Poihaere Hakipene 1887-1952. My inspiration.

Poihaere Hakipene (1887-1952) married Te Waipurukamu Pene Haweti and had 7 children. Her parents died together in1909 and she was sent to live on the outskirts her tribal area. From her parents she belonged to many hundreds of acres of land; but by the time she began to have children most of her land had been taken by the Crown or sold under dubious circumstances. She had 8 children in all. Through colonisation she lost the ability to provide land and resources such language, knowledge, traditions and values of Māori to her children. As a result her children did not have the opportunity to learn the ways of their mother. Poihaere died in 1952 landless and without opportunity to pass on her knowledge.

Author Dianne Te Tau

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Changing the way we care.

Kia whai ake te pono I nga wa katoa.

Seek to be honest at all times.

It is relatively simple for the elite to separate and divide the oppressed, but it is a difficult struggle for revolutionary leaders to unite them. The leaders must unite with themselves and with the people. One big obstacle for the oppressed individual to overcome is the idea that they are oppressed and that they do have hope to overcome it. Once a person becomes aware of their potential, they become a true, self-aware person.

*(*Paulo, 1968)

Abstract

This study is interested in the findings of interviews with women, services and individuals who experienced intensive social work support in their community of Counties Manukau, Auckland, New Zealand, while receiving antenatal care. We asked women who participated in this study about their experiences, feelings and understanding of their antenatal and postnatal care. The name of the model used in this study is **Te Waiora,** and focuses on the social and health wellbeing of pregnant women in a holistic and intensive way.

The study captured similarities and differences in the care pregnant women experienced, and asked them to compare them to other pregnancies. The study wanted to know if there were any social and health differences for the women, and what they were.

We asked services such as child protection services and legal services that experienced work being done by Te Waiora, what (if any) were the benefits for them. We talked to midwives to see how they found the service.

The study sought feedback from community health workers who delivered the service, and asked them to reflect on the relationships they formed with the women and their whānau. Other feedback included a family court lawyer, an Oranga Tamariki supervisor and Midwives. These will be discussed further in the study.

During the implementation phase of Te Waiora, my observations as the social worker, found that the skills, experience, confidence, and passion of the team members could influence the outcomes the pregnant women would experience. The willingness of staff to sit beside the women in a number of often uncomfortable situations for extended periods of time, improved the trust between the worker and the woman.

When a worker demonstrated they were there no matter what, the women trusted the relationship where it was the woman making contact and being proactive in her plans. When the woman engaged at this level, data showed a decrease in nonattendance to her antenatal care. All women Te Waiora worked with had been identified in the CMH health system as posing a risk to their unborn, and were subject to health risk alerts both locally and nationally. The women we interviewed took their babies home despite being assessed as at risk of harming their baby, this study wants to know how this happened.

Introduction

The study discusses the current processes polices and systems determined by of Ministry of Health (MoH) and how they are adapted and implemented at Counties Manukau Health (CMH) when determining social and health risk associated with pregnant women.

The study suggests that the needs of the women are being seen as risk factors, so they could be placed on risk registers that meant their unborn babies were seen as “at risk of harm”. More importantly, this process was failing to offer support to women in early pregnancy that could improve her social and health situation. For example homelessness, poverty, and poor antenatal attendance are considered a risk to the unborn. When these women were seen by Te Waiora, the social stressors were considered needs, and a solution focus was adopted to improve the women’s social situation. It was not uncommon for a client to be assisted into a motel and taken to WINZ for financial support in her antenatal or postnatal care.

The study looks at how risk to an unborn is identified and the processes that are currently followed by CMH. The study argues that by focusing on the risk to the unborn child, the social and health needs of the pregnant woman can be over looked by health and social work professionals.

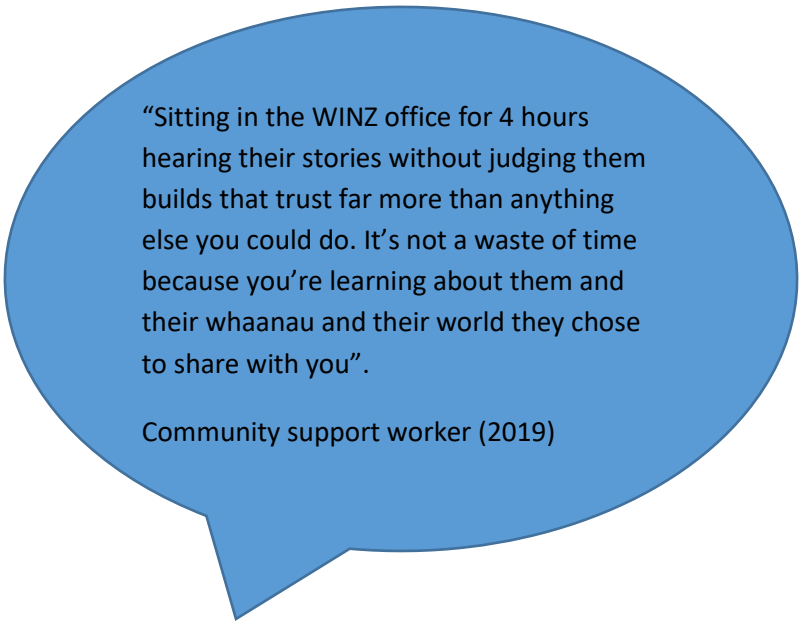
Before 2017, the social worker at CMH Community Midwifery had only been concerned with risk mitigation and worked in sync with CMH Child Protection Service and Oranga Tamariki. Any opportunity to work in community with the pregnant woman and her whānau was not a focus of the work.

In late 2017, CMH Community Midwifery's social worker trailed a model of care that focused solely on the social and health needs of women. The model worked alongside health professionals and other services the woman may be involved with, to ensure she had antenatal community support that met her social and health needs.

Although Oranga Tamariki may be involved with the mother because of a Child At Risk notification, any risk to child safety should be assessed by New Zealand's child protection services such as Oranga Tamariki, (OT) and Police. This was not the prime focus of a Te Waiora, also referred to as the Multi-Agency Support planning groups or (MAGs).

Operating from a needs based paradigm meant the way we worked with the woman changed the way we worked with child safety services such as OT. Rather than working with OT to manage and support child

safety, MAGs plans were concerned with working alongside the woman to address her complex needs during pregnancy.



Some feedback in 2017 was very positive and encouraging, identifying Te Waiora could work very well alongside OT and the woman in her maternity care. However, there have been some interactions with OT and CMH Child Protection Services by Te Waiora staff that have not been met with the same positivity.

In 2018 and 2019, there had been some feedback from OT and CMH Child Protection Service that had been critical of staff, and resulted in formal complaints by OT and CMH Child Protection Service.

Of note, although there were women unable to keep their babies, the support for them was as intense and supportive as it was for women who took their babies home. This was because we were concerned with her care during pregnancy. We did not interview the women who lost the custody of their baby, as the impact on them was significant, and this process could have traumatised them further. Therefore, this study evaluated the outcomes only involving women who took their babies home.

In reviewing women placed on high risk health registers by the CMH processes, it was found Māori women figured prominently in this statistic. If women are experiencing multiple layers of complex health and social needs while pregnant and are Māori, there is a significantly increased chance the baby would be identified as "at risk of neglect or harm".

The method/methodology

The research takes a qualitative approach to allow the unique experiences of the women to be captured and interpreted. Nash, Munford & O'Donoghue (2005) state that qualitative methodology recognises that truth is socially constructed, therefore experiences can be valued in their natural environment.

The method/methodology needed to coexist with the research, the participants, and the researcher. Applying Kaupapa Māori principles would guide the research and the participants would be valued by the very nature of what Kaupapa Māori means in research. Smith & Cram (1999) provide guidance on research and evaluation in a Kaupapa Māori context consisting of eight principles:

- *Whānaungatanga* refers to the building and maintenance of relationships. It's the process of establishing meaningful, reciprocal and whānau or family-like relationships through cultural respect, connectedness and engagement.
- *Manaakitanga* describes sharing, hosting and being generous. It supports collaborative research and evaluation and helps knowledge flow both ways between researcher/evaluator and participant.
- *Aroha* means love but it also means respect. Treating people with respect means allowing them control: where to meet and on their own terms, and when to meet. Aroha also relates to the information collected. You should let the participant decide what information will become public and what will stay confidential. They can also choose whether to participate anonymously.
- *Mahaki* is about showing humility when sharing knowledge. Mahaki reminds us to share knowledge and experiences to understand each other better and to foster trust in the research or evaluator relationship.
- *Mana* relates to power, dignity and respect. Kaua e takahia te mana o te tangata "Do not trample on the mana or dignity of a person". People are the experts on their own lives, including their problems, needs and aspirations. Look for ways to work together.
- *Titiro, whaakarongo, korero* means to look, listen and then speak. When researching and evaluating it's important to look and listen to develop understanding and find a place to speak from. You need to take time to understand people's day-to-day realities, priorities and aspirations. This will make your questions relevant to the participant.
- *Kia Tupato* is being cautious. You need to be politically savvy, culturally safe, and reflective about your insider or outsider status. Staying safe might mean working with elders and others in the community who can guide your research and evaluation.

- *He kanohi kitea* means being a familiar face. You should seek to be involved with communities and familiar to them to build trust and communication
- *Ata* is about building strong and healthy relationships with participants as they gather and analyse evidence. In the Kaupapa Māori framework, these relationships are built on mutual trust, respect, reciprocity and Whānaungatanga.

Smith & Cram (2020)

Cunningham (1998) as cited in Moyle (2014) states that a Māori centred approach employs Māori and non-Māori methods, theories, and analytical tools such as Grounded Theory. Charmaz (2005) argues Grounded Theory entails evolving abstract ideas about research participants' meanings and categories. Further, Grounded Theory is also helpful when looking at issues around social justice. For example, are the systems, policies, and processes labelling Māori women as at risk of harming their baby fair, just, and accurate?

The qualitative analysis of the data set used a General Inductive approach (Thomas, 2006) for initial review and coding, with a research team member reading over the material and developing codes into an initial coding framework for team discussion and review (Staniforth & Beddoe, 2012).

This research positions the women inside the research and values their expertise about their lives. We give currency to their journey and experiences ensuring they feel heard and their views are accurately recorded. The women are provided a consent form and information sheet about the research and were informed of the reasons of the research face to face.

Demographics

Māori residing in Counties Manukau are often found living in poor socioeconomic environments. Part of the review entails looking at existing data to better understand the population and demographics that can contribute to health and social wellbeing in Counties Manukau.

Walker & Rutter (2021) argue the New Zealand healthcare system is consistently spoiled by poor health outcomes for Māori and Pacific Islander populations. They suggest the reasons for these inequalities are multifactorial and interconnected, oscillating from racism to socioeconomic disparities.

The deprivation levels in Counties Manukau suggest 38% of Māori children and 53% of Pacific children and 36% of Counties Manukau residents were living in areas defined as the most socioeconomically deprived. The following graph demonstrates the disparities between Māori and non-Māori.

Table 1 Differences between Māori and non-Māori populations in major public health and demographic criteria

Health and demographic criteria	Māori	Non-Māori	Difference
Life expectancy (years), 2012–2014	73.0 (male) 77.1 (female)	80.3 (male) 83.9 (female)	7.3 (male) 6.8 (female)
Amenable mortality (rate ratios Māori: Non-Māori), 2015	~ 2 (male) 2.39 (female)	~ 1 (male) 1.00 (female)	2: 1 2.39: 1
Infant mortality (deaths per 1000 live births per year), 2012–2014	5.8	4.6	1.2
Total fertility rate (live births per 1000 women of reproductive age per year), 2014	2.34	1.92 (total NZ population)	0.42
Percent aged < 15 years, 2013	33.7%	18.0%	15.7%
Percent school completion (level 2 +, 15+ years), 2013	45.1%	64.3%	19.2%
Percent unemployed (15+ years), 2013	10.4%	4.0%	6.4%

Health and demographic criteria	Māori	Non-Māori	Difference
Percent total personal income < $10,000 (15+ years), 2013	24.1%	18.4%	5.7%
Percent receiving income support (15+ years), 2013	30.4%	13.8%	16.6%
Percent household crowding, 2013	18.6%	7.7%	10.9%
Footnote: Amenable mortality is an important measure for inequity among populations, and is defined in the Wai 2575 Māori Health Trends Report as deaths below the age of 75 which could have potentially been avoided with "effective and timely healthcare"			

Values derived from the New Zealand Ministry of Health and Statistics NZ, which had the most recent publicly available data as of 2019 According to Statistics NZ, Pacific Islander life expectancies were similar to Māori rates. Life expectancy was 78.7 years for females and 74.5 years for males in 2012-2014 (Walker & Rutter, 2021)

The 2013 census showed 22% of residents in CM were living in a crowded household. Using the Canadian National Occupancy Standard this figure was much higher for Māori (32%) and Pacific peoples (48.5%). Children were particularly likely to be living in crowded households - 31% of CM children aged 0-14 years. The percentage living in deprivation in NZ (deciles 9 & 10) in 2013 was much higher for Māori (58%) and Pacific peoples (76%) compared to European (7%), Asian (22%) and MELAA (29%) groups. (New Zealand Census, 2013)

Cram (2012) argues that internationally indigenous children have over-populated the child welfare systems, and systemic racism continues to support that notion.

Social work CMH.

According to the CMH definition social work provides:

Social workers who are registered health professionals' work together with health practitioners to provide a comprehensive service to patients and their family/whānau. Social workers undertake a comprehensive biopsychosocial assessment with patients.

This includes a review of a patient's social, emotional, spiritual, environmental, financial and support needs, and determines how this may impact on the patient's health and wellbeing. CM Health Social workers also support the patient and their family/whānau with accessing supports. Social workers work in the hospital as well as with outpatients and community. (Counties M
Manakau Health , 2019)

Introduction of the Social Work Alert Process.

Social Work Alerts were introduced at CMH two years after the death of the Kahui twins on the 12 June 2006. At the time there were robust discussions which included the internal processes of the CMH systems that address child safety.

CMH Social worker Angela Todman developed and implemented the Social Work Alert process. She states the model followed the same administrative pathway as the CMH Child Protection policy of Child Protection Alerts. The process would be to approve or decline. If approved the alert would be entered on the CMH data base.

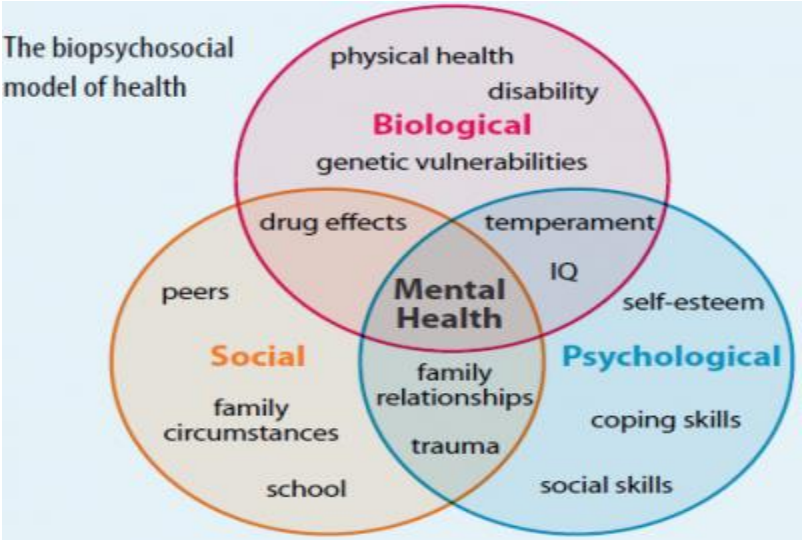
The Social Work Alert identifies potential risk to an unborn baby but does not show how this conclusion is drawn except at a Social Work Alert committee meeting where cases come with no thorough analysis.

In the case of the Social Work Alert and the high risk register the women is not informed she is considered at risk of harming her unborn. Her unique situation is not discussed and there are no recognised and consistent processes to offer support and guidance to the mother and her unborn at that time in her pregnancy.

A moot point, as a regular attendee on the Social Work Alert committee, is the discussion is not solution focused therefore it is understandable that any capacity to assist the women in this process is limited. There is an absence of social work framework and it is irrelevant to both the woman and her unborn, because it does not offer her any opportunities for support.

Bronfenbrenner (1979) argues it is the environment, the stressors, and supports that effect how a parent may be caring for the child. Therefore capacity, external support, and environmental arrangement must be considered when considering risk or potential risk.

The purpose of the alert is to raise an alarm bell to hospital maternity social work and the maternity service that the patient may need to be seen, but more specifically she may need a biopsychosocial assessment. In searching for a definition, a web search found a graph provides components of assessment in a Biopsychosocial model of assessment.



The biopsychosocial (BPS) model an approach that emphasises the importance of a systemic view of the individual and an integration of biological, psychological, and sociocultural factors on human growth and functioning. The Biopsychosocial Interview is an assessment usually conducted at the beginning of therapy. It assesses for biological, psychological and social factors that can be contributing to a problem or problems with a client. It's considered a holistic assessment, looking at a client on different levels. The Biopsychosocial Interview is utilised because problems usually don't exist in a vacuum. They all influence each other in different ways, and it is not enough just to look at a person; you have to examine their environment as well. (Fava & Sonino, 2007)

Barkly (2009) argues these assessments in a health setting do not go deep enough to be effective in understanding the needs of the patient. The biological component of these assessments poses a dilemma for a social worker who needs to understand exactly what that means when gathering information, and who is contributing to the information. This study also questions why these assessments are being done so late in the women's pregnancy.

The New Zealand Health Social Work Scope of Practice (2017) states:

"*Health social workers provide a significant contribution to care by maintaining an ecological focus on the individual, their family/whānau, and their environment. It is this understanding that distinguishes social work from other health professions.*

Health social workers are regularly involved with individuals and families/whānau experiencing complex social, psychological, relational and institutional dynamics that are physical, mental, and intellectual or disability related. Health social workers offer a unique and valuable contribution which contributes significantly to the provisions of effective health services and outcomes." (National DHB Health social work leaders Council, 2017).

The study argues the scope of social work practice at CMH was linked to the memorandum of understanding. A Memorandum of Understanding (MoU) between Oranga Tamariki and CMH developed the policies guiding social work and child protection following the death of the Kahui twins.

The overall findings in the report by Dobbs & Eruera (2014) where a high number of Māori women are being reported as involved in incidents of family violence. The research acknowledges that in some instances a baby cannot remain with their mother, because the facts are so obvious that should she leave with her baby, harm is likely. This, although an important topic itself, will not be discussed in this research.

CMH child protection services.

Child protection at CMH are intended to ensure that children and/or babies born at CMH are reported to risk registers where there is the possibility of harm to the child or unborn. This process is consistent throughout all DHBs in New Zealand. However, the delivery of Child Protection Services may vary from DHB to DHB. (CMH MoH Child Protection Management Policy, 2018)

Child protection service at CMH

The following information has been gleamed from the Child Protection Alert Management Policy (2018).

Within CMH sits the Child Protection team (CP). This team does not provide case management and there is no patient interface. CP keeps a record of children (including unborn) who have risk factors that have the potential to cause harm to them. They provide guidance and support to anyone who feels they need to discuss individual cases about child protection.

They also provide training in areas such as family violence. The model of communication and process is the multi-disciplinary (MDT) approach and cases are regularly taken to MDT to decide if the case warrants particular alerts for risk factors.

According to the MoH Alert Management process there is a local alert system and a national alert system (CMH MoH Child Protection Management Policy, 2018).

In the case of child protection alerts:

The purpose of entering an alert on the National/Local Health Index Warning System is to make relevant health information available to other DHBs as the child moves around the country.

In the case of unborn alerts, the policy states:

Women may present in pregnancy in circumstances which create high risk for the baby after delivery. Further, failure to recognise and respond to these women appropriately may result in poor outcomes.

When an alert is created it gets very little attention unless the women presents to hospital during and/or after the birth. The CMH child protection team would request a birth plan from OT and advise them when the baby has birthed. At that time the ward social worker will be alerted through the Social Work Alert system and normally try and engage with the mother.

Depending on the outcomes predetermined by OT, the mother may or may not leave the hospital with her baby. Further, the mother and whānau may not be made aware that the baby will be taken from her care until after the birth. Currently in 2021, this process is under review by CMH relating to the findings of reports by the Waitangi Tribunal and the Ombudsman in 2020/2021 on the uplift of children after birth.

Cultural implications

Cooper (2006) argues that Māori are often positioned as the problem when they fail in the education system and the outcome is to apply remedial actions to try and resolve the problem. He suggests that when we apply a Kaupapa Māori lens to the situation it provokes a new school of thought around where the problem lies. Cooper argues that the notion of western epistemology positions Māori as the problem because there is no values to being Māori if you are failing in westernized systems and structures in postcolonial New Zealand.

As a group, Māori families differ significantly from European. They tend to have children at younger ages, and to have more children; there is a greater percentage of sole-parent families (though many of them live with other family members); grandparents and other whānau are more closely involved in children's upbringing. There are different patterns again for Pacifica and Asian families (Hughes, 2004).

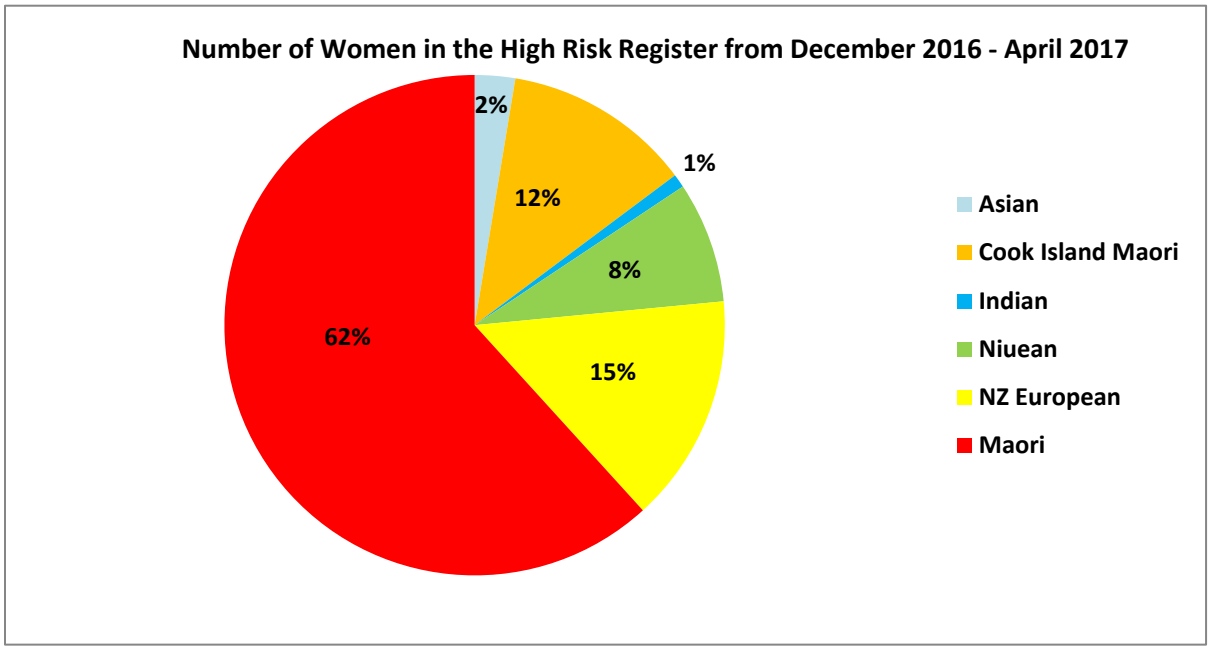
Of particular interest was the number of Māori woman being referred for a BPS assessment and placed on a Social Work Alert in the health system. Since the commencement of the alert process in 2008, Māori women have consistently been the highest number referred for Social Work Alerts. This is consistent with

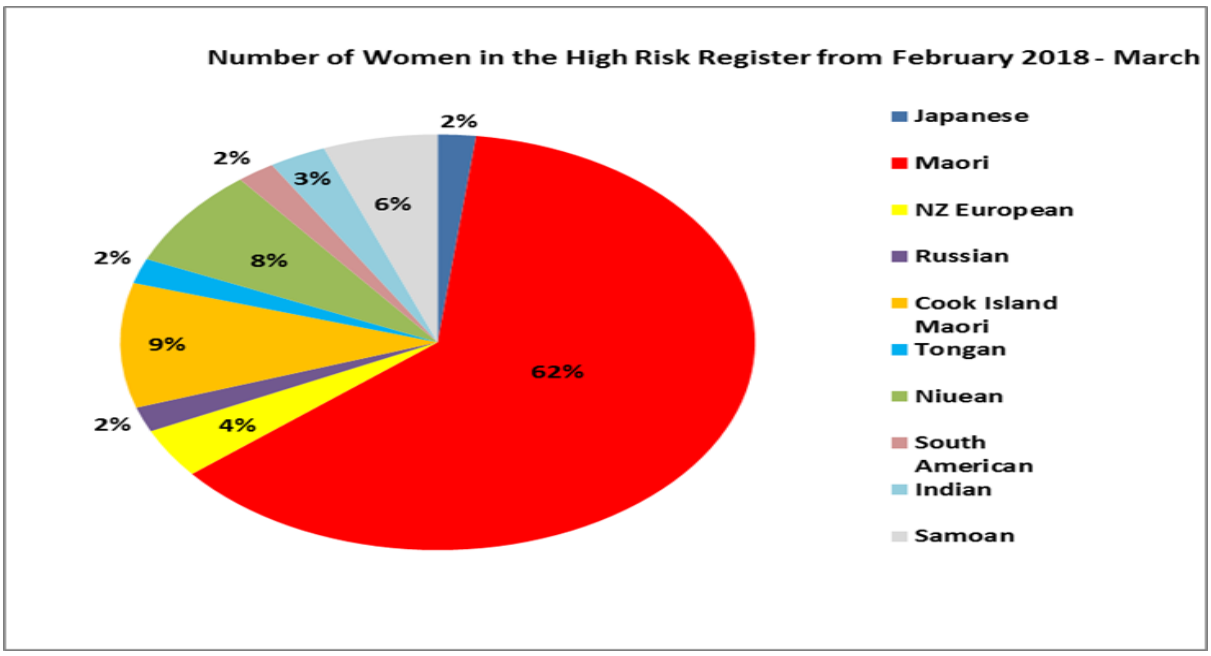
children who are placed out of whānau care. Family violence has been a reoccurring risk identified for these women.

Māori women losing their children to the State is well recorded in the statistics of children being taken into state, out of home, and home for life care. Compared to 30 June 2016, the number of children and young people in the custody of the Chief Executive increased by 7 % from 5,312 to 5,708. There was also a 7% increase in the number of out-of-home placements from 4,394 to 4,716 (Oranga Tamariki, 2017). In 2015, Paora Moyle (as part of an MA research assignment) sent a letter to the Ministry of Social Development asking about the ethnicity of the children who were part of the Family Group Conferences processes and in state care. The Ministry response to those questions was that in 2013 55% of children who were subject to an FGC or Family Group conference process were Māori. In 2014 there were 56% identified as Māori. Broken down by age, children 0-4 were the highest group to be subject to an FGC in 2013 and 2014.

In 2013 the number of children who were placed in a "Home For Life" by Oranga Tamariki was 63% Māori and in 2014 60% were Māori tamariki. The 0-4 years are group represented by 43% of the children were permanently placed out of their mothers care. In 2014, 44% of children aged 0-4 years were permanently placed outside their mothers care. 63% of those children were Māori. Moyle (2015) found that in New Zealand, the statistics of new-borns taken into statutory care are not made public, they had to be requested through the Official Information Act process. In the 2012 -2013, 13 new-born Māori, from a total of 26 were removed from the birthing table, and 80 Māori babies from a total of 157 were removed from their mother within 30 days of their birth. Moyle explains that these children are often placed with state approved non-Māori caregivers. Māori make up 16% of the total New Zealand populations. With the removal of nearly 100 infants a year from their mothers, many are not returned, essentially wiping out future generations of Māori. Further, Moyle suggests that in 2015, the removal of these babies significantly increased, and more uplifted were Māori babies. The real number is likely to be much higher

as the primary ethnicity is recorded by the social worker. (Moyle, 2015).





Pie Chart (1) December 2016- April 2017) (2) (February 2018-March 2019) ethnicity of women on the high risk register derived from Child Protection at CMH.

Graph 1

	Population (priotised,2016)	% of CM population	% of NZ that CM population represents for that ethnicity	% of NZ population
Maaori*	85,000	16%	12%	16%
Pacific	112,990	21%	37%	6%
Asian	130,860	24%	21%	14%
NZ European/ Othe	205,830	38%	7%	64%
Total	534,750		11%	

[PM1]

Birth rates and Midwifery care in CM.

[PM2]

" I have found MAGS essential for women I work with who are predominately Māori.

MAGS is pivotal in empowering my women to take responsibility for their choices.

Many of the women have addictions, family violence and are involved with Oranga tamariki.

MAGS has allowed them to make huge progress to either keep their pepe with support or make the necessary changes to work towards that"

Midwife (2019).

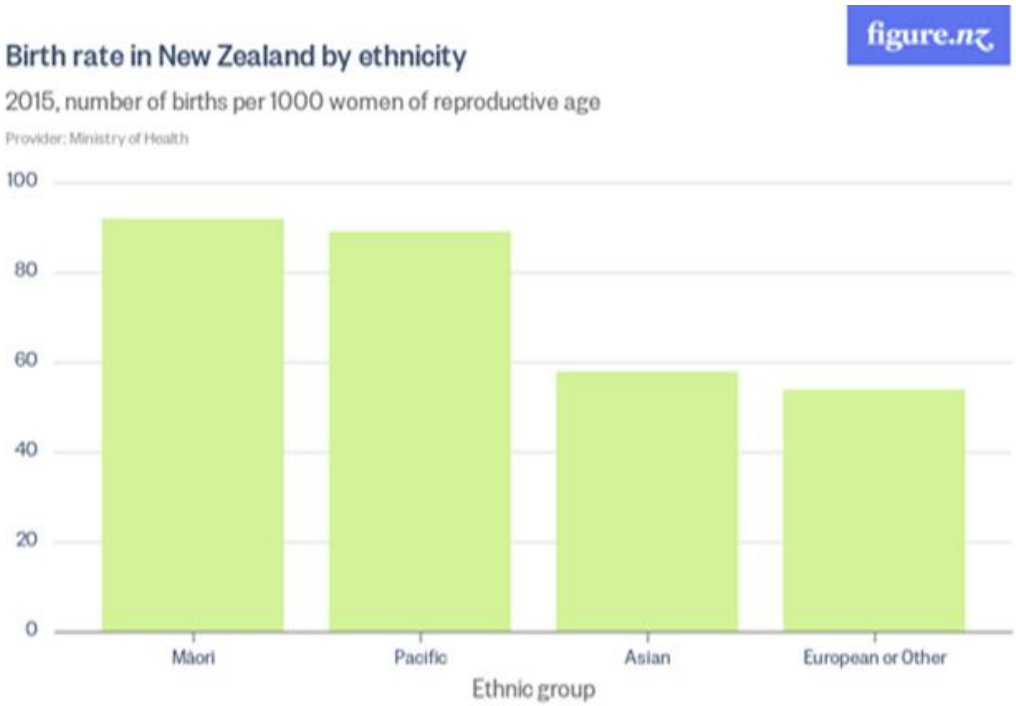
Midwives are professionals who are qualified to deliver care to women in their pregnancy and usually up to six weeks post-natal. The World Health Organisation identify a midwife as someone who: *"Encompasses care of women during pregnancy, labour, and the postpartum period, as well as care of the new-born. It includes measures aimed at preventing health problems in pregnancy, the detection of abnormal conditions, the procurement of medical assistance when necessary, and the execution of emergency measures in the absence of medical help."* (World Health Organisation, 2022)

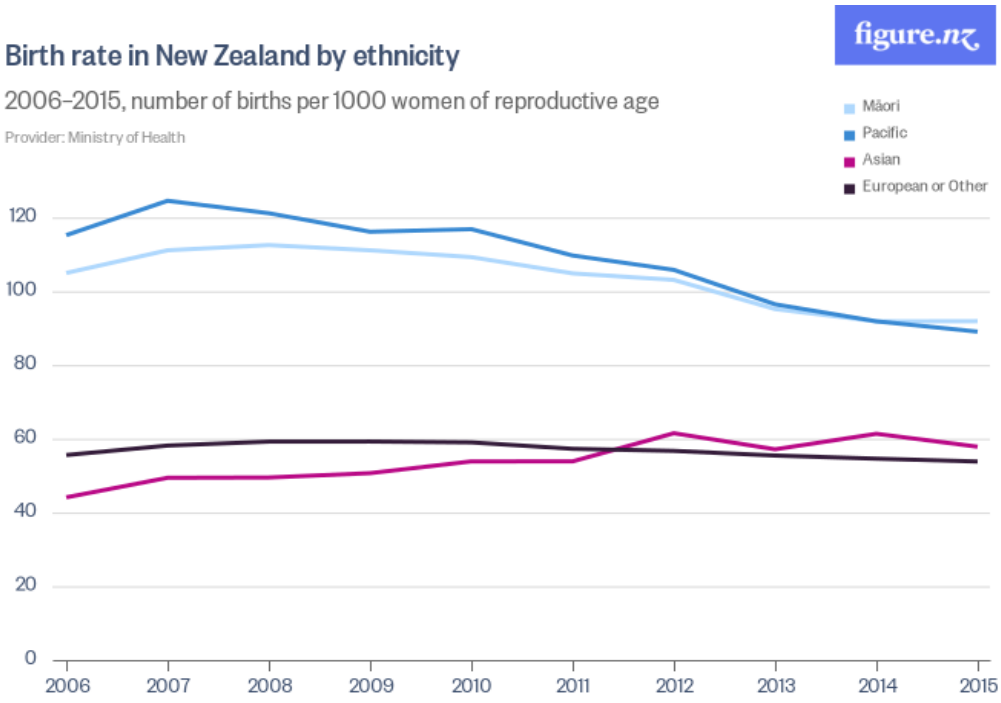
CMH employs community midwives, however this is the only health provider in New Zealand that has paid community midwives. Throughout New Zealand midwives are largely self-employed in community.

A salient point here is that community midwifery only covers about 30% of all pregnant women in South Auckland. Isabella Smart, the Community Midwifery Service Manager states that in 2016, 7276 women birthed in Counties Manukau based on the Maternity Annual Report (2016).

The other 70% usually go to an independent midwife (LMC) who does not have ready access to social work support. Ms Smart states that when an LMC finds the case is too complex with multiple social issues she may ask for the case to come to Community Midwifery. Midwives can then make referrals to social work through an online referral system. In these cases community social work would follow up, but often it is very late in the pregnancy where capacity to provide meaningful support is limited. (Smart, 2018).

The birth rate has shown that more Māori and Pacifica women are giving birth in New Zealand compared to other cultures. According to the Women's Health and New-born Annual Report (2016-2017) CM district has the second highest number of Māori (Waikato being the first) and the highest number of Pacifica people in New Zealand. The graph below reports births in 2015 by Ethnicity in New Zealand. The second graph demonstares births by ethnicity from 2006-2015 where Māori and Pacifica share has the highest reported births rates. Between 2012-2016 location of women birthing in Counties Manakau is identifed.





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These figures suggest that the Asian population will increase the fastest followed by Pacifica and Māori. Based on the 2013 census 36% Of the CM population lived in social deprivation, most of which were Māori and Pacifica peoples. Māori women under the age of 20 living in Counties Manukau had the highest birth rate between 2012-2016. The graph below identifies that in 2015 the ethnicity of women in Counties Manukau and the rest of New Zealand. The next graph reports the births at DHB and other birthing facilities in the larger Auckland area. Counties Manukau is clearly leading the number of births in Auckland and the rest of New Zealand.

DHB Location of Birthing	2012	2013	2014	2015	2016
Counties Manukau	7424	6840	6775	6696	6679
Auckland facilities	1085	1064	1196	1165	1227

	Counties Manakau		Rest of New Zealand	
ETHNICITY	No.	%	No.	%
Māori	1881	22.9%	12774	25.2%
Pacific Islander	2509	30.6%	3577	7.1%
Asian	1856	22.6%	7390	14.6%
European/Other	1948	23.8%	26990	53.2%
Unknown	7	0.1%	22	0.0%
Total	8201		50753	

Characteristics of women birthing in 2015

DHB Location of Birthing	2012	2013	2014	2015	2016
Counties Manukau	7424	6840	6775	6696	6679
Auckland facilities	1085	1064	1196	1165	1227
Waitamata facilities	50	50	41	48	66
Elsewhere	72	74	88	88	79
Total	8631	8028	8100	7997	8051

Percentage birthing at Counties	86.0%	85.2%	83.6%	83.7%	83.0%

Family Violence historical context

Dobbs & Eruera (2014) argue that there are key components in understanding why Māori have the highest rate of family violence incidents, they point to:

- The breakdown of traditional Māori structures, the imposition of the westernized "nuclear family" and the reconstruction of whānau and gender roles.
- Introduction of patriarchal ideology, redefining the role of women.
- The undermining of Māori cultural practice giving more value to patriarchal practices of colonizers.

However, it is argued that traditionally Māori society valued the role of women in society:

"There is no historical support for claims that traditional Māori society tolerated violence and abuse towards children and women, or that some members of the group were lesser value than others..." (Durie, as cited in Dobbs & Eruera, 2014).

Dobbs and Eruera argue that colonisation, poverty, social marginalisation, racism, and stressors such as unemployment for Māori (as with other colonised people's) needs to be considered as a beginning of understanding how we resolve the problem. To achieve this means returning to the cultural philosophies and knowledge of Māori society and a Kaupapa Māori approach. If a woman is pregnant and is experiencing family violence, they can expect to be monitored by health, child protection and social work as someone who's unborn is at risk. This thinking needs to be challenged, and things need to change.

A primary reason why children are being removed from the whanau is because of reported family violence. Police initiatives such as the Family Harm teams in the 1990's were initiated to help reduce the incidences of family harm in New Zealand. Legal processes such as the Protection Orders, Family Safety Orders and Trespass Orders were to help people feel safe from the perpetrator. However, in the 21st century, family violence remains a major problem in New Zealand. The initiation of Stopping Violence programs attempt to change the behaviour of the perpetrator, while other programs were set up to help victims realise the risks and consequences of remaining in the relationship. There are very few services who commit to working with the relationship, and how they can work together with others without fear or feelings of shame. The women in our study were often in relationships where family violence was

happening. When this was evident we could establish a trust with the women to develop plans around her care and safety. We could work alongside the Police Family Harm teams to ensure the women could be assisted whenever she required it without risking her wellbeing.

The trauma associated with violence is numerous and varied, but until recently the impact on people who are victims of this trauma have often been neglected while we treat the presenting behaviours such as alcohol and drugs misuse, criminal offending, anti-social behaviours, risk taking, and mental health issues. Atkinson (2002) argued that when a nation of people such as Aboriginal in Australia is conquered and their culture, land and resources removed, the outcomes was devastating. The traditional values of Aboriginal society valued each other and all contributions; children were nurtured and loved.

Aboriginal culture leaves a child virtually untrammelled for five or six years. In infancy it lies in a smooth, well rounded coolamon which is airy and constraining and rocks if the child moves to any great extent. A cry brings immediate fondling. (Akinston, 2002).

The trampling of their mana came in the form of colonisation where there was no value placed on the way Aboriginal children were raised. The demise of lore, culture, value and beliefs arguably positioned the colonised as beneath that of the coloniser.

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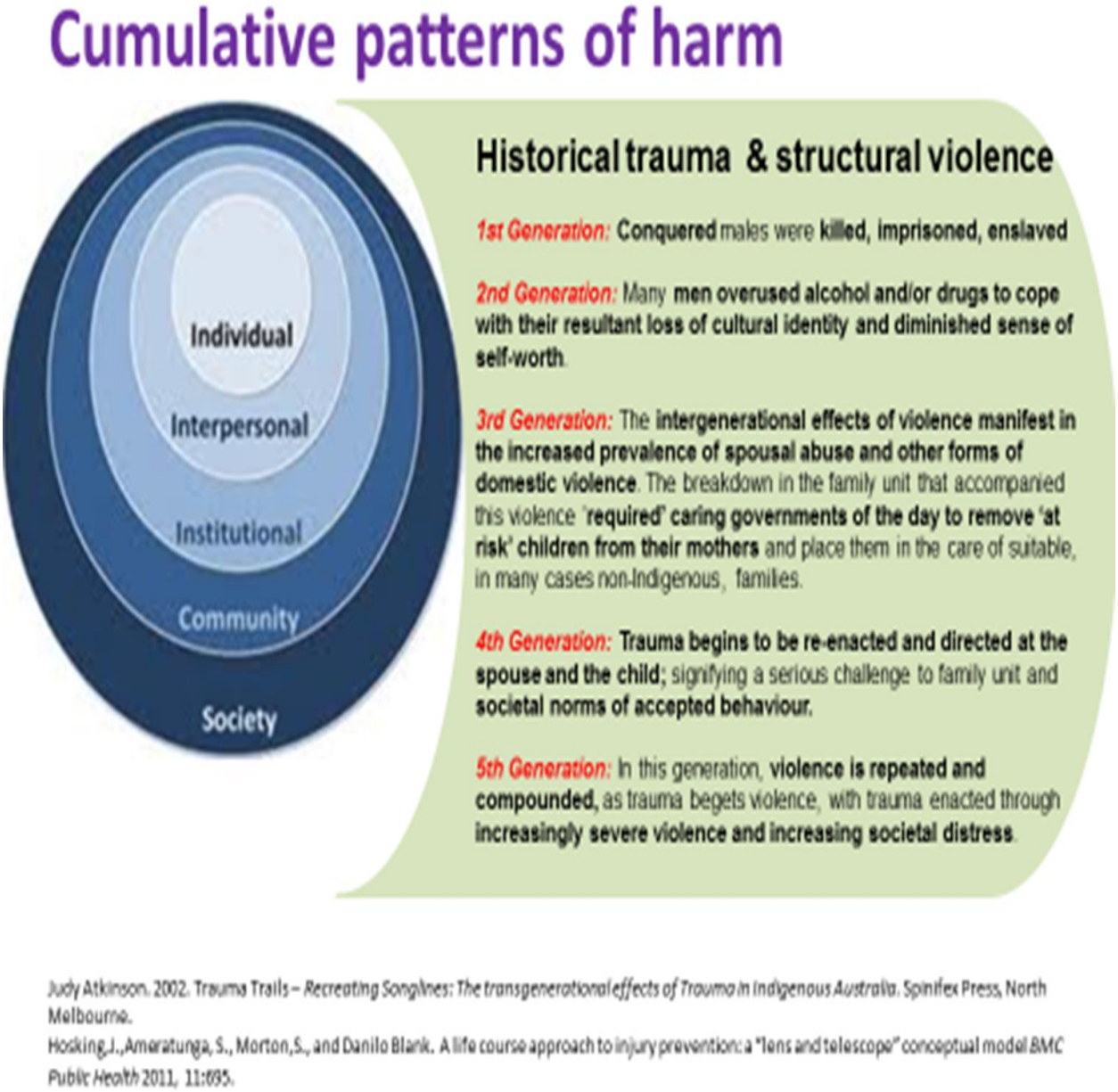

Judy Atkinson. 2002. Trauma Trails – *Recreating Songlines: The transgenerational effects of Trauma in Indigenous Australia*. Spinifex Press, North Melbourne.
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https://www.police.govt.nz/advice-services/family-violence/family-harm-approach-resources

"Many women do not apply for protection orders for the same reasons that they remain in abusive relationships. These include shame, dread of losing custody of their children, and above all else, fear. Having a low income but not qualifying for legal aid may prevent some from applying for a protection order. Lack of money limits options for women wanting to escape a violent situation and make a new life

for themselves. Women in some ethnic and religious groups can find that they are condemned rather than supported by their families and communities." (Te Ara, 2018)

When treatment is considered alongside the trauma that identifies the uniqueness of the individual and their story, the healing can be almost immediate. The study found the key is the trust that is built without judgement or condemnation.

Changing the mode of care in community midwifery

This study asks the question: could health social work in the community, driven by support and advocacy rather than risk and alerts, improve outcomes for women and their children? Further, with more intensive social, health and community support, could a woman who is on a high risk register with an open case with OT, take her baby home? In the next part of the research, we will consider the experiences of women who were part of the multi-agency support (MAG's) Te Waiora process. All the women had a Social Work Alert, were recorded on the high risk register, known to Oranga Tamariki, and were likely to have their baby removed after birth.

Defining processes

"There is research that suggests Māori-initiated programmes that promote Māori parenting practices have been found to have a positive impact on participants' parenting skills and confidence. The incorporation of Māori concepts and values into domestic violence programmes and into addictions services for Māori has also been found to benefit participants. Community development approaches to preventing child maltreatment may also be effective at bolstering community protection mechanisms along with providing support to whānau who have had a child or children removed." Cram (2012).

The Social Policy and Evaluation Unit (2015) found that when parenting programmes were structured around Kaupapa Māori and culturally adapted programmes, they were more enjoyable and effective for the participants.

Underpinning the model are keys elements associated with a Kaupapa Māori worldview. Jon Royal and the writer developed a model of care founded on the work of Dr Rangimarie Pere and Te Wheke. The model is called H.E.A.L. The concepts are underpinned by the idea that change and healing can work simultaneously if they are delivered in an intense coordinated and reflective manner. The model is driven by a passionate team, and the women participating show commitment and energy to work with Te Waiora. H.E.A.L stands for Honesty, Empowerment, Aspirations and Learning.

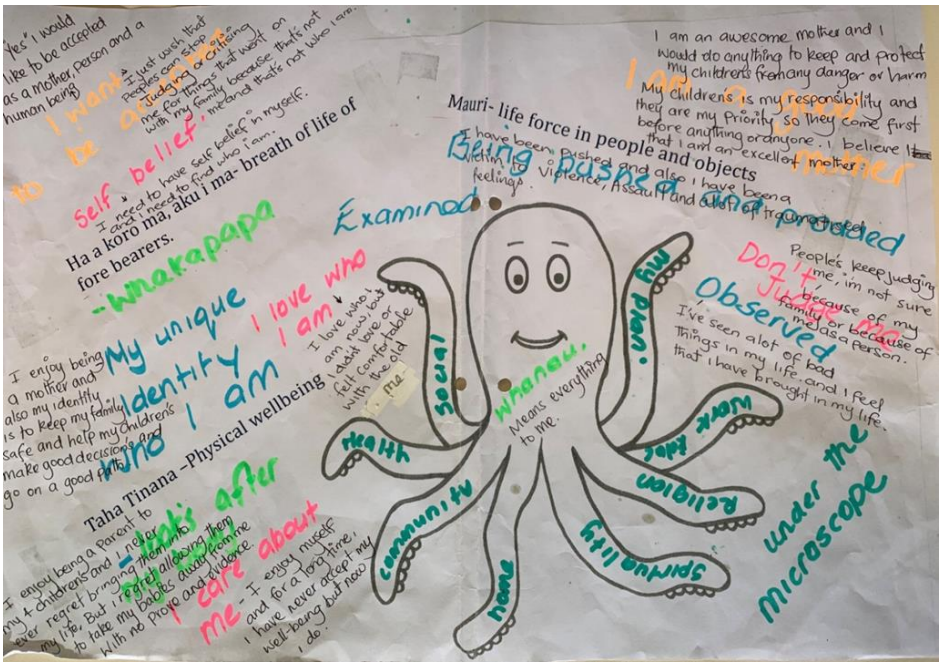
H.E A. L.  Key elements to making changes and *healing*.

Honesty	• Be honest with yourself, before you attempt to be honest with others • Be totally open about the *'snags'* that cause you to falter – particularly ones that you have more influence over • Be clear about the changes you want to effect in your life • Take personal responsibility for your actions • Write down your thoughts and apply the "Am I being totally honest with myself" lens	*Kia whai ake te pono i nga wa katoa.* "Seek to be honest at all times" This is a simple whakatauki, expressing an expectation that being open and honest is an essential component to healing
Empowerment	• "The ball is in your court" – you have the real power to make your life better • Identify your strengths, and combine them with your aspirations to create the future you desire • Visualise "success" factors and then write down how you intend achieving them	*He kai kei aku ringa* "There is food at the end of my hands" This whakatauki is said by a person who can use his own basic abilities and resources to create success.
Aspirations	• Don't be afraid to dream • Set goals and work towards achieving them • Ask yourself "what do you want for yourself; for your family?"	*Whāia te iti kahurangi ki te tūohu koe me he maunga teitei.* "Seek the treasure you value most dearly: if you bow your head, let it be to a lofty mountain" This whakatauki is about aiming high or for what is truly valuable, but its real

		message is to be persistent and don't let obstacles stop you from reaching your goal.
Learning	• Life is a series of constant learning • You are either achieving, or learning from your mistakes made along the way • Do lots of reading, and study at any given occasion • Take opportunities to mix with (and learn from) others • Take on any challenge as a chance to further gain knowledge	*Whaia te matauranga, hei oranga mo koutou.* Seek after learning for the sake of your wellbeing This whakatauki is about encouraging an individual to always be open to learning opportunities in search of sustained happiness and wellbeing.

(Royal & Te Tau, 2016)

"The model would include a streamlined and coordinated approach to ensure that referrals give a voice to the family/whānau." (Te Tau, 2017).



A part assessment with a woman expressing herself after her children had been taken from her care previous to this pregnancy (2018).

Giving a voice to people is validating their world and what has happened to them. It provides a therapeutic component to healing and listens to real stories. Waitamata DHB provides a model known as Te Aka Ora (the vine of wellness). This model was developed through a steering committee from maternity services, social work, child protection, Māori health and maternal mental health. They wanted to support vulnerable families through collaboration, planning care conscientiously together, and communicating clearly. A set of triggers were developed that allowed Lead Maternity Carers to make referrals to the service. Unlike CMH, Waitamata do not have community midwifery services that sits under the DHB, rather their midwives are self-employed LMC or Lead Maternity Carers. The support in this model is about the LMC having capacity to bring cases to a forum and get advice as to how they could work with the presenting issues of the pregnant women. A steering group helped develop a *Vulnerable Families Forum (VFF).*

The Steering Group consisted of a wide range of representatives:

- Maternity services
- Social Work
- Child Protection
- Māori Health
- Maternal mental health
- Community Alcohol & Drugs (CADS) pregnancy and parenting services
- Community mental health

This allowed debate of complex privacy and confidentiality issues and develops a clear understanding of how we can share information and protect and support vulnerable families.

There are differences in this model and that of Te Waiora noted below:

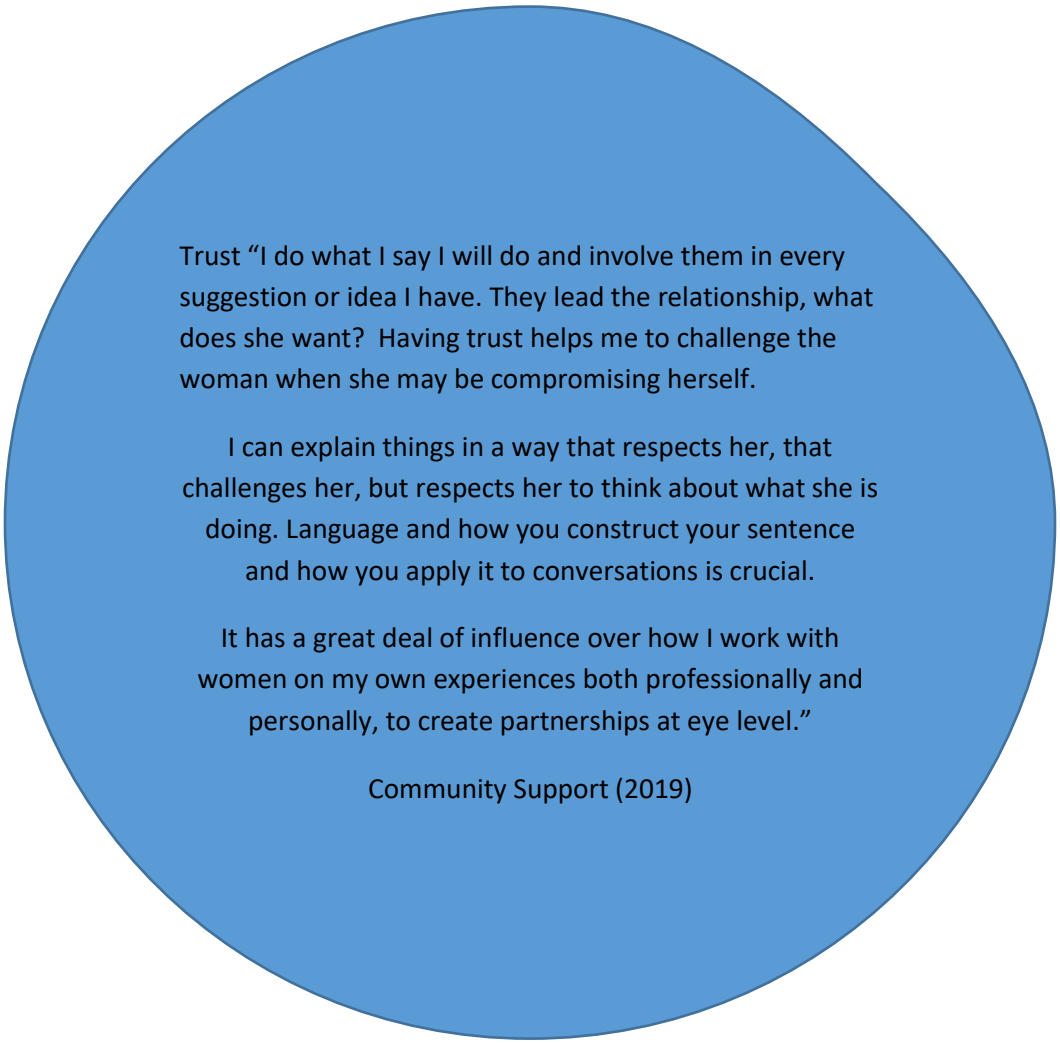
1. Waitamata LMC Midwives do not have easy access to community social work. CMH midwifery has a social work team attached to their service.
2. Waitamata Vulnerable Families Forum (VFF) does not usually ask consent from the women or whānau to speak about them in this forum.
3. VFF do not have capacity to offer full and comprehensive social and community support by way of a fully mobile community team.
4. Waitamata involve Child Protection Services in planning, whereas Te Waiora does not see child protection as having a role in the community care of the women and her whānau.

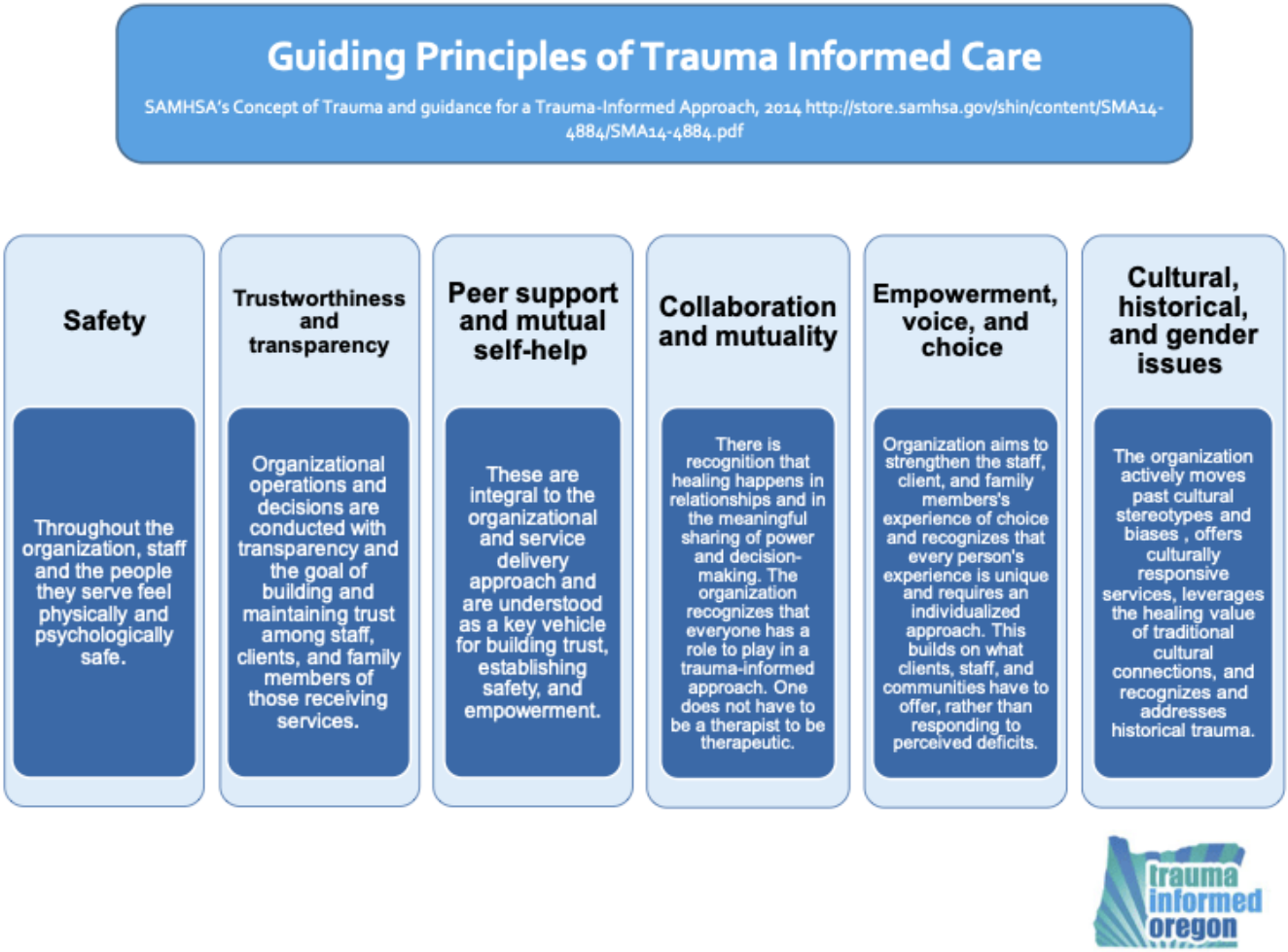
Trauma informed theories

The study found consistently that the women in this study had experienced trauma from childhood through to their adulthood. A trauma informed approach to supporting women in Te Waiora was a key area which was addressed through internal training with all community midwifery staff. Bruce Perry's work on Trauma Informed Practice identifies keys areas we focused on when working with women.

Trauma Informed Care Principles:

- Safety.
- Trustworthiness and transparency.
- Peer support and mutual self-help.
- Collaboration and mutuality.
- Empowerment voice and choice.
- Cultural, historical, and gender issues.





Trauma Informed Oregon, Regional Research Institute for Human Services Portland State University (2021).

The number of interventions is always driven by need. The Intensive Case Management model (ICM) is based on the notion that intensive care in the community can render better outcomes for health and social wellbeing. ICM has been used extensively with mental health services. James, Rivera, Sullivan, & Valenti (2007) argue that when patients' have community support they are more likely to engage with services resulting in overall better outcomes than brokering services through referrals. These full-service treatments, often referred to as intensive case management programs, exist in a variety of forms—for example, assertive community treatment and strengths-based treatment. These programs

consistently proved effective in retaining patients in treatment, reducing time spent in the hospital, and increasing patient satisfaction with treatment. (James et al. 2007)

When a woman is seen on the ward, a referral to a provider may be accepted by the patient. However no follow up is required, so it is difficult to see if the women or the services have engaged and that it is an on-going problem. It was important that Te Waiora was able to capture the needs of the woman and adopt an intensive approach to meet multiple complex needs in the woman's community.

Forming a team

Te Waiora and MAGs process is delivered by community health workers, social workers and the service management team who has oversight of the service. The teams' commitment and passion is an overarching component of the work done by Te Waiora. Having team members who show a commitment to empowering women to make informed choices means that an hour a week is not enough time to work with people who have multiple needs. Team members have spent whole days with one women because that was what was required. Other team members were able to support that team member by managing other demands ensuring everyone was supported. Where team members differed was in their passion and commitment to change their day to accommodate others. As evident in helping services across the world there are varying degrees of passion and commitment, but it is always important to try and nurture these qualities when they are evident.

Developing processes.

To operationalise the tools, the Te Waiora team members developed a needs criteria driven by health and social needs for referrals. The criteria were decided through discussion with staff working on the MAGS policies and processes. The referral system was put in place where all referrals would come through the CMH Maternity department's referral email to one place that could be accessed by the team. 98% of all Te Waiora referrals are generated from midwives.

Allocations

Once a referral is received it is discussed according to urgency. If the woman is in very early pregnancy contact is usually made (if she consents) in her second trimester. If the referral is urgent then it may be actioned the same day. Once consent is received and engagement is made, the process is discussed with patient. Confidentiality is discussed and we commence building the relationship. The staff members delivering the face to face service were given training around the model, and now assist in the delivery of

training to others. During this phase the social worker (with consent) can provide an assessment opportunity; the plan always includes the women's needs and goals. There is a strong focus on how the women interact in their community. This assists social workers to understand where the strengths, weaknesses and resistance lay in the community, and the impact on the patient and her whānau. It is also important to ensure they are using a tool that safe and appropriate for each patient. The absence of trust, particularly engaging with services, also contributes to why women do not seek out support.

When asked, Community Health worker D explains what she most enjoys about the MAGS work she does. D says *"The thing that is most rewarding is it is all about the mother and helping her in its entirety and not about all the others around her. It's about her. Giving the mother opportunities. It's not about her past. We give them a chance open the door, and we lead them through it. It's a professional friendship"*

What do you think about the processes we use to work with women and their whānau?

"The processes we use are great as long as they are tailored to meet the women's needs." Each women is unique and we have at adjust the way we work to meet her needs, so the way I work with one woman is not going to work with another women. I have to be allowed the flexibility to be spontaneous. But I am still aware of MAGS and our processes.

How do you measure a successful outcome?

"When she trusts me then we can work together as a team, without trust nothing will happen"

Why do you think that using this approach works?

It works because of all the women we have worked with. There are no tick boxes, it's not official, it's a real relationship about her and her needs.

If it was formalised and you were expected to tick boxes would this have the same outcome?

No, it wouldn't work because it's no longer about her, it would become about me ticking those boxes".

The case of Z

Z had multiple health complications and a referral was made by her midwife. A home visit was done where a social work assessment was completed. Her case was discussed with the MAG's team and D was allocated as her community health worker. Another home visit was arranged and introduction was completed. A social work assessment consistent with the Kaupapa Māori philosophes of Te Wheke, and underpinned in HEAL, was applied. The uniqueness of the mother and her situation were identified so the plan could be tailor-made for her needs. MAGS supported the woman to appointments. This could be for

health, housing, legal or WINZ. D calculated she completed 140 hours (based on calendar records) with patient Z from her 26th week of pregnancy until 6 weeks postnatal.

To break it down further, the patient asked for support with her complex health needs including getting to and from doctors and specialist appointments. She also required support with Child Protection Services including attending meetings and providing updates. D provided supports including attending a parenting support programme several kilometres from Z's home. Practical support included helping Z with funding applications for furniture, fixing her car, clothing and other needs as they occurred.

The case of Y

In the case of Y, her community support was E. She was a young mother at 18 and having her second child, the first being removed from her care by Oranga Tamariki. A referral was sent to the community social worker, and a home visit was initiated. When she realised that the support we could offer was about her antenatal care and we placed significance on her journey through her pregnancy, she engaged immediately. When she was asked about her experience with MAGS she said “I felt heard”. When she had to meet with Oranga Tamariki she would ask MAGS for support, we would always make ourselves available for her even if it meant changing other things.

Close to her birth she was assessed by Oranga Tamariki because she had already had her first child removed. Her community health worker E waited all day with Y, the OT social worker arrived in the late afternoon. This meant E was not in the office for several hours, but was able to ensure that Y was supported. When the social work assessment was completed, Y was advised she would be taking this baby home but there would be a Family Group Conference (FGC). At that point all the progress Y had made meant there were no care concerns, and case was closed.

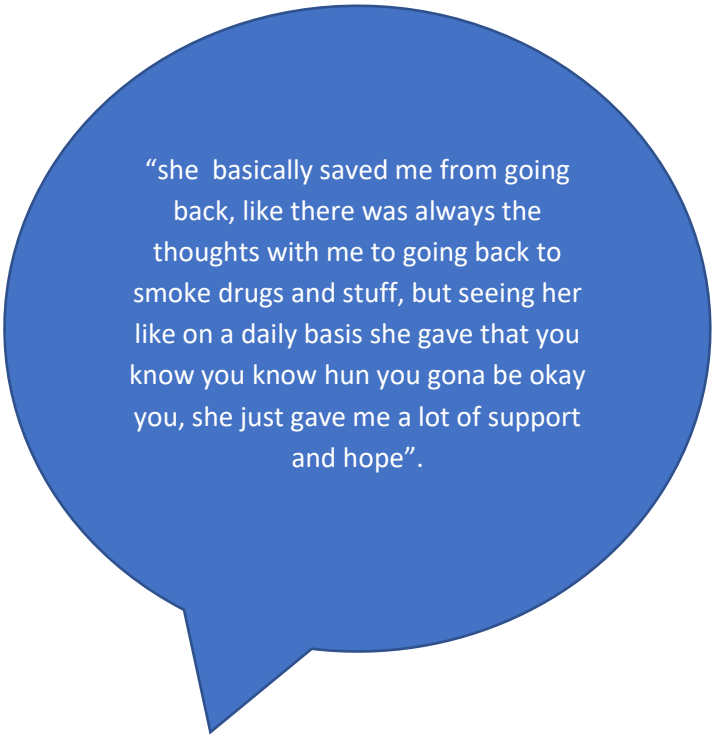
The case of F

In the case of F she had all her previous children removed and was in a relationship with her baby's father. Her case was referred to MAGS by her midwife. She was first seen on the ward at about 22 weeks gestation. Baby had some health concerns, so Community health worker D and A community social worker visited on the ward. F interacted well. Her partner however, was not so engaging. We told them that our work is about giving mother and baby the best support through their antenatal care and up to six weeks postnatal. There were several incidents of family violence between mother and father and we talked openly about this at length with them both. The key point was they were not judged for being in the relationship. To understand the relationship, and how we could best support mother and baby, we had to tailor our plan to include her partner. That meant getting consent to transport both parents in work vehicles, as he wanted to be part of her support plan.

Once approved we could support the couple with attending all the appointments including criminal court, Oranga Tamariki, specialist appointments, discussion with whānau, and WINZ appointments. The couple agreed for MAGs to work with Oranga Tamariki, but we would always share our outcomes and discussions to keep the relationship equitable. A planning meeting commenced, and follow-up meetings were held monthly until birth, with a final meeting one month postnatal. Their Oranga Tamariki social worker told F she would be taking her baby home. This came as a surprise to the couple.

The case C

C had lost custody of all 5 of her previous children. She became pregnant with her 6th baby and was using meth on a regular basis. She wanted to keep this baby and detoxed herself off meth. C says that having the extra support helped with her confidence and ability to stay off meth.



None of the women we interviewed understood documents such as s78 & s101 Orders, Affidavits, Home For Life. This meant that the women were essentially disempowered to contest or stop the taking of their children. Although OT should advise the women of their rights, there is little evidence to support this from our interviews. Therefore, part of our assessment was to establish legal advocacy that could be accessed by/for the mother once the baby was born. We sought feedback from lawyers we worked with about how they found our service in supporting this process.

" The tautoko that MAGS have provided for our mutual client has been inspirational to watch in action. Many of our people involved with the Court lack 'real' support. You have provided our mutual client with Aroha and Whānaungatanga and have allowed this whaanau to maintain and build their mana. You have been a voice for them and in turn have helped them to gain a voice amongst a continually moving and confusing environment".

Lawyer (2019).

Te Waiora has now extended to assist with teen pregnancy, and workers can form relationships with the patients and whānau (when they were able to be located). The new approach focuses on the immediate need of the young person. Feedback from the social workers indicated that this group is one of the most difficult to engage, and require a lot of patient and persistence. Sometimes buying them lunch was the only way to get their attention. This often gave staff an opportunity to start developing a relationship with them, because they had no income, they were not usually at home, and were under 18 years of age, so helping meet their basic need for food became a good starting point. This work is on-going but lack of resourcing means we cannot always work intensely with these young, often Māori, women.

Findings

Our data shows 100% of the women we interviewed have not had any major health and or social issues with their children after utilizing this intervention. Trust, intensiveness, sensitivity, continuity, flexibility, and believing in the women, influenced change with women who had experienced their children being removed from their care previously. One day a fortnight or an 8 week parenting programme had little impact on the outcomes for these women. Providing intensive support throughout their pregnancy, where there is trust that we are working with them, establishes strong links between the mother and her worker. The Te Waiora staff experienced that CMH policies, systems, and structures pertaining to women receiving maternity care and identified as at risk of harming their baby, is profiling Māori women in particular as the problem. Further, child protection policies and procedures play an instrumental role in placing inaccurate and misleading information on CMH data systems. This needs to change and quickly.

There is an urgent need to address the disparities for Māori and Pacifica in CMH health, and it should start in antenatal care. Currently, we remain risk focused, and place less value on long term wellbeing. That is why we cannot address poor social and health outcomes for our most vulnerable. The following recommendations are based on redirecting health social work to consider how we maintain strong links with the community and the people who access our services, with the aim of:

1. Reduced admissions to hospital.
2. Challenge unhelpful systems that prevent people having access to good services.
3. Reduce silos and set up multi-agency systems that cross over into the multiple needs of people.
4. Ensure culturally sound practice that permits people to be valued.
5. Eliminating risk focused practice.
6. Reorganising systems that are not cost effective.

Recommendations

The report recommends the following:

1. A review of women's maternity social work policies, systems, structures, and practice at CMH. This review should include a review of the effectiveness of ward social work practices. The review should examine the value of psychosocial assessments in terms of improving health and social outcomes. Psychosocial assessments can be replaced with a needs focused assessment, where short interventions such as ward social work can be more effective.
2. The report recommends a review of the functions of child protection policies and procedures that demonstrates that there are effective outcomes (i.e. any decrease in the number of family violence and/or child abuse cases in CM) for patients, their whānau, and their communities. Capturing the data about these outcomes gives consideration to the number of staff in CP team that have the largely administrative roles of placing alerts on vulnerable people and attending Multi-disciplinary meetings (MDT). The current process is not cost effective and does not seem to contribute to better health and social outcomes.
3. A review of training being provided for family violence with particular consideration of the bicultural content of the training. Training in FV must aim to train staff on the multiple facets of family violence.
4. Consideration needs to be given to locating more social work practices in the community based on the current Te Waiora model. This is more cost effective than the current procedures because women and their babies are not returning to healthcare with social and health needs

after being supported by Te Waiora. All women who had their babies removed went on to have other children removed multiple times. This stopped after the women experienced Te Waiora.

5. Consideration is given to the support of independent LMC's who supply most of the maternity care in South Auckland. The Ministry of Health and Ministry of Social Development must consider providing more resourcing so clinical health social work can function in partnership in the community. The current models of care do not demonstrate the same level of intensity provided by Te Waiora. The research argues this should to be considered as a big picture social development issue.
6. The development of compulsory training for social workers and community workers to work effectively with complex needs. All social worker should be afforded core training in working using a Trauma Informed Care model. This training could be delivered internally.
7. Development of a complex care model that ensures intensive, long term care is streamlined to meet the needs of patients with multiple complex needs including a multi-systemic approach to care. Working in silos means that patient care is stifled when services needs override the needs of patients. CMH need to embark on a *joined up response model* that encapsulates the services within CMH, but where external providers like MoJ or similar can draw commitment to improving outcomes.
8. Cultural supervision and training that enhances opportunities to develop cultural congruencies to meet population demands.

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Abbreviations

- CMH – Counties Manukau Health
- CM Counties Manukau
- CP Child protection.
- CHW Community health worker.
- DHB –District health board.
- FGC Family Group Conference
- FV Family Violence
- ICM Intensive case management
- LMC Lead Maternity Carer.
- MAGS Multi Agency support service
- MSD Ministry of Social Development.
- MoH Ministry of Health.
- MoU Memorandum of Understanding
- OT Oranga Tamariki.