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Kaupapa Māori approaches to Trauma Informed Care

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He waiata whakamana – Kia tū tonu tātou

I ruia mai i ngā taketake māhaki	We come from humble beginnings
Kia mau ki ō tātou ake ahureia	Treasure your uniqueness
Ka oranga mātou hei whakarite tatai	We are here for a reason
Ngā maramara o rātou, ka mate, ka ora.	Our tupuna live through us
Kia tū tonu tātou	Continue to stand proud
Kaua e wareware a rātou nei mamaetanga	Don't forget the struggles they went through for us
Koia anō, me tūtuki ai tatou pērā ki a rātou	Indeed, let us achieve as they have achieved
Ko rātou te ranga wairua	They are our inspiration
Mā te oranga o te iwi, ka mamahi mihikore	We all make sacrifices for our people
Ko te hua o ngā mahi to tātou ake utu	Let the fruits of our hard work be our reward
Kei roto te tino rawe teitei	Our beauty is within us, stand tall, stand proud.
Whakahōnore tō mauri	Honour your mauri
Whakahōnore mauri kē	Respect the mauri of others
Ārahi tōtika i ngā uri, e heke mai ana.	We must lead the way for those to come.

Nā Kathleen Nelson

Nō Te Roroa, Ngāti Whātua me Ngāpuhi

Abstract

Health and social service providers within Aotearoa New Zealand have struggled to meet the needs and aspirations of tāngata whenua. Colonisation and its impact on tāngata whenua have been at the root of intergenerational, cultural, and historical trauma.

Embedding Kaupapa Māori theory and practice in healthcare and social service delivery is the change needed within mainstream organisations. Therefore, this research examines: How do Kaupapa Māori values and beliefs within social work practice align with being trauma informed to deliver better health outcomes for Māori?

Triangulation of Kaupapa Māori methodology, Trauma Informed Care (theory and practice) and qualitative interviews with Māori health social workers were utilised to conduct this research, with Kaupapa Māori research overarching the entire project.

Trauma Informed Care (TIC) and Adverse Childhood Experiences (ACE's) are two models being used with whānau Māori in the health and social services sector in Aotearoa New Zealand. Each model is explored through its origins and current application. However Indigenous literature on trauma calls for the restoration of traditional ways of healing through cultural protective factors.

First-hand experiences from Māori social workers who have worked or are working in mainstream health (DHB's) identify the gaps in delivery and how their values and beliefs make a difference to their social work practice.

Historical Māori health and social work literature and the failings of Government social services on the current media reflects the minimal health and wellbeing improvements made for Māori. Optimal health and well-being are a universal right, but if the system is not working for Māori, then the system needs a different approach and tāngata whenua worldviews are key to its success.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person, nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature……

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Acknowledgements

Ehara tāku toa i te toa takitahi,
Engari he toa takitini
My success should not be bestowed on me alone,
It was not individual success but the success of a collective

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Chapter 1: Introduction

> A 'one size fits all' model tends in practice to suit the needs of the majority, who are rarely the group in most need of help. Even when they can access mainstream aid and services, minority groups such as Māori have often found that what is being provided simply does not work for them or is so alienating that they prefer to disengage. (Waitangi Tribunal, 2017, p. 3776)

According to the findings of the Waitangi Tribunal (2017), mainstream support services are failing Māori. The New Zealand health system is irrefutably flawed with the 'one size fits all' and 'business as usual' disposition. Limited research is available on Kaupapa Māori approaches to Trauma Informed Care (TIC) in health social work delivery. However, there is extensive research on TIC, by and large, void of Indigenous reference and *mātauranga Māori* (Māori knowledge).

Background and Context

Colonisation's role in trying to eradicate cultural protective factors such as *te reo Māori* (the Māori language), *tikanga* (ways of doing things correctly) and traditional ways of healing, is relevant to this research as these are vital protective factors for a flourishing cultural identity.
Education and awareness of Māori experiences of trauma, inflicted through colonisation, has been widely ignored in the development of TIC.

The need to address TIC in Aotearoa New Zealand and what trauma looks like from a Māori perspective is imperative, as the current political shift towards Māori reclaiming Indigenous rights and fighting for ownership over health and social work delivery, by Māori for Māori, has intensified. Disparities between Māori and non-Māori and health inequities that permeate throughout life spans and generations should no longer be acceptable as the norm, and therefore change is needed.

The call for change is not new, the *Pūao-Te-Ata-Tū* report (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988) proved to be a critical document that identified racism throughout the social work sector. Despite the Report's recommendations, minimal changes were implemented in the sector, and this has resulted in damage that can still be traced in the contemporary political and social landscape of Aotearoa New Zealand.

Kaupapa Māori values and beliefs have influenced social work practice to provide meaningful interaction with a depth of practice that has to be lived to be delivered. Henry and Pene (2001) present a succinct definition of a Kaupapa Māori approach that has guided this study:

> Kaupapa Māori is both a set of philosophical beliefs and a set of social practices (tikanga). These are founded on the collective (whanaungatanga) interdependence between and among humankind (kotahitanga), a sacred relationship to the 'gods' and the cosmos

> (wairuatanga), and acknowledgement that humans are guardians of the environment (kaitiakitanga), combining in the interconnections between mind, body and spirit. Taken together, these ethics inform Māori ontology and assumptions about human nature; that is, 'what is real' for Maori. Traditional Māori ethics and philosophy also drive Māori epistemology; that is, to live according to tikanga Maori, that which is tika and true. (p. 237)

Key Te Ao Māori principles are reflected in this statement, which brings together the realities that whānau Māori experience. The holistic natures of Māori ontology and epistemology are clearly identified and underpin all phases of the research process. As a paradigm, it imbues the research with Māori ways of knowing and articulating the world.

The Research Question from a Kaupapa Māori Social Work Lens

As a tāngata whenua practitioner working in a DHB and part of a TIC working group, my role at the table was to research and implement a Māori worldview of TIC within the department I was employed by. I then embarked on this research journey. Initially, the research question looked to explore whether Trauma Informed Care (TIC) principles, within a Māori values and beliefs framework, deliver better social service outcomes to *whānau Māori*. However, the literature was more consistent with the question 'How do Kaupapa Māori values and beliefs within social work practice align with being trauma informed to deliver better health outcomes for Māori?' What transpired from the research is Kaupapa Māori values and beliefs already provide the framework that addresses trauma.

The Research Process

Triangulation brings together Kaupapa Māori theory and practice, TIC theory and practice, and qualitative interviews to develop culturally appropriate practice principles that can be utilised by health social workers. Thematic analysis was used to identify the diverse views and opinions within the evident themes. Kaupapa Māori theory and practice underpinned the entire project to capture the lived realities of Māori and illustrate the interconnected way in which Māori view the world. The intention of a Kaupapa Māori methodology reinforces and adds to research done by Māori, for Māori.

Overview Of Chapters

This chapter has given context to the research on why and how the research has been conducted. In chapter 2, I provide an insider's perspective to the intergenerational trauma felt at an *iwi* (tribal) level through Te Roroa's history. A *hapū* (subtribe) and *whānau* (family) narrative, is illustrated which highlights societal racism that impacted on vulnerable identities. The healing of trauma followed, through strengthening links to one's *tūrangawaewae* (a place to stand), *aroha tētahi ki tētahi* (love for one another), resilience, and the reclamation of identity.

Chapter 3 focuses on three areas of literature. Firstly, Intergenerational, cultural, and historical trauma from an Indigenous perspective, secondly, Kaupapa Māori values and beliefs in addressing these types of traumas and thirdly, Trauma Informed Care (TIC), the origins of Adverse Childhood Events (ACEs) and its application in healthcare/social service delivery.

Chapter 4 explains the research design and ethical considerations taken to conduct this research as qualitative interviews was a carefully chosen method to encapsulate Māori health social work experiences within a DHB (District Health Board) setting.

Chapter 5 presents the rich personal and professional accounts of social work experience from Māori practitioners. They are practitioners who have woven mātauranga Māori into their practice and have worked tirelessly to maintain, within a challenging DHB environment.

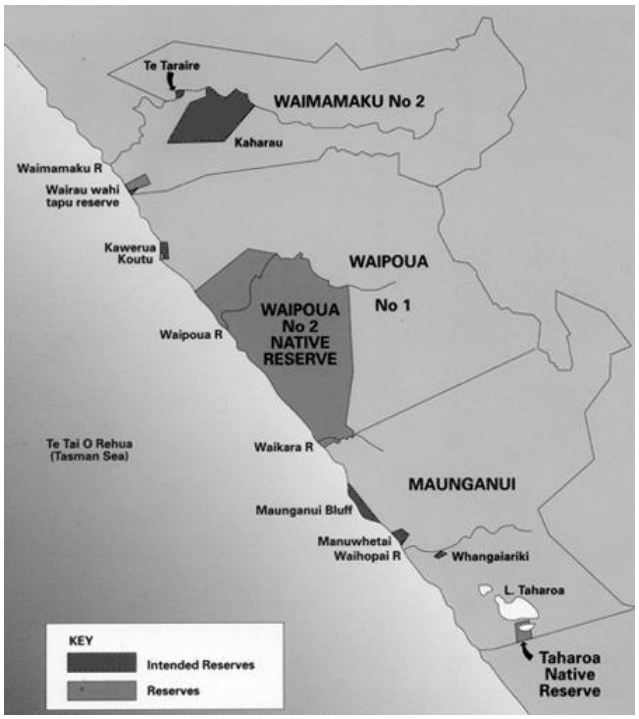
The research concludes by bringing all the evidence together that supports the critical importance of Kaupapa Māori values and beliefs within social work practice that provides the framework for TIC, to deliver better health outcomes for Māori.

Chapter 2: Positioning the researcher

Ko Maunganui te maunga
Ko Ripiro te moana
Ko Kaihu te awa
Ko Māhuhu ki te rangi te waka
Ko Raniera te Rangatira
Ko Waikaraka te marae
Ko Te Roroa, ko Ngāti Whātua, ko Ngāpuhi ōku iwi

My *Taitokerau* (Northern) whakapapa to Te Roroa, Ngāti Whātua and Ngā Puhi is my mother's gift. My Pākehā heritage can be traced back to England and Clan Crawford, Scotland. Whakapapa (genealogical ties) and *tūrangawaewae* (place of belonging) are the focus in this chapter and the damaging implications that ripple through the generations if these are under threat. My upbringing and exposure to societal racism and injustice has shaped how I view the world, yet more importantly how I address trauma and embrace change for future generations.

Figure 1
Te Rohe o Te Roroa



Note. Map of the Te Roroa area. From *The Te Roroa Report* (Report no. Wai 38), Waitangi Tribunal, 1992 (https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_68462675/Te%20Roroa%201992.compressed.pdf).

My great grandparents Hori Kapu Rahui and Kereihi Raniera Taoho Te Rore Rahui eventually settled in Kaihu, near Dargaville. This is our *tūrangawaewae* (place of belonging through whakapapa – genealogical ties), the place I feel strongly and immutably connected to. Te Roroa covers the West Coast from the Hokianga to Tokatoka, in the Kaipara region. Te Roroa lands were obtained through fraudulent means by the Crown and were sold on to private landowners. Te Roroa filed their claim against the Crown in 1986 with the Waitangi Tribunal. The *Te Roroa Report*

(WAI 38) (Waitangi Tribunal, 1992) captures the context and essence of intergenerational trauma that underpin this study.

The image in Figure 2 captures the mana, resilience and sheer determination felt by the people of Te Roroa at this time. *Pōuritanga* (sadness, despondency, gloom, unhappiness) and *mamae* (hurt, be painful, sore, ache, injury, wound) were also experienced by the iwi, following a long, arduous history between Te Roroa and the Crown.

Figure 2
Protecting one of Te Roroa's Sacred Sites

***Note*.** Left to right: Great Aunt Keti Raniera Nathan (née Te Rore), my cousin Janaya Rehu, and my Great Grandmother Kereihi Raniera Taoho Te Rore Rahui, protecting one of Te Roroa's sacred sites. Family photograph, published in North and South magazine, circa 1989.

Prior to the signing of The Treaty of Waitangi 1840, settler groups and the Crown inflicted grief and trauma on Māori, through political violence and cultural and land alienation (McClintock et al., 2018). Fanon (1963) portrays the devastation of colonisation:

> Colonialism is not satisfied merely with holding a people in its grip and emptying the native's brain of all form and content. By a kind of perverted logic, it turns to the past of the oppressed people, and distorts, disfigures, and destroys it. This work of devaluing pre-colonial history takes on a dialectical significance today (p. 210).

This is evident in the historical experiences of *tāngata whenua* (people belonging to the land). The lands and *mana* (honour and prestige) of the chiefs and people of Te Roroa were waning from the late 1870s. By the 1920s the iwi was described as "the sea birds which perch upon a rock because they have no other resting place. Through the loss of land, they had become morehu, that is, mere survivors who were no longer able to control their own lives" (Waitangi Tribunal, 1992, p. 171).

The Waitangi Tribunal's (1992) findings accuse the Crown of using methods that separated Te Roroa from their lands. Hon. Dr Michael Cullen acknowledged Te Roroa's sustained efforts to challenge the Crown's breaches of the Treaty of Waitangi since at least 1861 in his apology:

> These breaches have left Te Roroa virtually landless. In this settlement the Crown also acknowledges that the separation of Te Roroa from their wāhi tapu and taonga has been a source of great spiritual and emotional pain for Te Roroa (Cullen, 2008).

Te Roroa, which in this context can be seen as a microcosm of all iwi is testament to the destruction evidenced in the diaspora, loss of language and poverty. The breaches of the Treaty from the Crown had devastating effects as traditional resources were threatened and traditional ways of sourcing food and living deteriorated. Although the Treaty settlement can never fully restore what was stolen from Te Roroa, Te Roroa reasserted *mana whenua* (territorial rights) over lands, including the magnificent kauri forest at Waipoua forest and Kai Iwi Lakes.

According to Kruger et al. (2004) colonisation has resulted in the destruction and distortion of Kaupapa Māori values and beliefs within whānau, hapū and iwi Māori. Edwards (1999) contends that "many Māori without knowledge of their cultural identity may not lead as full and meaningful lives as they might should they possess a sounder knowledge of their culture and cultural identity" (p.13). To this end I have made a personal commitment to learning *te reo Māori me ngā tikanga,* as *te reo Māori* was not spoken in my home. I also made a conscious effort not only to engage with my iwi but to use the skills that I have, to support my *marae* in Kaihu. I served as an executive committee member of Waikaraka marae for many years, that saw the rebuild of a marae complex to bring whānau back home to their tūrangawaewae.

Figure 4
Waikaraka Marae

Note. Waikaraka marae (new building), Kaihu. Author's photograph.

My personal philosophy of service is guided by the beliefs and values that persist within my whanau, hapū and iwi, despite the brutality of colonialism. The famous Te Roroa *whakataukī* (proverb) can be interpreted as a metaphor for this phenomenon:

Kei raro i te tarutaru, te tuhi o ngā tūpuna
The signs of the ancestors are beneath the plantings.

‘*Tarutaru*’ is a word that is more commonly translated as weeds. I see my own quest for cultural knowledge through the weeds that represent colonisation. The onus is on each generation to ensure the tarutaru continue to be cleared so the signs of our *tupuna* (ancestors) are kept visible. Hall (2015) states “trauma can be understood to have a whakapapa; this is where unresolved trauma remains nested in the whānau system, where underlying difficulties in everyday whānau life remain in the collective unconscious realities of whānau, hapū and iwi life” (p. 72).

The wider impacts of colonisation can be traced through the generations if there has been no healing:

> …offspring are taught to share in the ancestral pain of their people and may have strong feelings of unresolved grief, persecution and distrust. They may also experience original trauma through loss of culture and language, as well as through proximate, firsthand experiences of discrimination, injustice, poverty, and social inequality. Such experiences validate their ancestral knowledge of historical trauma and reinforce the historical trauma experience and response (Sotero, 2006, p. 100).

I grew up with three generations in a state house in Remuera, Tāmaki Makaurau Auckland, where my mother and her siblings were raised since the 1970s. Here my mother was a single parent raising four children.

Parties, cannabis and family violence were the backdrop to our early childhood. My experiences reflect the reality that “Indigenous peoples have experienced trauma through colonisation, dispossession and dislocation, as well as the trauma of on-going racism, family violence and other events in which the effects are indisputably unacceptable” (McClintock et al., 2018, p. 6). Societal impacts of colonisation are evident, but it does not excuse the perpetrators of violence and their actions. First-hand experiences of discrimination, injustice and social inequality were lived by my elders throughout their residence in Remuera in the mid-1960s.

Crown initiatives, in particular the pepper potting policy of the 1950s, were manifestations of institutional racism that permeated through New Zealand society.

In 1948 the State Advances Corporation Committee (SAC) and the Department of Māori Affairs established a Māori housing scheme that would see my grandmother allocated a house in the middle of Remuera, Auckland. The aim of this scheme was to intersperse Māori among Pākehā and to advance an assimilation agenda.

Schrader (2007) quotes from a staff memorandum of SAC:

> …in the selection of tenants to occupy the houses set aside for Maori’s the Allocation Committee will in addition to the over-riding consideration of housing hardship suffered by the applicants, have regard to the ability of the families to fit into the industrial and economic life of the community and to adjust themselves generally to the Pakeha way of living.

SAC later merged with the Housing Division of the Ministry of Works to form the Housing Corporation of New Zealand, now known as Kāinga Ora.

Whānau accounts of racism and the realities of 'pepper potting' (a form of mixed tenure development) relates to the experience of my heavily pregnant mother, forced off a bus in Remuera. The driver argued that no Māori live in Remuera. Despite her protests, my mum had to walk the next two kilometres home. My uncle, as a young teenager, was picked up on more than one occasion in Remuera and escorted home by police; he had to prove he lived at our address. It was as if Māori were out of place and did not belong in Remuera, a predominantly Pākehā suburb.

Racism and discrimination in the 1970s and 80s hit international coverage as seen from the eviction of tāngata whenua belonging to Bastion Point in 1977 and 78, and the Springbok Tour in 1981. This was the environment Māori lived through, which continues today, as seen in land occupations such as Ihumātao. Racism today is more insidious, hidden in poverty, health, education and justice disparities.

As a child of an incarcerated parent, I was driven by seeing injustice and poverty around me to advocate for change. For me, cultural alienation was exacerbated by growing up in what society would class as a dysfunctional family. Eventually, social work became my chosen profession, to support others that were going through or had endured trauma and were seeking pathways to healing and resilience.

My experiences growing up in a diasporic, dysfunctional whānau give me insights into the challenges that whānau I serve are confronted with, every day. In that sense this is truly insider research. As a Māori social work practitioner, I have always intrinsically practiced Kaupapa Māori values and beliefs. Despite lived experiences of trauma, healing can take place and resilience can be fostered. I have witnessed the healing of trauma: my siblings and I have seen great transformation in our mothers' journey, as her mokopuna (grandchildren and one great granddaughter) have anchored her in unconditional and unequivocal aroha and adoration. Maintaining healthy relationships within whānau, hapū and iwi informs my social practice. The Kaupapa Māori lens through which I view the world and my lived experiences allows me to see through the trauma and identify the strengths and hope that whānau carry.

Te mahi whakamana, or mana-enhancing practice, reinforces my social work practice by providing service to others and fostering a sense of their self-worth, while maintaining integrity in self and practice. It requires resilience and fortitude, because "…retelling narratives of loss and trauma can be distressing. Nevertheless, these can be recast as stories of mana and resilience in the face of adversity. Social workers can play an important role in nurturing stories of mana" (Ruwhiu, 2013, p. 106). Te mahi whakamana is embedded in the history, narratives and Māori concepts of Māori wellbeing (Eruera & Ruwhiu, 2018; Ruwhiu, 2013).

Tikanga have guided my decision-making processes and are embedded as normative practice for me personally. My learnings have not come easy mistakes have been made and I've learnt valuable lessons throughout my career. There have also been many challenges in having to traverse both Māori and Pākehā worlds to get the best outcome for whānau I have worked with. I have learnt from some of the best Kaupapa Māori social work practitioners. Not compromising my values and beliefs for organisational tick-box processes allows me peace of mind, at the end of the day.

This study provides an opportunity to integrate Kaupapa Māori practices into a mainstream social work environment in a way that is truly meaningful.
I began my career as an NGO (Non-Government Organisation) social worker. I have worked mainly with Māori and Pasifika whānau, providing support and advocacy on family violence, alcohol, drug misuse and relationship breakdowns. Systemic challenges with NZ Police, Corrections, Health, Oranga Tamariki and WINZ were encountered each day. More times than not, whānau needed support to effectively engage with these government institutions.

I then spent two and a half years in Starship Community ADHB, the first Māori Practice Supervisor there in many years. During my time there I brought together a team of Māori and Pākehā social work practitioners to build relationships with tertiary providers (Manukau Institute of Technology, Unitec and Te Wananga o Aotearoa), to increase the visibility of Māori students, and eventually Māori social work practitioners, in the DHB. One result of this work was the first Māori social work student doing placement with Starship Community in over 10 years.

Trauma Informed Care (TIC) was introduced to the service during this time. I was part of the working group tasked to implement TIC in Starship Community. My role was to bring a Kaupapa Māori lens on TIC. The first step was understanding TIC, introduced through an offshore Oregon model to be discussed further in the literature review. I then set out on a journey to explore other Māori social work practitioners' experiences of how they work with whānau that have endured trauma, and what Kaupapa Māori approaches they utilise in their practice. This will be explored more in Chapter 5: Findings.

The ACEs research and screening tool, covered in the literature review, is considered as it is the main driver in implementing TIC internationally and in New Zealand's child protection and health systems. The ACE's screening tool does not acknowledge colonial, historical or intergenerational trauma from a cultural perspective. This concerned me, as most children presenting with high health and child protection needs are *tamariki Māori* (Māori children) and collating a care plan based on their ACEs score would not necessarily meet their intricate and complex needs.

Based on my upbringing, my ACE score is very high. However, I am fortunate enough to share the cultural buffers that offered resiliency in my early adulthood. However, the narrative of my journey provided me with key learnings, embedded in a Kaupapa Māori worldview that has provided me with strength. One of my biggest key learnings is that identity is at the heart of every interaction with others, this is where my understanding of 'what works for Māori works for everyone' rings true. Identity should be fostered and nurtured as part of mana-enhancing practice.

My current role with a Kaupapa Māori organisation provides whānau-based health, wellness and social services to the Counties Manukau and Auckland DHB areas. The approach to wellbeing and trauma is different to the DHB's service delivery. There is a Hauora Wellness Team made up of cultural healers whose teachings are facilitated through wānanga, such as: *maramataka* (Māori lunar calendar), *orokorua* (Māori meditation), and *wairuatanga (spirituality)*, which is seen as key in healing processes.

The next chapter explores views on approaches to trauma, both Western and through a Kaupapa Māori lens and how this translates in social work practice. TIC, ACEs and their relevance to health and social services are investigated to provide an overview of the current landscape in addressing trauma.

Chapter 3: Literature review

This literature review was conducted through online searching, utilising libraries, face to face communication, workshops, training and wānanga. The literature covers two main areas that covers the overall analysis on how Kaupapa Māori values and beliefs are integral in social work when working with trauma and its efficacy in mainstream DHBs.

Ontology and epistemology from a tāngata whenua perspective was canvassed to explore values and belief systems and what this means for a tāngata whenua social work practitioner, two social work models are explored to showcase practice.

Because approaches to trauma are an integral aspect of clinical practice a critical analysis of TIC, its origins and development, practice principles and organisational approaches, will be described in detail to ascertain its efficacy in health social work delivery when working with Māori. The application of Adverse Childhood Events (ACE's) as an assessment tool and its contribution to the development of TIC will be explored to gauge the full extent of mainstream models and its offshore origins and what this means for *tamariki Māori* (Māori children) in the health system.
This review gives comparison to Māori and non-Māori ways of working, which are crucial to optimal wellbeing and whānau Māori aspirations. The review is not to diminish Western or tāngata whenua ways of working, but to explore potential grafting and collaboration between the two and bringing mātauranga Māori to the forefront of applied practice.

Trauma Informed Care (TIC) acknowledges the harmful effects of intergenerational trauma, and there is a growing body of national and international literature associating trauma with the colonial experience (Atkinson, 2013; Brady, 1995; Dumbrill & Green, 2008; Evans-Campbell, 2008; Gone, 2009; Walters et al., 2011). There is also a growing body of literature on the harmful effects of intergenerational trauma (Atkinson, 2013; Linklater, 2011; Brave Heart & DeBruyn, 1998; Cutuli et al., 2019). Figley (2012) suggests that childhood trauma can distort a worldview of trust, safety, beliefs, and identity; these early childhood experiences could lead to adult vulnerability to dysregulation and destructive behaviours.

International Indigenous literature has paved the way for Māori to conceptualize our own experiences of colonisation and oppression (Waretini-Karena, 2012; Pihama et al., 2014; Wirihana & Smith, 2019). This work is the catalyst for this study, which aspires to support the development of Kaupapa Māori approaches to TIC delivery in the health care sector in Aotearoa, New Zealand.

An exploration of the TIC elements that interact with Kaupapa Māori and Indigenous theories, and a consideration of existing models (Huata, 1997; Pohatu, 2003) provides a platform for developing effective delivery in the social work sector.

However, there is not one definitive Kaupapa Māori or TIC approach. The range of different interpretations in the field of social work theory and practice is a work in progress. In relation to this

study, they inform the development of a Kaupapa Māori/TIC social work model for delivery to *tamariki* (children) and their whānau in health delivery.

Intergenerational, Cultural and Historical Trauma

This section covers the collective experiences of intergenerational trauma and the long-term impacts on Indigenous people. The review shows how people are affected by trauma and the political restoration needed to address intergenerational trauma. This has great significance for Indigenous people “the majority of Indigenous peoples have lived, or are living, in trauma; and in most cases, this trauma is multigenerational' (Linklater, 2011, p. 13).

Brave Heart et al. (2011) explains historical trauma as "cumulative emotional and psychological wounding, over the lifespan and across generations, emanating from massive group trauma experiences" (p. 58). The Jewish holocaust is used as a comparison to the American Indian holocaust (Brave Heart & DeBruyn, 1998). This comparison is centred within a collective and cultural worldview, as Alexander (2004) identifies cultural trauma as occurring “when members of a collectivity feel they have been subjected to a horrendous event that leave indelible marks upon their group consciousness, marking their memories forever and changing their future identity in fundamental and irrevocable ways” (p. 1).

Additionally, Lehrner & Yehuda (2018) shares a critical view on how cultural trauma translates in transgenerational epigenetic transference:

> Evidence in cultural trauma in past generations may leave traces in the epigenome may serve to validate offspring experiences or to imply a legacy of damage. As with the experience of trauma itself, the narrative we tell about its meaning has much power in determining the consequences (p. 1773).

The Waitangi Tribunal (2019) provides an enlightening perspective on the “intergenerational transference of whakamā” (p. 116), (*whakamā* meaning shame or embarrassment) from the 19th century, which saw devastating land theft and cultural destruction. This whakamā was carried by that generation and inherited by the next.

The emerging Indigenous literature on trauma informed care places a strong emphasis on historical and intergenerational trauma, holding the colonisers’ systems to account for the lack of redress, and emphasise the need to acknowledge traditional ways of healing within health care delivery (Brave Heart et al., 2011; Evans-Campbell, 2008; Pihama et al., 2014; Walters et al., 2011; Waretini-Karena, 2012).

Although there is extensive literature on colonial history in Aotearoa New Zealand and its impact on tāngata whenua, the more recent literature (Atwool, 2019; Eruera & Ruwhiu, 2018; Hollis-English, 2016; McClintock et al., 2018) focuses on the impact of colonial and historical trauma and the need for social services to have a trauma informed approach. The impact of historical traumatic

events has had a detrimental effect on the intergenerational transmission of Māori cultural protective factors such as te reo, tikanga and historical narratives (Walters & Simoni, 2002).

Pihama et al. (2017) argues that Māori have experienced historical, colonial and collective trauma (multiple forms of racism) for nearly 170 years. Therefore, approaches to trauma need to be different, as “trauma is an experience that can impact on all people, Māori experience trauma in distinct ways that are linked to the experience of colonisation, racism and discrimination, negative stereotyping and subsequent unequal rates of violence, poverty and ill health” (p. 18).

McClintock et al. (2018) propose that "a national approach to Trauma Informed Care in Aotearoa New Zealand relevant to Māori must consider the effects of historical, cumulative, intergenerational and situational trauma" (p. 3). This view is shared by Atwool (2019), who outlines the impact of historical trauma for Indigenous people in the context of Aotearoa New Zealand’s colonial history and argues that it is incumbent on governments to acknowledge the impact of colonisation and the commitment needed to work in partnership with iwi.

Pihama, Cameron, and Te Nana (2019) propose that Kaupapa Māori and historical trauma must be anchored in any development of trauma informed care frameworks, as the current Western frameworks lack comprehensive understanding of collective trauma and its impact on Māori.

Te Pou o Te Whakaaro Nui (2019) propose that cultural identity should be the central focus of wellbeing and recovery, as this approach can enhance the strengths, protective factors and resiliency of the whānau that social workers are working with. They recommend that the Treaty of Waitangi must underpin all discussions on trauma within Aotearoa New Zealand, as due to colonisation Māori experience intergenerational trauma at an individual and collective level.

Despite the existing literature, there is a still a need for more research around Māori practices that address historical trauma and the facilitation of healing that follows (Wirihana & Smith, 2019).

Having established Indigenous and more particularly Māori views of trauma, I now turn to the application of understanding trauma and the implication for social work in Aotearoa New Zealand, with young people particularly.

Trauma, Social Work and the Impact of Colonisation

In July 2014, the IFSW (International Federation of Social Workers) and the IASSW (International Association School of Social Work) General Assembly approved the following definition of social work:

> Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility, and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledges, social work engages people and structures to address life challenges and enhance wellbeing. The above definition may be amplified at national and /or regional levels. (International Federation of Social Workers.

This definition recognises Indigenous knowledge as a body of knowledge that underpins practice for engagement. The IFSW support Indigenous social workers in identifying social work issues and developing solutions, “Indigenous social workers should take the lead in development initiatives and services for Indigenous peoples” (International Federation of Social Workers, 2012). Prior to this, in 2009 the Tāngata Whenua Social Workers Association (TWSWA) initiated discussions on having an Indigenous voice within IFSW. With persistence and determination TWSWA achieved this aim, with the establishment of an Indigenous Commission in July 2020.

TIC in Aotearoa New Zealand has been defined as “grounded in and directed by a thorough understanding of the care neurological, biological, psychological and social effects of trauma on people” (McClintock et al., 2018, p. 10). This definition fails to address how trauma affects people spiritually, which would be central to a definition from a Māori worldview.

According to Pihama et al. (2017) there is a critical need for “research that specifically seeks to define and create Kaupapa Māori approaches to the growing focus on Trauma Informed Care within Aotearoa in order to ensure culturally grounded approaches and practices are underpinned by a strong evidence base” (p. 22). This alludes to more research done by Māori, for Māori.

Some authors argue that the implementation of practice principles in social work practice needs to reflect the context of colonisation for Māori (Waretini-Karena, 2012; Pihama et al., 2014; Wirihana & Smith, 2019). Linklater (2011) proposes linking colonial history to current health issues and integrating cultural perspectives and worldviews need to be a high priority in the provision of health education and awareness.

According to Brown (2018), social workers need to clearly understand how colonisation and historical trauma have had negative impacts on communities, and the moral and ethical responsibilities in responding to affected communities. Brown (2018) further explains that efforts made by dominant cultures that hold different practices, values and beliefs have done more harm than good in developing support systems which should be avoided by future social workers. An example is the removal of babies from their mothers by Oranga Tamariki social workers and the power and control exhibited by Oranga Tamariki social workers when working with Māori mothers (Office of the Children’s Commissioner, 2020).

Ruwhiu (2001) suggests non-Māori social work practitioners have a responsibility to be educated and prepared when working across cultures and not leave *tāngata whaiora* (Māori persons in recovery or clients) for Māori practitioners. Part of the education needed is to understand the effects of post colonisation trauma on both Māori and non-Māori and any power imbalance within the working relationship non-Māori have with the whānau they are working with.

It is evident social workers are working with Māori that have experienced trauma, however the systems put in place to support Māori are retraumatising them. This is not new and was clearly identified in the ground-breaking *Pūao-Te-Ata-Tū* report (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988).

The *Pūao-Te-Ata-Tū* report, that exposed concerns from Māori of social work policy and practice, still stands today. In 1985, over thirty years ago, John Te Rangi-Aniwaniwa Rangihau, a well-known and respected *kaumātua (male elders)* from Tūhoe, was appointed by the Minister of Social Welfare to investigate the Department of Social Welfare, from a Māori perspective. The investigative Committee travelled to marae settings throughout Aotearoa New Zealand to meet with government Departments, institutions and people who utilised these services, to discuss the challenges faced by Māori and their experiences of racism. The Report identified the loss of *tino rangatiratanga* (self-determination or sovereignty) for Māori*,* which came as no surprise to Māori*:*

> Throughout colonial history, inappropriate structures and Pakeha involvement in issues critical for Maori have worked to break down traditional Maori society by weakening its base—the whanau, hapu, iwi. It has been almost impossible for Maori to maintain tribal responsibility for their own people. (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1998, p. 18)

The *Pūao-Te-Ata-Tū* report is a critical document for Aotearoa New Zealand and has been described as "second only to the *Tiriti o Waitangi* in its significance for Māori social workers" (Hollis-English, 2016, p. 41) and was a watershed moment for social policy, as it looked to Māori knowledge to address social issues, which had not previously been done.

Six years after the *Pūao-Te-Ata-Tū* report, the Department of Social Welfare released the *Te Punga* report (Department of Social Welfare, 1994) which reiterated the recommendations of the *Pūao-Te-Ata-Tū* report and was based on these principles:

- the redressing of historical imbalances
- a commitment to end all forms of racism
- the allocation of an equitable share of resources to Māori
- incorporating the values, cultures and beliefs of the Māori people in all policies
- attacking and eliminating deprivation and alienation
- ensuring that Departmental recruitment, staffing and training policies do not disadvantage Māori
- recognising and utilising appropriately different skills of Māori staff
- promoting/funding schemes which harness the initiative of Māori and the wider community to address problems
- ensuring effective coordination of planning, policy, and practice to tackle serious economic and social problems. (p. 14)

However, none of the recommendations made by the Ministerial Committee were implemented successfully, if at all (Atwool, 2019; Dobbs, 2015). The *Pūao-Te-Ata-Tū* report (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988) had the potential to transform social work practice. Mainstream organisations today could look very different if the recommendations and principles had been followed through and had subsequently created enhanced positive outcomes for Māori*.* This report was the first government document that acknowledged Māori social work practices. Its overarching message was that Māori culture was not the problem, it was the solution; this message is still largely ignored today.

The lack of redress and minimal changes for Māori in mainstream services have been widely identified. According to Lloyd (2018) “despite some culturally appropriate programmes to improve Māori wellbeing, our education, healthcare, justice, welfare and corrections services are still mainly defined and governed by what works for Pākēha” (p. 2).

Over thirty years after the release of *Pūao-Te-Ata-Tū,* The Children, Young Persons and their Families Act 1989, now known as the Oranga Tamariki Act 1989, has implemented section 7AA, which came into effect July 1, 2019. Section 7AA is specific to *tamariki Māori (*Māori children), and requires the Chief Executive of Oranga Tamariki to provide, at a minimum, an annual report of progress made that improves outcomes for tamariki Māori.

In July 2020, the first report was released by Oranga Tamariki Ministry for Children: *Improving outcomes for tamariki Māori, whānau, hapū and iwi*. The report acknowledged *Pūao-Te-Ata-Tū* as “the most significant and poignant reflection of Māori views on child protection and youth justice” (p. 9). However, there is little evidence to show *Pūao-Te-Ata-Tū* made a difference to the overall ethos at Oranga Tamariki.

Action is needed on the state of care and protection in Aotearoa New Zealand, given the damning review of Oranga Tamariki in *Te Kuku o te Manawa* (Office of the Children’s Commissioner, 2020), which clearly outlines the unprofessional statutory social work practice and the experiences of racism and discrimination from Oranga Tamariki staff towards Māori mothers.

An urgent Waitangi Tribunal inquiry into Oranga Tamariki practices took place in July 2020, because of widespread protests from Māori throughout Aotearoa New Zealand. Lady Tureiti Moxon, director of Te Kohao, the Waikato Māori health provider, declared at the hearing, “Māori are ready, we’ve been ready for a long time and we are ready to take back our *tamariki* and they need to give them back with the full resources, empowerment that it takes for us to do this mahi” (Johnsen, 2020).

Kaupapa Māori/Indigenous Experience and Practice

The current research, both local and international, identifies culturally appropriate, trauma informed care as best practice for Indigenous people (Atkinson, 2013; Beristain, Paez, & González, 2000; Brave Heart et al., 2011; Evans-Campbell et al., 2011; Wirihana & Smith, 2019; Reeves, 2015).

Ullrich (2019) provides a clear rationale for the development of frameworks/care plans for children to be culturally embedded as:

> deepening our understanding of indigenous connectedness can assist the restoration of knowledge and practices that promote child wellbeing. When children can engage in environmental, community, family, intergenerational, and spiritual connectedness, this contributes to a synergistic outcome of collective wellbeing. (p. 121)

This rationale signifies the importance of being connected to all facets of a person's life which enhances well-being, not only as an individual but collectively, as a people, which is often missing from Western worldviews.

Walters and Simoni (2002) developed an Indigenous Stress-Coping model which identifies 'cultural buffers' that moderate the effects of historical trauma on American Indian Alaskan Native (AIAN) women. AIAN women are the focus of this model, based on the recognition of women's roles in their community and the responsibilities and obligations they carry:

> Contemporarily, Native women's power is manifested in their roles as sacred life givers, teachers, socializers of children, healers, doctors, seers, and warriors. With their status in these powerful roles, Native women have formed the core of indigenous resistance to colonization, and the health of their communities in many ways depends upon them (p. 520).

This quote reflects the well-known Māori *whakataukī* (proverb), "*he wāhine, he whenua e ngaro ai te tāngata*" which is often translated as 'by women and land, men are lost'. The whakataukī alludes to the significant nurturing roles Māori women play in their whānau, hapū and iwi (Mikaere, 1994; Smith, 1993). The whakataukī is also critical as it impacts the whole community and brings emphasis to why the removal of *pēpi Māori* (Māori babies) from whānau is detrimental to whānau, hapū and iwi.

The Indigenous Stress Coping Model (Walters & Simoni, 2002) identifies key practice competencies for better health outcomes incorporating holistic beliefs and values that are shared and recognised by all Indigenous peoples. It is congruent with values such as *aroha* (love) and *manaaki* (to care for) from a *Te Ao Māori* perspective. Linklater (2011) identifies other Indigenous protective factors, including family relationships, community, resources that are culturally and spiritually appropriate, and a sense of belonging that is grounded by a shared collective history.

Implementing Māori Values and Beliefs in Social Work

According to Cunningham (2000), "a Māori analysis is not inherently better than a mainstream method, it is simply more appropriately employed but it can produce very different results based on its different values and philosophies" (p. 66). Māori have always had their own philosophical foundations that inform social work theoretical frameworks, which stem from cultural values and beliefs. Cultural processes are critical in the facilitation and decision-making processes when whānau are ready to embark on their healing journey (Ruwhiu, 1995).

These philosophical foundations are not new. Over 40 years ago, Freire (1972) proposed that emancipation is a part of transformative practice and identified the need to confront oppression and marginalisation, to restore humanity. For Māori, this means to work with people in a way that acknowledges their whole being, so that they can then discover their own liberation as an expression and recognition of their *tino rangatiratanga* (self-determination).

Munford and Saunders (2011) suggests Māori traditional practices and worldviews have shaped and enhanced numerous social work practice frameworks that are integrated and holistic in nature and has deepened the approach to working respectfully with people. They conclude, “a key for practitioners in seeking to create ‘change-ful-environments’ is being able to work with culturally embedded narratives and to understand how these can be harnessed in the helping relationships” (p. 74).

Moreover, Robyn & Munford (2011) indicates “Māori worldviews, knowledge and language have brought vibrancy to practice” (p. 64) and highlight the need to reinvent mainstream models of social work practice with Indigenous knowledge. This is supported by McLachlan et al. (2017) who discusses a growing body of research that proves Māori values enhance engagement and utilising mātauranga Māori (Māori knowledge) in clinical practice has direct therapeutic benefits. Examples of weaving mātauranga Māori (Māori knowledge) into practice is done through *pūrākau* (stories), *waiata* (songs), *mihi (acknowledgment)* whakataukī, and *whakapapa* stories that are valued by the *whānau* and practitioner.

In social work practice, *whakawhanaungatanga* (ability to connect with others) and discussing *whakapapa* is imperative when engaging with Māori. Genograms (a tool used in social work to map out genealogical ties) and knowledge of whānau/ancestral ties can provide the social worker with a historical and current picture of significant relationships within the whānau. Only whānau can dictate what their whānau make-up looks like, which may include *whānau whānui* (extended family).

Central to this is knowledge of the term *whakapapa*. According to Mikaere (2011):

> *Whakapapa* embodies a comprehensive conceptual framework that enables us to make sense of our world. It allows us to explain where we have come from and to envisage where we are going. It provides us with guidance on how we should behave towards one another and it helps us to understand how we fit into the world around us. It shapes the way we think about ourselves and about the issues that confront us from one day to the next. (pp. 285-286)

Mikaere captures the essence of what whakapapa should look like within social work frameworks that address the past, present and future. Ruwhiu (2001) articulates the significance of whakapapa, “as one's future is linked with one’s past” (p. 65), which reflects a trauma informed approach, as practitioners ask the question, “what has happened to you rather than what is wrong with you?” (Bloom, 1995, p. 9).

Everyone is born with mana. Ruwhiu (2009) illustrates how mana-enhancing practices are built on the notion of wellbeing, respect and honour, which, he argues, is restorative for whānau Māori that have experienced trauma, and ensures the person’s mana increases, not decreases, through processes of engagement and healing. Being trauma informed requires self-awareness and

reflection, with the ability to identify and acknowledge inherent privileges, whether in race, status, education, gender or class, as these are potential barriers to engaging with people that have experienced disadvantage, marginalisation and cultural trauma (Menschner & Maul, 2016).

Shayne Walker (2015), a social worker and educator, proposed important practical questions underpinned by Māori values and beliefs to use in social work delivery, when working from a trauma informed perspective. Walker integrates the four concepts of Durie's (1998) Te Whare Tapa Wha model: *wairua* (spiritual), *hinengaro* (mental), *tinana* (physical) and whānau in his questions and encourages practitioners to engage openly and honestly when working with whānau:

- What is your *puku* (stomach) saying to you?
- What is your *ngākau* (heart) saying to you?
- What is your *wairua* (spirit) saying to you?
- What kind of fabric is being woven?
  (p. 54)

These questions are tacit in nature and reflect an inner intuition that is needed when working in social work. They would be challenging to emulate if you do not live and breathe Kaupapa Māori values and beliefs. Not only are they valuable in practice, but they are also effective for social work supervision to support practitioners to reflect on their practice, which is critical in being trauma informed. These questions can also be used within the *Pōwhiri Poutama* model (Huata, 1997; Waretini-Karena, 2012) that will be discussed in Chapter 5: Findings.

Hollis-English (2015) noted that not all whānau Māori share the same ideologies of Te Ao Māori and do not wish to work with Māori processes, which illustrates colonisation processes at work, something Māori social work practitioners need to be mindful of when working with whānau. Implementing tikanga, or Māori processes, can put strain and pressure on whānau who are not familiar with them. However, not raising the opportunities for tikanga or Māori processes can also undermine whānau.

Similarly, Walsh-Tapiata (2004) explains the importance of social workers having to understand pre-colonial history and the impacts that are felt today. Furthermore, non-Māori practitioners who are culturally responsive, have an awareness of what they don't know and are able to engage without being defensive are enabled to work alongside Māori practitioners as allies (Atwool, 2019; Hollis-English, 2015; Ruwhiu, 2018; Walker, 2015).

Using a Māori lens, Eruera & Ruwhiu (2018) define trauma as the trampling of mana and violation of *tapu* (sacredness). Furthermore, they argue mana is a cultural adhesive that binds the spiritual, natural and human dimensions of Māori culture and tapu containing protective factors.

According to Henare (2001), tapu cannot be separated from mana and all tamariki are born with both. When a person's tapu is violated, it can lead to disharmony and imbalance which has implications for the person's health. The tapu of a person needs to be "protected, strengthened, and constantly confirmed so that balance, harmony, and potentialities can be fulfilled" (Henare,

2001, p. 208). Mana and tapu are two very significant concepts that are foundational to a Māori worldview, as they are a direct link to *Ātua Māori* (Māori Gods).

Understanding Kaupapa Māori values and beliefs is critical for effective social work practice, as the traditional narratives not only reveal the trauma, but they also provide steps towards healing and implementing a culturally safe care plan (Ruwhiu, 2001).

Traditional Kaupapa Māori values and beliefs such as whanaungatanga, whakapapa, aroha and te reo Māori are all seen as fundamental to understanding how tikanga is implemented in social work practice (Smith, 1997).

Tikanga Māori & Social Work

According to Mead (2003), tikanga "involves moral judgements about appropriate ways of behaving and acting in everyday life" (p. 6). Tikanga provides structure to social work practice. Hollis (2006) explains the functions of tikanga as "the overarching protection or the cultural paradigm in which researchers, social workers, or anyone who identifies with Kaupapa Māori should function" (p. 44). Mead (2003) identifies that the understanding of tikanga is varied today and was almost lost to colonisation, as "the suppression of tikanga Māori and mātauranga Māori was thought to be necessary in order to speed the process of assimilation into Western ways" (p. 3.). Durie (1998) also refers to the Tohunga Suppression Act 1907, intended to eradicate Māori approaches to healing.

Pihama, Simmonds and Waitoki (2019) propose that tikanga that have been handed down through the generations are "rich sources of applied principled practice" (p. 31). Examples given are the sharing of *kai* (food), tikanga around health, values and beliefs, and the practice of manaakitanga. Mead (2003) evaluates manaakitanga as a value which underpins tikanga, as do other values that are important to Māori, and therefore hold certain expectations and standards of behaviour around those values.

Hollis (2006) outlines tikanga and practice: "tikanga Māori such as whakawhanaungatanga, wairuatanga (spirituality) and aroha are all fundamental aspects of Māori social work methods, are vital to their relationships with clients and also their approach in the organisational environment" (p. 86).

The following discussion explores the origins of TIC and opens a pathway to bringing TIC and Kaupapa Māori together in social work.

Defining Trauma Informed Care

The etymology of the word trauma originates from a Greek word that means 'wound' (Figley, 2012); hence traumatology was originally the study of wounds. The term trauma has expanded beyond the medical field (it was previously aligned with post-traumatic stress disorder or PTSD,

after the Vietnam War, which ended in 1975) and is now used broadly to encompass social and political environments. The field of trauma studies developed in the early 1990s as an ethical response for the need to explore more diverse cultural experiences of trauma, amid the saturation of Western literature on trauma (Andermahr, 2015). According to Fallot and Harris (2002), trauma is pervasive and has a long-lasting impact on people; however, healing can be facilitated within the context of relationships.

Andermahr (2015) challenges authors in the field of trauma studies to engage in postcolonial and global perspectives. Flores-Rodriguez and Jordan (2012) are “adamant in advocating that intellectuals and leaders put their skills to use in benefit of the people rather than to ... justify/normalize the colonial order that condemns people to a certain fate" (p. 6). Fanon (1963) is considered a pioneer in the impact of trauma on Indigenous populations, with his classic contribution to the psychological impact of colonisation on the colonised. This is reflected in *The Wretched of The Earth*. Subsequent literature based on Fanons views demands that social, environmental, political, colonial and cultural domains be at the forefront when assessing trauma (Anderhahr, 2015; Flores & Rodriguez, 2012; Gozee, 2020).

For Smith (2015), trauma for Māori is embedded in the understandings of” patu ngākau*”* which can be translated as “a strike or assault to the heart or the source of the emotions” (p. 264). *Pōuritanga* (sadness, despondency, gloom, unhappiness) and *mamae* (hurt, be painful, sore, ache, injury, wound) are symptomatic of trauma for Māori (Smith, 2015). Although mamae and pōuritanga are translated literally in this text, there is more depth and more layers to their meanings.

Moran (2008) depicts trauma as "a sudden harmful disruption impacting on all of the spirit, body, mind, and heart that requires healing" (p. 153). Duran et al. (2008) also describes trauma as a “soul wound” and puts emphasis on treatment that includes an understanding of the soul wound (p. 289). The descriptions and interpretations of trauma mentioned are not medicalised terms commonly used by health practitioners, but these are the experiences of Indigenous people. How a practitioner understands trauma determines the approach in which support can be put in place.

There is a range of trauma informed models of care utilised by health providers that complements a Kaupapa Māori social work approach (Bloom & Sreedhar, 2008; McClintock et al., 2018; Menschner & Maul, 2016).

TIC and Indigenous Social Work

The Substance Abuse and Mental Health Services Administration (SAMHSA) is a US based organisation. It includes an American Indian and Alaskan Native workforce, working with Indigenous communities that have experienced trauma, who are trained in TIC delivery from clinical and Indigenous perspectives.

The SAMHSA principles are recognized and implemented globally in Indigenous social services (Fallot & Harris, 2002; Wall et al., 2016; Te Pou o Te Whakaaro Nui, 2018; Atwool, 2019; Menschner & Maul, 2016).

The six key principles of TIC developed by SAMHSA are:

1. Safety – looking after the physical and psychological safety of the organisation, workers and people accessing services
2. Trustworthiness and Transparency – organisational operations and decisions are transparent, and trust is built and maintained
3. Peer Support – people who have experienced trauma and healing are key in establishing safety and hope
4. Collaboration and Mutuality – the organisation acknowledges everyone has a role to play in a trauma informed approach
5. Empowerment, Voice and Choice – throughout the organisation and among workers and people accessing services, skills are developed, as necessary
6. Cultural, Historical and Gender Issues – the organisation actively moves past cultural stereotypes and biases (SAMHSA, 2014, p. 10)

However, the adoption of TIC is not without its challenges. Kezelman and Stavropoulos (2012) believe upskilling and professional development needs to be ongoing, using TIC principles (SAMHSA, 2014).

This requisite for social workers working with vulnerable individuals and families is widely endorsed (Hornor et al., 2019; Kezelman & Stavropoulos, 2012; Menschner & Maul, 2016). Despite the recognition of the value of TIC, organisations continue to struggle with identifying what exactly it means to be trauma informed and how best to implement it (Hartas, 2019; Hornor et al., 2019; Olivet et al., 2010).

It is also widely accepted that the impact of trauma in adults can often be traced back to their childhood, this was a key finding in seminal research known as Adverse Childhood Experiences (Felitti et al., 1998). As a Kaupapa Māori approach involves relational care and the collective whānau, adverse childhood events (ACE) contributed meaningfully to this study.

Adverse Childhood Events (ACEs)

ACEs as a trauma assessment tool, focuses on children and their whānau. The following overview of the 1998 ACE study gives a solid insight into the model and its implementation. It is significant because it has contributed to the development of TIC theory and practice.

The ACE Study

Ross (2009) identified that “painful events experienced in childhood reduce the capacity to respond well to further traumatic events even as adults” (p. 13). This proved to be a truism in the ACE study. Undertaken in California, from 1995 to 1997, it was a joint project between the Centre for Disease Control and the private medical insurer Kaiser Permanente Health Care Organization (Felitti et al., 1998).

A significant finding from the study is the recognition that experiencing traumatic events as a child has an impact on brain development (Purewal et al., 2016; Perry, 2005). Stevens (2019) discusses the link between childhood adversities and brain development, the brain does not distinguish the different adversities, as once the brain is affected by the adversity it then becomes toxic stress. Furthermore, Gatwiri et al. (2019) explain that trauma affects the neurological pathways for regulating emotions hindering the ability of children to respond appropriately to difficult situations, which can be taken into adulthood.

Another significant outcome of the study was that adverse childhood experiences in traumatised adults were often linked to a high prevalence of childhood sexual abuse. At the time, the study was one of the largest investigations into childhood abuse and neglect in the household environment.

The ACE study's strengths lie in the large sample size and identifying the impact of trauma on outcomes in later life. Bloom and Sreedhar (2008) argue that by understanding the effects of adverse childhood experiences, social workers and health practitioners are then able to explore the mitigation effects of ACEs and subsequently look at prevention, intervention and care plans for individuals and families.

According to Te Pou o te Whakaaro Nui (2018) a national centre of evidence-based workforce development for the mental health, addiction and disability sectors in Aotearoa New Zealand, ACEs are used to describe "all types of childhood abuse, neglect and other experiences that occur to people under the age of 18 years." Gillespie (2019) makes it clear that screening for ACEs of a child or adult, through assessment, is a preventative measure in addressing and preventing intergenerational transmission of trauma and toxic stress. There is a certain need for awareness and training on ACEs and TIC. Purewal et al. (2016) argue health practitioners that are trained in TIC are in a better position to understand the current health status of their patient.

Limitations of the ACE Study

The ACE study participants were predominantly (78%) white, middle-class adults with private health insurance (Kaiser Permanente), (McEwen & Gregerson, 2019). They included 4,197 women and 5,187 men over the age of 50 (Felitti et al., 1998). McEwen and Gregerson (2019) justifiably criticised the study as unrepresentative of the population. The scope of the study was seriously limited in terms of income brackets of the participants.

Kelly-Irving and Delpierre (2019) criticises ACE's as an ill-adapted tool used by social workers, child protection workers and medical practitioners. They argue that it can stigmatise families and children (racial profiling, low-income families), perpetuate inequality, and should not be used to predict individuals at risk.

White et al. (2019) acknowledge that although ACEs is a well-intentioned initiative, it contains weak measures. The margin of error is significant, and the statistical methods need to be more

transparent. They go on to observe, “there are large inconsistencies around severity, timing and duration. There is inability to capture confounding contextual issues that are beyond parental control and that can harm people emotionally and physically" (2019, p. 458). This means the severity of the ACEs and how long it took place in a child’s life is not an accurate account to capture the impact of that trauma.

Perhaps the major limitation of the original ACE study is that it does not include political, historical, cultural, intergenerational, spiritual and colonial trauma. In other words, it is a mainstream, Eurocentric model that focuses on the individual, rather than a holistic, multi-dimensional approach. Stevens (2019) has expanded on the ACEs model, identifying further adversities, seen not just in the home but in the child’s surroundings, that have been categorised into three types: household, community, and environment.

The reason for the inclusion of the ACEs study in this literature overview is because it is responsive and receptive to changes that improve the model. This is demonstrated by the inclusion of historical trauma and structural racism that are visible in the community (Stevens, 2019). However, this development is also subject to critique.

Treanor’s (2019) critique of the ACEs framework addresses the need to focus on understanding poverty and how these understandings should be used to inform policy. She contends that the ACEs tool does not consider the application of benefit entitlements, or political, racial and systemic exploitation and discrimination. It also does not consider single parenting as a potentially positive, protective factor if the other parent is abusive.

Any discussions on culture, values and beliefs are largely absent in the ACEs literature. Culture is a crucial factor when assessing children and families, as culture is the framework within which parents and parenting takes place (Bornstein, 2012). According to Hartas (2019), “different cultural groups possess distinct beliefs and behave in unique ways with respect to their parenting. These beliefs and behaviours shape how parents care for and interact with their children” (p. 437).

Despite their shortcomings, ACEs assessment scoring tools are used widely in health. They predict that four or more ACEs, before the age of 18, can lead to poor health outcomes in adulthood. For example, the higher the ACE score, the more susceptible the person is to experiencing complex health issues as an adult, including an increased risk of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement and an early death (White et al., 2019).

ACEs are gaining attention here in Aotearoa New Zealand, particularly models that use trauma informed social work practice, as the research on TIC grows. In Aotearoa New Zealand, over the past few years, social workers across both statutory and NGO child welfare services are engaging in trauma informed awareness training. The ACES screening tool has been utilised in health, including child health, for example by the child protection unit of ADHB, who work predominantly with tamariki Māori (Māori children).

The Ministry of Social Development (MSD, 2019a, 2019b), released two research reports that draw data from New Zealand's longest longitudinal study of child development, to explore eight adverse childhood experiences in relation to school readiness and the protective factors of children at high risk of ACEs. According to MSD (2019b), the most protective factors for children faced with ACEs were the strength of the mother-partner relationship and the level of parental health and wellness. A sense of belonging to a community was also found to be a protective factor, however there was no mention of culture, and the study was not population representative.

Although there is very limited literature on ACEs from Aotearoa New Zealand perspectives, the model hasn't escaped scrutiny. Joy and Beddoe's (2019) critique is based on the absence of any reference to the impact of colonisation and its lingering effects on Māori. ACEs fail to adequately account for the complexities embedded within poverty, racism, and colonisation. This is deficit theory in practice. High ACE scores could shed light on care and protection issues and alert State intervention (Atwool, 2019) in which the pros and cons need to be investigated and all of these issues must be considered in developing TIC across the health sector (Evans-Campbell, 2008; Kezelman & Stavropoulos, 2012; Menschner & Maul, 2016; Reeves, 2015; Te Pou o te Whakaaro Nui, 2018).

The Need to Address TIC in Aotearoa New Zealand

At the core of TIC is the importance of service providers recognising past traumatic events and being responsive to the impact of trauma when working with children and families (Cutuili et al., 2019; Hornor et al., 2019). Purewal et al. (2016) supports the importance of relationships and identifies that a caring relationship with an adult enables the child's ability to self-regulate emotions, buffering them against toxic stress.

Since 2014, Trauma Informed Oregon has done extensive work on TIC, using a screening tool that has been widely used by health services overseas (Wall et al., 2016; Mieseler & Myers, 2013; Quadara, 2015). The TIC Screening Tool designed by Trauma Informed Oregon identifies four progressive stages of:

1. being trauma aware;
2. being trauma sensitive;
3. being trauma responsive;
4. providing trauma informed care.

These four stages propose a progressive cultural shift at a systemic level within the organisation that is implementing TIC. This TIC Screening Tool is currently being utilised in the Child Protection Unit Te Puaruruhau and Starship Community in the Auckland DHB.

According to Kezelman and Stavropoulos (2012), child health services will require a paradigm shift in attitudes, knowledge and skill sets, for practitioners to move from being trauma aware to then implementing TIC. This shift includes advocating for policies and practices that protect children and prevent intergenerational trauma.

The 2017 *Health Status of Māori Children and Young People in New Zealand* report refers to the unacceptable disparities between Māori and non-Māori hospitalisation rates for health conditions, reinforcing the need to address health inequities for Māori (Simpson et al., 2017).

Stage one of the Waitangi Tribunal's (2019) *Health Services and Outcomes Kaupapa Inquiry* (Wai 2575) clearly outlines that the primary health framework has failed Māori in achieving health equity and does not meet the needs of Māori. Further to these identified failings of the health system, Rolleston et al., (2020) state:

> The system should no longer privilege a Western medical model of health for a population plagued by problems that Western medicine has thus far failed to solve. Interventions therefore that are inclusive of Māori worldviews and values, grown from within Māori communities, where Māori are partners, will have more of an effect on the disparity gap than any intervention grown from colonial soil (p. 130).

As a minority population, nearly 70% of Māori have experienced trauma in their lifetime (Te Pou o Te Whakaaro Nui, 2018). Māori children have been identified in trauma profiles due to the state being responsible for children abused in state care. According to Fitzgerald (2019), over 227 children were abused in state care in 2018, and over half of the children were Māori.
Joy and Beddoe (2019) assesses the reality for many Māori children; that while Māori comprise 28% of the child population, they account for 40% of those notified to the statutory social work agency, and, in 2015 they made up 60% of the children in care.

The Office of the Children's Commissioner (2016) recognises the need for trauma informed practice to consider the impact of colonisation on Māori:

> The severed ties with whakapapa, the separation from language, the loss of identity - which have all contributed to the disadvantages that Māori experience today. We would therefore expect a trauma informed approach for mokopuna Māori to include cultural interventions required to move young people towards 'ora' or wellbeing (p. 29).

Unfortunately, the Commission neglects to state what the cultural interventions" are for mokopuna Māori. However, three years later, the Oranga Tamariki Act 1989/Children's and Young People's Act 1989 enforced Section 7AA(2)(a), designed with a trauma informed approach to meet the needs of Māori children. This statutory requirement imposes a "practical commitment" to the principles of the Treaty of Waitangi and places Māori at the table in the decision-making process, to provide a Kaupapa Māori approach. This should be facilitated through the development of strategic partnerships with iwi authorities and Māori organisations (Williams et al., 2019).

The Werry Workforce Whāraurau, a research centre based at the University of Auckland, provides online e-learning modules to raise awareness for caregivers of children and the infant and children's mental health workforce. Starship Community will look to implement the modules as part of the TIC training. The four e-modules are:

1. Childhood Trauma: Impact on Development and Behaviour
2. Trauma Informed Care for Caregivers
3. Trauma Informed Care for the Children's Workforce
4. Self-care in Trauma Informed Organisations

The Werry Workforce supports the need for the children's mental health workforce to be educated on the effects of trauma on tamariki and their whānau. The modules are accessible to public and people working in sectors who work directly with young people, such as education, health and the justice. The Werry Workforce website addresses a major gap in the literature on TIC modules from a Māori perspective. Their resources highlight how Māori approaches to self-care identify natural, human, and value/belief dimensions as sources of mana (honour, prestige, self-esteem, level of influence and voice), which encompass and encourage healing for those that may be suffering from trauma (Werry Workforce, n.d.). This is discussed in more detail in the next section.

The overarching findings in the literature sought to demonstrate how imperative Kaupapa Māori values and beliefs are for Māori social workers to implement in their practice. The following models illustrate Kaupapa Māori values and beliefs in action within social work practice.
While there are some differences in Kaupapa Māori social work models being utilised in practice, the Poutama model (1997) and Āta: Growing Respectful Relationships (2004) are two Kaupapa Māori social work models that can be used to address and work with whānau that have experienced or are experiencing trauma.

Paraire Huata's Poutama Model (1997)

The Poutama model is a Kaupapa Māori model that is used for therapeutic purposes when working with whānau and has been adapted within healthcare settings since its inception (Drury, 2007; Wikaira et al.,1999; Hollis-English, 2012; Huata, 1997; McLachlan et al., 2017; Stanley & Thompson, 1999; Waretini-Karena, 2012).
The origins of the Poutama model are based on the traditional Māori welcome ritual (*pōwhiri*) that takes place on a marae, and on the pattern which features a staircase design (*poutama*), often seen in the *tukutuku* (lattice) panels in *whare whakairo* (decorated meeting houses). The model is also known as the Pōwhiri Poutama model.

Drury (2007) makes the important point that marae encounters are "primarily about negotiating relationships within a context of kawa, a way of doing things that has both historic and contemporary significance" (p. 2). Therefore, the fusion of pōwhiri and poutama provides a culturally therapeutic model that encompasses growth, healing and wellbeing for whānau, as a journey is taken towards discovering one's potential (Waretini-Karena, 2012).

The model was originally developed for a women's addiction programme at Te Korowai Hauora o Hauraki. Although he did not claim exclusive authorship of the model, the stages, processes and meanings within the model were designed by Paraire Huata (Manning, 2014; Drury, 2007). Huata ran and operated Te Ngaru Learning Systems, a training establishment educating Māori health professionals in addiction and mental health.

This model is embedded in a Kaupapa Māori framework, with customary practices, values and beliefs, grounded in te reo Māori and ngā tikanga. Growth unfolds when the whānau/tangata whaiora are proficient at each step of the poutama and are ready to progress to the next level. The Pōwhiri Poutama Model (Huata, 1997) has been used to address historical and intergenerational trauma through steps of engagements guided by Māori customs and processes (Huata, 1997; Waretini-Karena, 2012; McLachlan et al., 2017).

The following stages, outline how the Pōwhiri process can be used to unpack trauma:

- Whakamoemiti – recognises the spiritual space
- Mihi Whakatau – recognises the kinship ties and all that are connected
- Whakapuaki – is the removal of the cap that allows the issues that have been dormant to be revealed
- Whakatangitangi – is the expression of acceptance or relief
- Whakaratarata – allows the emotions to settle and move forward
- Whakaoranga – honouring and respecting life with a renewed passion
- Whakaotinga – signifies the commitment to new beginnings (Huata, 1997)

Each stage of the Poutama model allows for any *pōuritanga* (depression, unhappiness, sadness) and *mamae* (hurt, pain, wound) to be addressed and explored, if the process is skilfully facilitated. Adaptions of Pōwhiri Poutama are congruent to the purpose of achieving culturally therapeutic, holistic, nuanced and relational health and wellbeing, using tikanga and Kaupapa Māori concepts.

Āta: Growing Respectful Relationships (2004)

Pohatu (2003) claims, “Kaupapa Māori strategies are counter hegemonic approaches to Western forms of market driven; competition focussed ideologies” (p. 10) and encourages Māori social work practitioners to utilise Kaupapa Māori strategies in practice. According to Pohatu (2005), *Āta*, meaning carefully or deliberately, is a social work practice strategy based on Kaupapa Māori principles, grounded in respectful relationships, creating boundaries and creating *āhurutanga* (a safe space). Āta provides a principled approach to effectively support and navigate relationships (Forsyth, 2017; Hollis-English, 2015; Lipsham, 2012).

In 2005, the Te Tohu Paetahi Ngā Poutoko Whakarara Oranga (Bachelor of Social Work [Biculturalism in practice]) programme was launched at Te Wānanga o Aotearoa, allowing Māori to explore and determine, from an insider’s perspective, Kaupapa Māori social work practice and professionalism (Akhter & Leonard, 2014). The social work programme was designed by Taina Pohatu and has the *takepū āhurutanga* (safe space) at the heart of the Bachelor of Social Work, enabling a conducive environment for practitioners to navigate Āta and takepū as applied principles (Akhter & Leonard, 2014).

This behavioural and theoretical strategy integrates practices of engaging with Māori and non-Māori, designed to shape and guide understandings of relationships and well-being based on Kaupapa Māori definitions and interpretations.

There are five elements that encompass the philosophy of Āta (Pohatu, 2013):

- *Āta-haere:* negotiating boundaries within a safe space and respectful humble approach
- *Āta-whakarongo:* engaging in conscious participation and intentional listening
- *Āta-noho:* allowing for respectful quality time (*wā*) and space (*wāhi*)
- *Āta-whakaaro* and *Āta-korero* are combined for creative, open and reflective deliberation

These are only five takepū (principles) that make up the wider Āta philosophy, and, when utilised correctly, critical reflection emerges that facilitates transformative relationships.

Kaupapa Māori principles can be applied to social work delivery and are crucial to developing a de-colonising framework and providing tools for developing cultural wellbeing.

Both Āta and Poutama are Kaupapa Māori social work strategies that derive from a Te Ao Māori perspective. They are models that address the needs of Māori who are experiencing mamae, pōuritanga or trauma and are anchored in traditional values and beliefs that also provide guidance in today's society. Cunningham (2000) expands on this view: "for Māori future knowledge stems from the past from the environment in which it was developed" (p. 63).

Conclusion

Reviewing relevant literature on Mātauranga Māori and Trauma Informed Care (TIC) assists in addressing the question: How do Kaupapa Māori values and beliefs within social work practice align with being trauma informed to deliver better health outcomes for Māori? This involved commentary on: Kaupapa Māori approaches to inform TIC development; a critical analysis of TIC models and the origins of ACE's; the development of key social work practices that inform understandings of trauma, and its role in social work practice.

Understanding the diverse interpretations of trauma has paved the way for identifying the social work approaches needed when working with whānau Māori (Atwool, 2019; Brown, 2018; Hollis-English, 2016; Walker, 2015). Since the implementation of ACEs and TIC into the Aotearoa New Zealand health system, there has been minimal acknowledgment of how Kaupapa Māori values and beliefs are critical to social work practice for Māori, when addressing trauma. The health system can be arduous for whānau to navigate without also having to endure the racism and discrimination that has always been embedded in the system.

Identifying trauma or, more especially, mamae and pōuritanga helps Māori social work practitioners define and own the space where healing takes place, as social work practice is tailored to meet the needs of whānau, through a Kaupapa Māori lens. It is clear the importance of whakapapa and relationships and understanding connectedness is crucial for social work approaches. Social workers need to be aware that it is a privilege to have a whānau that you are working for share their whakapapa narratives—the family and their whakapapa should be treated with mana and respect. The privilege of having someone share their whakapapa narrative requires

groundwork and a genuine process that embodies mana and manaakitanga. Āta and Poutama are only two social work models identified that can support this process.

Based on the ongoing detrimental statistics of Māori in all Ministries (e.g., Justice, Health and Children) for the past 150 years, it is hoped approaches to the treatment of trauma, pōuritanga and mamae can be grounded in Kaupapa Māori knowledge to meet the needs of Māori in the health system, as what is currently in place is not working for Māori.

Kaupapa Māori social work practice is grounded in relationships; healing takes place within relationships as this is where trauma can originate from. Whānau are crucial in the healing process of trauma, therefore social work practitioners need to be well versed in implementing a collective approach, as opposed to an individual approach, when working with trauma.

Chapter 4 describes how the research question was investigated by utilising three different methods and the ethical considerations given to ensure the research was conducted with integrity.

Chapter 4: Research Design

This study used triangulation (Fusch et al., 2018; McGloin, 2008), applying three methodological approaches, with Kaupapa Māori practice principles overarching the entire project. Triangulation was seen as the most suited research method based on the need to comprehensively understand the following three areas and the different sources needed for a thorough investigation:

1. Kaupapa Māori methodology
2. Trauma informed care (theory and practice)
3. Qualitative interviews

Ethical Considerations

Careful ethical consideration was given to the recruitment of participants and the process before, during and after the interviews were conducted. Ethics approval was granted by AUTEC (Auckland University of Technology) January 2020. I then began the recruitment process by emailing the Tāngata Whenua Social Workers Association to gauge interest. A brief of the research on Kaupapa Māori approaches to trauma informed care was provided, looking for social workers that identified as Māori and have worked in or are working in a DHB setting, here I gained my first participant.

I also sought support from the General Manager of Māori health ADHB (see Appendix D) and support from the Operations Manager at Starship Community ADHB who fully supported this research. I then reached out to tāngata whenua social work colleagues within ADHB to gauge interest and offered a Participant Information Sheet (Appendix C). Although there were 12 potential participants who worked in different departments of ADHB, only five of the participants were successfully recruited.

There were challenges where booking interview times during busy schedules proved to be difficult, exacerbated by COVID-19 and its restrictions. The Participation Information Sheet and Consent forms were discussed (Appendix B) and signed prior to commencement of interviews, I then interviewed all six tāngata whenua social work research participants. All data pertaining to the qualitative interviews have been stored on AUT premises in a locked cabinet for approximately six years before the data is shredded.

Reflexivity was fundamental to the research project as similar values, beliefs and social work experiences were held between me as the researcher and the research participants. This required holding my own biases and assumptions at a certain distance. Therefore, it was imperative to stay as close to the participants kōrero as possible as reflected in their quotes and discussion in Chapter 5.

Kaupapa Māori Methodology

Kaupapa Māori principles are integral to the research design and are given credence through the interview process. The overview of the literature review opens with an exploration of Kaupapa Māori theory and practice. This approach underpins the entire project, as it encapsulates the lived realities of Māori and their underlying values and beliefs that have formed a unique and distinctive identity, entrenched in the interconnectedness of all things (Durie, 1998; Henry & Pene, 2001; Kingi, 2007).

Kaupapa Māori research is evolving. However, the consensus is, that it is research for the benefit of Māori, conducted by Māori (Bishop, 1998; Cunningham, 2000; Cram, 2001; Pihama et al., 2002; Smith, 1999).

Freire (1972) has exerted a profound influence on the development of Kaupapa Māori Theory. Consequently, it is the emancipatory intent of non-Māori theorists that captures the attention of Kaupapa Māori proponents (Bishop, 1996; Mikaere, 2011; Smith, 1997). Freire (1972) argues that "it is only the oppressed who, by freeing themselves, can free their oppressors. The latter as an oppressive class, can free neither others nor themselves" (p. 56).

Trauma Informed Care (TIC) Theory and Practice

There is not a universal definition of TIC (Cutuli et al., 2019; Hornor et al., 2019). However, the American Substance Abuse and Mental Health Services Administration (SAMSHA) aptly describe TIC as:

> A strengths-based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities to rebuild a sense of control and empowerment (SAMSHA, 2014, p. 10).

Strait and Bolman (2017) extend the definition, describing TIC as a coordinated approach that can prevent, treat and heal the consequences of childhood trauma. This definition is indicative of a strength-based approach that acknowledges both the survivors of trauma and the service providers that may take on the trauma of others also known as vicarious trauma. The United States was the first country to implement a national policy in TIC.

One of the issues for Indigenous practitioners is mainstream theory and practice dismisses the impact of culture on healing. Rountree and Smith (2016) argue that "Western child and family wellbeing indicators measure health, economic and social deficits, and are not reflective of the indigenous worldview of wellbeing, which is 'holistic and grounded in balance and harmony in human relationships and the natural and spiritual world" (p. 207). Western models of practice are dominant models that fail to gauge what trauma looks like from a Māori perspective (Pihama,

Cameron & Te Nana, 2019). The question here is, if there isn't an understanding of Indigenous trauma, how can the therapeutic approach effect a positive outcome?

Qualitative Research Interviews

Qualitative interviews were considered the most effective strategy to explore the views and experiences of Māori health social workers committed to TIC within a Kaupapa Māori (KM) framework. Kvale (1996) describes qualitative interviews as a strategy to understand the world from the research participants perspective and experiences. In the process the researcher is given and sharing insights into their lived world.

The questions were designed to encourage participants to voice the challenges in implementing TIC/KM models in their practice. Semi-structured interviews were conducted in the workplace as requested by the participant.
Smith's (1996) ethical principles were applied throughout the interview process:

- *Aroha ki te tangata* (a respect for people): Interviews were conducted respectfully; the participants' kōrero was honoured and treated with respect.
- *Kanohi kitea* (face to face discussion): The interview processes were culturally appropriate and guided by Māori protocols of engagement (karakia, mihi, korero and koha).
- *Titiro, whakarongo, kōrero* (look, listen and speak): Participants were provided with a safe space to speak freely from their perspective and without judgement.

The interviews were designed to ensure that social workers' voices were heard. Their perspectives on working with their people in a Western-dominated environment and on power imbalances were safely and critically explored.

Tangata Tauwhiro Māori (Participant Profile)

The only criteria applied were Māori Health social workers, committed to making a difference to whānau Māori, who have worked in a DHB environment. All six participants have worked or are working in ADHB. Because the research cohort was small, tribal affiliations could potentially identify participants. To ensure confidentiality, tribal identity (iwi) are not documented. However, all the participants carry rich whakapapa that traces them back to their *kōiwi* (bones of their people) throughout Aotearoa. The relationship between the researcher and the participant is predicated on shared commitment to the Kaupapa Māori values and beliefs in practice and an understanding of TIC. This common "Kaupapa" drives all participants to want to be part of a project that benefits whānau Māori to achieve better health gains for whānau Māori.

The Qualitative Research Process

The interviews were co-designed with participants to cover Trauma Informed Care (TIC) and Kaupapa Māori principles in their practice. Interviews ranged from 45 minutes to 80 minutes in

duration. The participants were already aware of the interview procedures, as they had the information sheet in the recruitment phase.

Open-ended indicative questions were used as a guide throughout the interview. The prompts were designed to encourage participants to voice their social work experiences in a DHB. Of particular interest were their views on Kaupapa Māori and TIC in the workplace. All of the interviews were recorded via mobile phone and transcribed.

Participants were aware that ADHB had made a commitment to exploring TIC/KM as a way forward. Interviews were conducted in the workplace *kanohi ki te kanohi* (face to face) and their opinions/discussions were grafted into broad themes.

1. What Kaupapa Māori values and beliefs guide your practice and where did they come from? (In this context, values were explained as something that holds value and great importance to them, therefore they identified and defined their values and beliefs).
2. How do trauma informed principles apply to your practice or what do you know of trauma informed care?
3. Are there any challenges incorporating KM and TIC principles into your practice in a mainstream environment?
4. What is your understanding of the impact of historical trauma on Māori?
5. Do you have additional kōrero you want to add?

Each participant was named alphabetically in no order, to firstly protect their identity and secondly for the reader to track the comments of participants throughout the thesis. However, on the Participant Information Sheet it was clearly stated there is a possibility that the participant could be identified in the study, therefore only limited confidentiality was offered to them as a participant. No issues were anticipated, as the content of the interviews relates specifically to the participants' knowledge/experience of social work intervention in the DHB.

The Interview Process

As already intimated, Kaupapa Māori values permeate all facets of the research process and include but are not restricted to: *āwhina* (assisting/facilitating), *aroha* (caring), *tautoko* (mutual support), and *manaaki* (protecting/caring for). *Karakia* (prayer) was an option prior to interviews commencing. This was a personal choice with some participants preferring to perform this ritual prior to the interview. The nature of social work and the TIC Kaupapa that were explored in the interview process can be extremely stressful. *Karakia* traditionally offers protection and, in this context, relates to the social workers and the *whānau* references throughout the interview. Complying with Māori hospitality values and practices, participants were offered a beverage and refreshments prior to the interview and a koha of appreciation was given after the interview (participants were not aware of the koha prior to the interview).

Thematic Analysis

The information collected from the participants was analysed and interpreted using thematic analysis (Braun & Clarke, 2013). Thematic analysis involves summarising common themes within the transcripts (Abell & Myers, 2008). The process proved to be most effective for analysing data which included diverse views and opinions within themes. When comparing participants transcripts on responses, common keywords or phrases that were repetitive were identified and collated into themes. Themes were not hard to identify as values and beliefs, practice principles and issues working in DHBs were explicitly named and succinct. The themes that emerged from the interviews were:

1. Whakapapa
2. Whanaungatanga and tūhono
3. Tika and pono
4. TIC is not new and knowledge on working with trauma
5. Cultural vulnerability, lack of Māori social workers in DHB spaces and clash of Kaupapa Māori practice and DHB environment
6. Colonisation and the impact of historical trauma on social work practice

These themes will be discussed in Chapter 5.

Conclusion

The design methods fit the scope of this research, as Kaupapa Māori principles, *kanohi ki te kanohi* qualitative interviews and trauma informed theory guides the ethical and structural foundation on which the research is built. This research has aspired to contribute meaningfully to the development of culturally appropriate trauma informed principles that can be adopted by health social workers, to implement within their social work practice.

Kaupapa Māori values and beliefs have given great significance to this development. Research participants provided their social work experiences from a depth of oppression and emancipation, with rich personal narratives that addressed the urgent need to implement change in social work practice and DHBs, as evident in Chapter 5: Findings.

Chapter 5: Findings—Māori Social Work Perspectives

This chapter presents the findings from interviews with Māori social workers to better understand approaches in social work practice in addressing trauma. Findings are outlined within the four interview questions that were asked of the participants and then grafted into themes.

Interviews took place with six social workers who identify as Māori and have worked in, or are working in, a District Health Board (DHB). The participants were both wāhine and tāne, and between them they have over a hundred years' social work experience. Because of the small pool of Māori social workers within the DHB, the participants' identities have been kept anonymous. The interviews ranged from one hour to one hour and a half and were held at a location that was comfortable for the participant. The research participants brought their social work practice and rich life experiences to the table.

Thematic analysis, described by Braun and Clarke (2013), was the appropriately chosen method, as themes and patterns within the interviews were identified and analysed. The participants were asked four questions, with a fifth open question drawing out any last comments which are embedded in the themes. Six overarching themes were drawn from the thematic analysis, as listed within the questions below.

Questions:

1. What Kaupapa Māori values and beliefs guide your practice and where did they come from? In this context, values were explained as something that holds value and great importance to them, therefore they identified and defined their values and beliefs. All six participants led with either whānau, whakapapa or whanaungatanga. Each participant spoke at length of their whānau and the importance of whakapapa from a personal perspective and how that translates into professional practice. *Whakapapa*, *whanaungatanga* and *tūhono, tika* and *pono* were the main themes to come out of question one.

2. How do trauma informed principles apply to your practice or what do you know of trauma informed care? All participants understood what trauma is and how it affects people. The range of answers addressed trauma in crisis mode, trauma on a historical timeline pertaining to Māori or clinical trauma through physical injury. There was consensus that TIC is a Western framework, as trauma informed care for Māori is already embedded in practice when applying Kaupapa Māori principles. Knowledge of TIC through a Kaupapa Māori lens was the main theme to come out of question two.

3. Are there any challenges incorporating Kaupapa Māori and TIC principles into your practice in a mainstream environment? All six participants agreed that there have been challenges: The need for a Māori workforce to implement Kaupapa Māori practices; and the need to develop the already overworked Māori staff within the DHB. Lack of Māori leadership and representation on interview panels were also raised. Cultural vulnerability, lack of Māori social workers in DHB spaces and the clash of Kaupapa Māori practice in the work environment were the main themes to come out of question three.

4. What is your understanding of the impact of historical trauma on whānau Māori? All six participants described at length of how colonisation has been the most detrimental factor for Māori wellbeing. Colonisation and the impact of historical trauma on social work practice were the main themes to come out of question four.

Question 1: What Kaupapa Māori values and beliefs guide your practice and where did they come from?

Theme 1 – *Whakapapa*

According to Barlow (2004), whakapapa is "to lay one thing upon another" (p. 173). When a social worker understands and practices the ability to whakapapa, they are engaging in *whakawhiti korero* (the exchange of conversation) and building a foundation of familiar ground. Theme one discusses what whakapapa means to the participants and how that knowledge is implemented in their social work practice. Of the six participants, five referred to whakapapa as critical to informing social work practice.

> *Whakapapa in the sense of just truly understanding human knowledge and we are all connected and everyone that comes through the door here has a connection and understanding that this thing might be happening over here to these members of this whānau, but it impacts the wider whānau.* (Participant D)

Participant B attributes being able to whakapapa with clients as advantageous, describing her engagement with an elderly Māori male: "*we whakapapa, he started to relax and let me in he talked about a lot of things"*. The medical team involved (nurses, doctors, therapists) labelled him as *"rude and aggressive"* and "*hard to engage with"*.

> *They didn't get the same assessment as they don't understand that our people are not going to talk to people in the same way if they don't feel as if they are heard or have the same worldview…we are of the same worldview, we are of the same culture, and it made such a difference.* (Participant B)

Participant F reflected on his upbringing with his grandmother on the marae and whānau *"who naturally helped others for the betterment of Māori"* and how this has influenced his social work practice: *"I belonged before I even understood…it was through my whakapapa that I was connected."*

Four of the participants discussed their grandmothers, mothers, or matriarchs of the family, as they played a significant role in their upbringing and have provided lessons the participants can draw from, when needed, in practice. The notion of whakapapa can be explained to non-Māori practitioners; however, being able to practice from a Te Ao Māori perspective that recognises whakapapa carries obligations, and everything is connected illustrates the depth of practice Māori practitioners utilise when working with whānau.

Theme 2 – Whanaungatanga and tūhono

Significantly, all participants indicated the importance of connectedness, whether based on being connected through whakapapa, community and the environment, or connecting with whānau you are working with. Mead (2003) distinguishes the difference between whakapapa and whanaungatanga*: "*the whanaungatanga principle reached beyond actual whakapapa relationships and included relationships to non-kin persons who became like kin through shared experiences" (p. 28). In social work, connectedness and healthy working relationships are essential to successful engagement with whānau, when accessing support.

> *It's important to establish the relationship between myself and the whānau and young people we meet with, karakia, mihi, pepeha, it's a core part of practice.* (Participant F)

Participant D suggested everyone is connected whether they are conscious of it or not, and further proposed that collective thinking naturally shapes being trauma informed.

> *We acknowledge the interconnectedness and the wholeness of an individual and a whānau and I think for me that's when you think in that collective sense and that interconnected sense, you naturally become trauma informed.*
>
> *You need to understand that the person standing in front of you, you have to consider not only the ones behind but also the ones to come, you know and that's whakapapa… if we think whakapapa and we think from an Indigenous positioning and look through an Indigenous lens our values and way of living we address trauma naturally by the way that we kind of interact and position*. (Participant D)

Three of the participants discussed with humility their natural ability to connect with whānau Māori they are working with.

> *It's just intrinsic, and I say it's just something that you know it's just the way we do it cause you just know um but yeah I suppose from that principle and values I guess positioning it's definitely whakapapa, whānau, respect, you know just all those natural ingrained things that we have…the other biggest things are just integrity and transparency with whānau.* (Participant D)

Participant B reflected on Kaupapa Māori values and beliefs as being "*part of who I am intrinsically being tāngata whenua".*

Similarly, Participant C talked about the natural ability to connect with other Māori through te reo Māori and how she presents herself.

> *It's whanaungatanga…it's te reo, it's tikanga, it's mātauranga, it's those things innately that I think I practice without thinking sometimes what I'm doing when I'm with Māori, only when I'm with Māori. When I'm not with Māori I'm very mindful of what I'm saying, doing, asking, those sorts of things.*
> *Because of what I look like and how I present myself or approach my whānau Māori that in themselves just settles them down, where I say Kia ora and they're like aww, you know and it's just that familiarity.* (Participant C)

All six participants indicated the importance of embedding Māori values and beliefs in practice. Māori values and beliefs are not taught in social work training, as the participants have suggested they are embedded in a person's upbringing through whānau and the environment and are critical to guiding practice as a Māori social work practitioner.

Being able to practice from a Kaupapa Māori social work perspective has the advantage of being able to connect with whānau they are working with, at another level that separates them from other social work practitioners. Being able to discuss who and where a whānau Māori comes from incites an array of discussion points that takes both the social worker and whānau on a journey.

It was normal to discuss common *rangatira* (chiefs) and *tūpuna* (ancestors) during the conversation. Participants based their Māori worldview on their participation in Kaupapa Māori oriented spaces such as *Kōhanga Reo* (learning nests for early childhood), *mau rakau* (Māori weaponry training) and *kapa haka* (Māori cultural performing). These experiences were important to them, as they were on a journey of reclaiming or strengthening their identity as Māori. Two of the participants spoke of their proficient ability to speak in te reo Māori where needed when working with whānau.

Two participants talked at length of how they work with whānau that are disconnected from their iwi.

> *A lot of our urban Māori community within Auckland um many of them are quite disconnected or are not quite as involved or have not grown up in that environment of going back home and so anything to expose them to Māori spaces I try to implement that into my short space of time working with them.* (Participant F)

> *Many of our people have no connections at all to their iwi or things Māori which you have to respect…explore that a little bit and how they got to that place.* (Participant E)

Participant E uses genograms as a method of unravelling the narrative of their journey, and he can see the effects of colonisation through the generations and the amount of healing work that needs

to be done. The commonality in making his assessments is the disconnect many Māori have from their whānau and the unhealthy relationships that have ensued.

Working with whānau that have been disconnected from their ancestral roots is common in social work, the importance of being able to connect to where you come from and to your *whakapapa* is considered a cultural buffer as covered in the literature review (Chapter 3).

Theme 3 – *Tika* and *pono*

The third main theme evident in the interviews was *tika* and *pono* in practice, with *tikanga* as a reference base. Mead (2003) takes the position that tikanga "is the set of beliefs associated with practices and procedures to be followed in conducting the affairs of a group or individual" (p. 12). Mead further illustrates the word *tika* (meaning right or correct), thus the practice of any tikanga needs to be done with care. *Tika* usually goes hand in hand with *pono. Pono*, meaning true or genuine, reflects the standard within which tikanga is viewed. Tika and pono provide the cultural integrity that guides professional practice.

> *To be clear with your intentions and clear in your communications in working with whānau, having a clear set structure and tikanga that is perceived and understood by the whānau you work with is just really a principle in working with Māori.* (Participant F)

> *When it comes to trustworthiness and transparency, I'm working with family violence and child protection so being trustworthy is making sure that I tell them everything as soon as I introduce myself and everything about liaising with other government agencies…walking through that and using our own language…being very honest about what I'm doing.* (Participant C)

> *Working really transparently and respectfully, those are so massive for our whānau.* (Participant D)

This stance is imperative when working with whānau Māori, given that social workers tend to carry a stigma of not being trusted or transparent in their engagement processes.

All six participants illustrated how they implement tika and pono into their practice and how these principles underpin their "rituals of encounter" (Participant A and E).

Question 2: How do trauma informed principles apply to your practice or what do you know about trauma informed care?

TIC through a Kaupapa Māori lens. Participants' knowledge on the six trauma informed principles—safety, trustworthiness and transparency, peer support, collaboration and mutuality, empowerment and choice, and cultural, historical and gender issues (SAMHSA, 2014, p. 10) were explored. None of the six participants utilise the six principles in their practice under the notion of being 'trauma informed', but rather they practice the principles of tika and pono, whanaungatanga, manaakitanga and tūhono through a Kaupapa Māori lens, and have been practicing this way throughout their social work careers.

Participant B referred to the TIC principles as a *"wonderful process but they are common sense with clients I work with" and* has been working with these principles as a tāngata whenua social worker.

Three participants outlined Kaupapa Māori models of practice they use to address trauma. Participant A and B discussed the Poutama Model (Huata, 1997) and Participant E outlined the Hui Model (Lacey, Huria, Beckert, Gillies and Pitama, 2011). Both models have similar rituals of encounter, which can be seen on a marae or in a hui and takes the whānau and social workers through a process or journey that unpacks the trauma in a safe and effective way. These participants have taken Māori processes that they have grown up with and implemented these learnings into their social work practice.

Participant C referred to the principles (protection, participation and partnership) in Te Tiriti o Waitangi 1840, which shapes practice when working with whānau that have endured trauma. Participant D described the TIC approach as *"very Western that has only now come to the forefront"*, however Māori social workers who utilise Māori models of practice, such as Te Whare Tapa Whā (Durie, 1998), have been working holistically for years.

> *How amazing would it be if we as tāngata whenua knew that when we come into contact with the NZ health system (or any system for that matter), it held the wisdom to understand that a process of blending mātauranga does not diminish one's mana but enhances it and in return creates a system which truly strives for better outcomes for our people. (Participant D)*
>
> *TIC and KM values and beliefs can be integrated together in practice, however only Māori clinicians can make that process evolve where the Māori worldview comes first*. (Participant E)
>
> *Even though we can share these processes the way others use them won't be the same or have the same effect on whānau Māori.* (Participant B)
>
> *We do need trauma-based processes, we need our own processes, but we need to be in control of what that is, just like the social work policy, we need to put in what our processes are.* (Participant B)

The participants talked extensively of traversing both Western and Kaupapa Māori ways of working, having to tick boxes to meet policy requirements that didn't necessarily serve the best interests of whānau, but ensuring their needs were being met through a Kaupapa Māori approach.

Two participants asserted that mātauranga Māori is needed to address the disparities between Māori and non-Māori, as Western frameworks have failed to produce better health outcomes for Māori.

Participants described the DHB as a fast-paced environment that provides a limited timeframe and proposed, when working with whānau who are presenting with complex trauma, to allow plenty of time for assessment.

In trauma I find I always find emotion and there's always high emotions where people are not happy, they're quite sad, upset and angry…whānau are not able to deal with some of the rational things (Participant C).

Sitting with whānau and just allowing a space to be created where um they feel trust and that they feel heard and that they feel that their worries are validated and not to try and rush…it's really important to allow whānau to actually be in control of their time here because it's their appointment this is their space this is actually their Kaupapa not ours (Participant D).

It is not enough to treat the symptoms and send them on their way, we are gradually um taking some time to assess you know what trauma is there…everybody that we see has some sort of trauma in their past um whether recent past or some unresolved trauma from a long time ago. (Participant E)

It was clear from the participants that they knew and understood trauma and the approach needed when working with whānau, but they also dealt with systemic barriers and challenges working in DHBs and the impacts these challenges had to professional social work practice as a tāngata whenua social worker.

Question 3: Are there any challenges incorporating KM and TIC principles into your practice in a mainstream environment?

Cultural vulnerability, lack of Māori social workers in DHB departments and clash of Kaupapa Māori practice in a DHB environment. All six participants strongly agreed there have been challenges and a lack of Māori social workers in the DHBs, especially in leadership, management positions and interview panels.

Not enough Māori social workers to support Māori processes. (Participant A)

There is not enough of us. (Participant B, referring to Māori social workers)

Half of the participants expressed the need for a Māori network or support group forums for Māori social work practitioners and the importance of having kuia/kaumātua present in these forums for guidance and consultation when needed. Participant C referred to feeling like she works in isolation sometimes as a Māori social worker, after the disestablishment of a Māori working group. Despite this, Participant C continued to integrate Kaupapa Māori processes into her practice:

You gotta present it first (referring to KM process) before you carry on with it if you don't then you are making disservice to the whānau, to that person, that's discrimination almost.

Participant D was the only Māori in what was considered a large hospital department and discussed that potentially not the best people were at the top making decisions when it came to cultural matters.

> *You need the Māori workforce to implement KM values and beliefs/processes…There are few Māori clinicians in mainstream. Not all Māori clinicians choose to identify as Māori that puts more responsibility on other Māori clinicians which leaves potential for burn out.* (Participant E)

> *The consequences of having a lack of Māori in health spaces puts added pressure on Māori staff that have the potential to burn out.* (Participant F)

Four participants raised the issue of Māori staff they work with who choose not to self-identify as Māori, or that not all Māori they work with follow Kaupapa Māori values and beliefs.
No reasons were given as to why they think this situation exists, it was almost as if no answers were needed, given the context of Māori being a colonised people.
All six participants exemplified their Māori identity from a strength-based perspective and what this means for them as social work practitioners, despite the challenges within DHB spaces.
Participant B discussed the dual approach she takes, traversing both Māori and Western ways of working with whanau:

> *You have to be able to present professionally, but on a level that they understand otherwise you are going to get nowhere you have to be able to see them without all the trauma they come with even though it is there, to be able to cope with the trauma.*

> *To be able to articulate what you are doing even though it's a tāngata whenua process and hang it on a Pākehā model that management will understand, being able to justify what you do.*

Participant B further explains that the DHB is a clinical space that doesn't appeal to Māori, and more culturally friendly spaces are needed, as she shares her view on how she is perceived*:*

> *in the DHB I am a social worker that happens to be Māori, I'm not a Māori social worker, it doesn't fit with their Kaupapa.*

However Participant C proposed a different point of view:

> *I am a Māori who is a social worker rather than a social worker who is Māori so that will always come first, my Māoriness, my Māori whatever even if I don't speak Māori fluently doesn't make me any less of a Māori*.

Marshall & Paul (1999) adds to the understanding of self and practice as Māori, "we may be social workers but at the end of the day we are still Māori" (p. 18).
Participants demonstrated their ongoing struggle in holding people to account and advocating for themselves and whānau they work with.

> *Yeah there's lots of challenges…it can be exhausting, um yeah, ensuring that yeah you know the basic things that honour Māori are met, and you know in our team basic things like pronunciation, people's names.* (Participant E)

> *In regards to advocating on behalf of Māori it has been quite challenging at the same time like you know I guess my attitude is like this is how I operate; this is how we operate if you have a problem move to the side and let us do what we need to do.* (Participant F)

Participant F further expressed the opinion that there are layers of challenges within the DHB and *"a lot of white privilege"* and fragility:

> *Colleagues are not comfortable in talking about racism and not only are you advocating for whānau Māori that come through the door, but you are continuously advocating for yourself as a Māori practitioner and things Kaupapa Māori.*

Participant D discussed the preconceived ideas and unconscious bias towards whānau Māori from non-Māori colleagues, and the need to challenge these views when advocating:

> *The medical environment is individualistic in focus therefore you have to push harder in advocating for Māori.*

The key aspect in the participants' kōrero is the tenacity to do what needs to be done in serving the whānau they work for in a challenging work environment, through tacit knowledge handed down and the Kaupapa Māori values and beliefs they live and breathe.

Question 4: What is your understanding of the impact of historical trauma on whānau Māori?

Colonisation and the impact of historical trauma on social work practice. All six participants talked at length on the effects of colonisation on Māori and how it affects their work in the DHB. It was unanimous: the lingering effects of colonisation are seen and felt in everyday work settings.

> *Colonisation is huge and pretty much in all parts of the system.* (Participant A)

> *Colonisation is one of the longest ongoing partner abuse situations there is that it starts right back where a partner came to stay in your whare which is Aotearoa that an agreement was shared with responsibilities and shared resources and that, and then over the decades legislation and processes happened with the government that slowly eroded that.* (Participant B)

> *As Māori for us as a collective huge stuff went on huge stuff and we can see it on TV we can see it everywhere, we are still having to um…fight is that the word, fight to let people know this did happen and we not gonna let it you know…just forget it didn't happen.* (Participant C)

> *Our people are having to constantly fight for our rightful place…it's hard work getting ahead when you're either trying to get a place at the table, justifying your place at the table, validating your place at the table, or simply just trying to gain entry to the room where the table is located…never mind looking at the table to see what it is made out of and where it came from.* (Participant D)
> *The fact that so many of our people do not understand that they descend from lines of greatness is testament to the success of the coloniser's quest.* (Participant D)

> *If you're a tree and you cut off the roots the tree will die its sort of a believer that if you deny part of yourself its sort of um say if you deny your Māori side you are denying yourself to life that is whole and again the whole sense of who you are…I think it all contributes to the trauma, and reconnecting to your identity can be re-traumatising*. (Participant E)

> *In terms of trauma how do we as an Indigenous people who have been colonised how does that manifest in the health system and the justice system and I think not only from a wairua perspective it impacts us as a people…and intense trauma can be transferred through your DNA.* (Participant F)

All the participants were clear on the impacts of colonisation on themselves, personally and professionally. The impacts of historical trauma have shaped social work practice and how they work with whānau Māori who are accessing the health system today.

> *I ended up being if you like the care and protection social worker partly it was because I was Māori and a lot of the women that were coming through who had care and protection issues for their babies were Māori…I worked with mums in violent relationships and had substance abuse they were real survivors, but majority were abused, and they were continuing to be abused by their partners.* (Participant A)

> *Things happen to tāngata whenua just because of who they are regardless of whether they are entrenched or not…most of my tāngata whenua clients are just so much more traumatic in things they present with.* (Participant B)

> *That's what's coming through our ED (Emergency Department) drugs and addictions it's having to feel good some other way, instead of feeling good about themselves being Māori, being who they are.* (Participant C)

> *Historical trauma has impacted every facet of the existence of tāngata whenua, our communities, our way of living were intentionally decimated by the colonisers, they made every effort to disconnect and disempower, divide and conquer and they did a good job at it…current legislation, systems, institutions and embedded societal understandings, expectations, beliefs continue their life's work.* (Participant D)

> *Disproportionate number of Māori accessing support services which is an ongoing effect of being colonised…historical trauma is an ongoing issue, most of the vulnerable people are usually the most displaced.* (Participant E)

> *Māori were murdered, and land stolen by the Crown and how do such events manifest into intergenerational trauma in the whānau we see today.* (Participant F)

The implications of these findings clearly identify the need to address health inequities, systemic racism and systemic issues within DHB systems that have dire consequences for whānau utilising the health system, these issues are reflected in the damaging Māori health statistics.

Conclusion

There was consensus that all participants practice with a Kaupapa Māori lens, which has provided a rich depth of inherent knowledge to draw from when working with whānau. Each participant described having to walk in two worlds, as a tāngata whenua social worker in a mainstream

organisation, whilst fully conscious of the discrimination, bias and racism entrenched in the colonised systems built to support the whānau they work for.

What is strongly evident throughout the interviews is the empathy all six participants have for their people and the hope that they hold for the whānau they work for. Their lived experiences and comprehensive understanding of tāngata whenua history provides the driving force in continuing to 'fight' for Māori advancement in health and to continue practicing from a Kaupapa Māori perspective.

Chapter 6: Conclusion

> Too often, others look in from the outside and have made determinations about our needs and problems, failing to see the potential that is evident. Our major challenge is to understand the context in which our people live and to transform it. It is not only about surviving any more but about how we can be leaders of today and tomorrow. (Walsh–Tapiata, 2004, p. 12)

This research explored Kaupapa Māori values and beliefs in social work practice, as a culturally appropriate framework to support whānau Māori that have endured trauma. The research is relevant to the current health, social and political landscape, as reflected in the dire statistics for Māori for over one hundred years and Māori are calling for change.

My perspective as an insider to the research provided intimate knowledge of personal accounts of trauma at a whānau, hapu and iwi level. The intended destruction of the Māori identity was historically damaging, and attempts are now being made to reclaim what was once lost.

The detrimental effects of colonial, historical, cultural, and intergenerational trauma for Māori reveal the power imbalance and restoration needed. The causative effects of colonisation are largely ignored in health policies, which reflects the lack of awareness (or ignorance) in policy development.

Social work education and training that integrates cultural protective factors to support trauma recovery are critical to practice. Most social work models in health care are void of Indigenous knowledge. Trauma Informed Care and the ACEs model have been successful overseas, however both approaches lack mātauranga Māori and are additional to the vast Westernised models of health care. To meet the needs of Māori the approach needs to be dismantled and rebuilt, so Kaupapa Māori approaches to trauma are at the forefront.

The resurfacing of how instrumental to change the *Pūao-te-Ata-tū* report (1998) could have been, if the Government heeded the recommendations made, is a reminder of the lack of progress this country has made in efforts to escalate Māori health and aspirations.

Kaupapa Māori values and beliefs can be shared with non-Māori social work allies to gain understanding and awareness, but they are fundamentally part of who Māori are and the obligation they have to pass down to the next generation. If trauma can be passed down, so can resilience and mana-enhancing principles and practices.

Having Māori social work practitioners share their narratives has been invaluable. I was humbled by their intrinsic practice which they have mastered over the years, to successfully walk in both worlds through their acute awareness of what works best for whānau and being able to navigate a health system designed to re-traumatise whānau.

The tenet of this thesis is that Kaupapa Māori values and beliefs can empower Māori social work practitioners and the whānau they work with and all attempts to heal trauma needs to have Māori practitioners in all phases of the practice design.

Further Research

Education and awareness on historical, intergenerational, cultural and colonial trauma needs to be taught in mainstream and Kaupapa Māori education. It is also imperative that health and social services have a thorough understanding of how these types of trauma need a tailored approach that is cognisant of a Māori worldview.

Equitable health outcomes for Māori need to be prioritised, one hundred plus years of poor health for Māori is not acceptable. Systemic barriers and challenges in DHBs need to be identified, challenged, and actioned by both Māori and non-Māori practitioners, to dismantle the barriers for a more effective health system.

More skilled Māori health social workers are needed at all levels in leadership and management within mainstream organisations. Committed recruitment processes and supportive pathways that foster, nurture, and professionally develop Māori social work aspirations. A network that encourages *tino rangatiratanga* for Māori social workers and is inclusive of *te mahi whakamana* is indispensable, so the whānau they serve are afforded the service they deserve.

Māori must be at the table where decisions, design and development choices are made to self-determine what health approaches should look like for Māori. More research is needed, by Māori for Māori, on trauma-based processes; it is pertinent that Māori practitioners name and claim this space. The use of the Māori language is key in clarifying what trauma looks like for Māori, *pōuritanga, mamae* and *whakamā* are more accurate reflections of trauma.

The scope of this research was limited to six participants. More research is needed with perspectives from social workers who choose not to self-identify as Māori social workers, and on how non-Māori allies can support in the field, particularly those in influential positions.

As mentioned by the research participants, being able to have someone connect with you that is from the same culture makes a difference, hence the need for more skilled Māori practitioners. Kaupapa Māori values and beliefs are fundamental to the approach in working with whānau Māori effectively to achieve better health and social service outcomes.

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Appendix A – Confidentiality Agreement

Confidentiality Agreement

Project title: *Cultural TIC*
Project Supervisor: ***Hinematau McNeill***
Researcher: ***Kathleen Nelson***

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....
Transcriber's name: .....
Transcriber's Contact Details (if appropriate):
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Date:

Project Supervisor's Contact Details (if appropriate):
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Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number
Note: The Transcriber should retain a copy of this form.

Consent Form

Project title: ***Can trauma-informed care (TIC) principles within a kaupapa Māori framework deliver better social services outcomes to whānau Māori? A DHB case study.***

Project Supervisor: ***Professor Hinematau McNeill***

Researcher: ***Kathleen Nelson***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated _____
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand and accept that only limited confidentiality is able to be offered in this study.
- ○ I understand that if I withdraw from the study. I will be asked if I want any data that belongs to me removed. I can also agree to allowing it to be used. However, once the findings are completed and written I understand that the removing my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 23/01/2020 AUTEC Reference number 19/436

Note: The Participant should retain a copy of this form.

Participant Information Sheet

Date Information Sheet Produced:
9 November 2019

Project Title

Can trauma-informed care (TIC) principles within a Māori values and beliefs framework deliver better social services outcomes to whānau Māori? A DHB case study.

An Invitation

Kia ora. Ko Kathleen Nelson tōku ingoa. I am working alongside you to make a difference to whānau Māori in our field, social work. This is an invitation to you to participate in a research project that explores the idea of bringing trauma informed care (TIC) principles and Māori values and beliefs together as a strategy to achieve better health/social outcomes. The indications, from the literature are that TIC is an effective tool that is congruent with kaupapa Māori frameworks. You are also probably aware I am a member of a team within Starship Community, based in Greenlane hospital, that is working towards implementing trauma informed practice. This research adds another dimension to this workstream by exploring the possibilities that TIC and Māori social work practices can bring to our organisation.

A Kaupapa Māori approach underpins the entire project as it encapsulates the realities that exist for Māori and the underlying values and beliefs that have formed a unique and distinctive identity. You are aware, as the concept of TIC is topical in the health services that TIC acknowledges the harmful effects of intergenerational trauma and there is a growing body of national and international literature associating trauma with the colonial experience. There is also a growing body of literature on the harmful effects of intergenerational trauma.

Triangulation will bring together, Māori values and beliefs, TIC principles, and data from qualitative interviews to develop culturally appropriate practice principles that can be adopted by health social workers and possibly other health practitioners to achieve better outcomes for whānau. The research will also be a significant contributor to my Master of Arts degree.

What is the purpose of this research?

To investigate implementing trauma informed practice within a Māori values and beliefs framework to hospital social services. The case study is the DHB social work practice teams, based in Auckland catchment.

How was I identified and why am I being invited to participate in this research?

I have asked you to be part of the study because you a respected member of the social work discipline delivering care to whānau Māori. I am also aware of your reputation as a social worker who takes your role beyond the call of duty. Your commitment to making a difference is recognised in our profession. If you agree to participate in the research, you will need to sign the consent form.

How do I agree to participate in this research?

I will get you to sign the consent form, that is a formal agreement to your participation, before we do the interview. It is your choice to be part of, or not, of the study. If you decide at any time, before I have put all the information from the interviews together, that you don't want to be part of the research, I will withdraw you. Unless the work is completed, I will take out all of your interview content and anything else that links you to study.

What will happen in this research?

You will be interviewed, and audio recorded using a digital voice recorder and then transcribed. The following indicative questions will be used as a guide throughout the interview:

1. What Kaupapa Māori principles (KM) guide your social work?
2. How does Trauma informed principles (TIP) apply to your practice?
3. Are there any challenges incorporating KM and TI principles that into your practice?
4. What is your understanding of the impact of historical trauma on whānau Māori?
5. Is there anything else you would like to add?

The topics that the interview will cover are based on the following guidelines:

The completed research will be available online as a thesis and the findings will be published and presented within the health and social work fields.

I also intend to further develop the findings (probably as a collaboration with other researchers/health professionals) to publish and present within social work/health fields. NZ journals such as Aotearoa New Zealand Social Work (ANSW) journal Kōtuitui: New Zealand Journal of Social Sciences.

What are the discomforts and risks?

There are no obvious discomforts or risks. However, you are dealing with whānau who have experienced trauma, and this may affect you.

How will these discomforts and risks be alleviated?

DHB counselling services are available to you free of charge if needed.

What are the benefits?

The research will contribute meaningfully to the development of culturally appropriate trauma informed principles within a Māori values and beliefs framework that can be adopted by health social workers to achieve better outcomes for whānau Māori.

How will my privacy be protected?

You will be not be identified in the study and, although the cohort of participants is small I am confident that no one will be able to correlate what is being said with a specific participant.

How will the interview be recorded?

The interview will be audio recorded using a digital voice recorder and it will be transcribed.

What are the costs of participating in this research?

I am expecting the interview to take about 45 minutes to one hour. I will travel and plan to do the interview at the hospital you are located in.

What opportunity do I have to consider this invitation?

I will contact you in two weeks to confirm that you are a participant in this study. At that time, we will set a time and place for the interview.

Will I receive feedback on the results of this research?

A (summary, around one – two pages) of the findings will be sent to you. Additionally, the entire thesis will be available online. I will send you the link when it is uploaded (after examination).

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Hinematau McNeill. hmcneill@aut.ac.nz, 921 9999 ext.6077.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Kathleen Nelson ktnelson@xtra.co.nz Note that for personal safety reasons, AUTEC does not allow researchers to provide home addresses or phone numbers.

Project Supervisor Contact Details:

Professor Hinematau McNeill. hmcneill@aut.ac.nz 921 9999 ext.6077.

Approved by the Auckland University of Technology Ethics Committee on *23/01/2020*, AUTEC Reference number *19/436*.

Appendix D – Letter of Support GM Māori Health ADHB

Friday, 11th October 2019

Tēnā koe

This letter is in support of Kathleen Nelson who is undertaking a research thesis as an Auckland University of Technology M.A. student on 'Trauma informed care through a Kaupapa Māori lens in social work delivery within the health sector'.

I understand Kathleen will be conducting kanohi ki te kanohi interviews with eight to ten social workers who self-identify as Māori and are working in the Auckland DHB area.

Kathleen has strong support from her research supervisor that is Māori, Hinematau McNeill from AUT, who will assist with the design and implementation of this research.

Kathleen has my full support from a DHB perspective and is able to access support from me where needed throughout her research.

If you have any questions, feel free to contact me on my details below.

Ngā mihi,

Riki Nia Nia
GM Māori Health
Auckland and Waitematā DHBs
027 272 4851