Māori, in the HPCA Act, the New Zealand Psychologists Board (NZPB), the New Zealand Psychological Society, and the College of Clinical Psychologists have documented opportunities for psychologists to be responsive to Māori. The NZPB Standards and Procedures document, written in collaboration with the Society and College, articulates guidelines for the accreditation of programmes and schemes leading to registration as a psychologist in Aotearoa/New Zealand (NZPB, 2016). The core competencies stand alongside *The Code of Ethics for Psychologists Working in Aotearoa/New Zealand* (New Zealand Psychological Society,2002) which includes a value statement that encourages psychologists to apply the principles of Te Tiriti of Waitangi to their work and "seek advice and undertake training in the appropriate way to show respect for the dignity and needs of Māori in their practice." (New Zealand Psychological Society, 2002, p. 6)

The Standards and Procedures document requires that professional training programmes (and supervision to registration schemes) meet the needs and aspirations of both Treaty/Te Tiriti o Waitangi partners' worldviews (NZPB, 2016 p.14). This includes specific clauses related to Māori health curriculum as follows:

"2.1.3. The teaching and learning methods include consideration of cultural frame of reference, values and world veiws, including those of Māori.

2.2.1. The curriculum is based on principles of scientific method and evidence-based practice, fosters the development of analytical and critical thinking, and includes consideration of indigenous psychologies.

6.2.5 In particular, where possible, students shall have the opportunity to undertake placements within Māori services and/or be supervised by Māori psychologists." (NZPB, 2016, pp 21-24).

APPENDIX A: HAUORA MĀORI CLINICAL GUIDE FOR PSYCHOLOGISTS: USING THE HUI PROCESS AND MEIHANA MODEL IN CLINICAL ASSESSMENT AND FORMULATION

MIHI/INITIATING THE SESSION

The mihi process provides a platform to establish a safe space for clients/whānau and clinicians and captures one or multiple points of contact/engagement with the client/whānau. The points below are dynamic and the order may change depending on the context and the preferences of the client/whānau.

Waka Hourua

Client/whānau: Greet client/whānau (clarify correct name pronunciation)

Client/whānau: Introduce yourself and your role to the client/whānau

Client/whānau: Identify whānau present and their relationships/role

Hinengaro: Identify client/whanau goals and/or aspirations for the interaction/assessment

Taiao: Consider how current therapeutic/assessment environment is impacting on the client/whānau e.g. accessibility of parking, room size, timing of sessions.

Clarify the presenting issue/kaupapa of the consultation

Ngā Roma Moana

Āhua: Consider if ethnicity is recorded correctly, confirm ethnicity where appropriate.

Āhua: Use te reo Māori, as led by client/whānau

Tikanga: Use whakatau protocol as requested by client

Tikanga: Identify client/whānau preference for karakia and facilitate when required

WHAKAWHĀNAUNGATANGA/BUILDING A THERAPEUTIC RELATIONSHIP

Whakawhānaungatanga involves the enquiry and then sharing of relevant and 'client/whānau-led' information that aligns with the Meihana Model between both the client/whānau and the clinician. It draws on clinically relevant information as a tool to help develop a therapeutic relationship and is used during each time of contact/engagement with the client/whānau.

Whakawhānaungatanga is an ongoing process by both parties which occurs throughout the assessment process.

Ngā Roma Moana

Ahua: Use of te reo Māori, as led by client/whānau. Clarify/explore meanings of Māori words/concepts being used

Whenua: Identify relevant whenua connections for client/whānau

Whānau: Identify relevant client roles/relationships within the whānau

Tikanga: Explore client-led discussion about te ao Māori specific activities e.g. waka ama, toi Māori, kapahaka, learning whakapapa, rongoā

Ngā Hau e Whā

Migration: Explore relevant client/whānau migration. Determine where client/whānau support networks are located

KAUPAPA/PURPOSE OF THE ENCOUNTER

Establishes the purpose for the interaction, either as an initial engagement or as a follow-up appointment. Draws on appropriate psychological assessment tools and methods to enable appropriate therapeutic care.

Although this is presented in a linear model, it is acknowledged the complexity of assessment will require a more dynamic approach to utilising the clinical guide and relevant psychometric testing. It is also acknowledged the need to establish where this specific kaupapa may sit in the client/whanau overall needs and life outcomes.

PRESENTING ISSUE(S) AND HISTORY

Presenting issue(s)

Waka Hourua

Hinengaro: Identify the presenting issue(s) and consider the possibility of impediments the client is not aware of

Hinengaro: Identify related issues that constitute the reason for the assessment, as well as the history of these issues

Hinengaro: Identify current stressors

Hinengaro: Identify cognitive issues/experiences e.g. attention, memory, language issues, hallucinations, delusions etc

Hinengaro: Identify possibility of self-harm, suicidality, aggressiveness or homicidality, exposure to violence, and suspicion of child abuse where appropriate.

Hinengaro: Explore coping strategies and self-efficacy e.g., help-seeking, self soothing, distraction, finding meaning

History of Presenting Issue(s)

Waka Hourua

Hinengaro: Identify onset of presenting issue(s), and any specific triggering event(s) acknowledged by the client/whānau

Hinengaro: Identify the course of the issue(s)

Hinengaro: Consider findings from previous assessments (e.g. client's perspective, clinical)

Ngā Roma Moana

Wairua: Identify client/whānau spiritual and cultural beliefs about illness, well- being and healing

Whānau: Identify client's perceptions and/or expectations of whānau involvement in their assessment and treatment

Whānau: Identify whānau expectations of the service and therapeutic outcomes

Tikanga: Identify what protocols and practices such as karakia may support the client/whānau within the clinical environment. Identify how these tikanga requests may be responded to

STAYING ON TRACK

Burwood Academy of Independent Living

Staying on Track – Peer lead telehealth to reduce secondary health complications

Rehabilitation medicine

12 months

1 Oct, 2020

This project will build a collaborative research partnership with Māori to co-design a peer-led telehealth programme that is Mana enhancing and supports Māori with SCI to live well. Māori sustain spinal cord injuries (SCI) at a rate that is 1.8 times higher than New Zealand Europeans. Secondary health conditions are common after SCI and are related to greater longer-term disability. Māori have difficulty accessing services responsive to the needs of tangata whenua that support and maintain hauora (health) equitably. Support provided by peers with SCI is increasingly recognised as effective at providing information to, and promoting self-management skills of, people with SCI. Telehealth provides a cost-effective means of providing health care services. The co-design process will explore how a better understanding of Matauranga Māori (knowledge) and Tikanga (customs/protocols) could lead to the empowerment of Māori to participate in a peer - led support programme that supports mana motuhake (self-realisation)

"What we all agree on... is that person-centred care is mostly nothing grand but rather, infinitely small, nimble,
and cumulative through micro-acts of care"
Gibson et al. (2019). The micro-politics of caring: tinkering with person-centred rehabilitation, Disability and Rehabilitation