TUKU IHO
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Culture in Māori Health Service Provision
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Ehara i te mea nō inaianei te aroha
Nō ngā tūpuna
I tuku iho
I tuku iho

That which keeps us strong
are from this time alone
But handed down
handed down
Executive Summary

This publication *Tuku Iho, Tuku Iho: Culture in Māori* (the indigenous people of Aotearoa/New Zealand) *Health Service Provision*, provides critical understanding of the notion of culture, cultural safety, cultural competency and cultural fluency especially central to Māori health service provision in Aotearoa. Interspersed within this account, supportive of the sourced literature, are experiences and research which enunciate a clarity of understanding through both a Māori voice and Māori worldview.

Definitions of cultural embrace the notion of “the set of distinctive spiritual, material, intellectual and emotional features of society or what a social group encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs” ([United Nations Educational, Scientific and Cultural Organization (UNESCO), 2001](https://www.unesco.org/), p. 4). The World Health Organisation ([WHO; 2015](https://www.who.int/)) and Napier (2014) argued for culture to be included in health, that “the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide” (Napier, 2014, p. 1568). Durie (2001) describes culture essentially as ways members of a group understand each other and communicate that understanding. Often the differences of meaning are generated by behaviour rather than words, and much of the interaction between members is determined by shared values operating at an unconscious or taken for granted level.

A personal account ([K. K. McClintock, personal communication, 25 September 2018](https://www.health.govt.nz/)) is offered that signals a need to be culturally aware and respectful otherwise unnecessary problems can occur through misunderstanding and ignorance. The example provided regards an encounter of the Authors with Mongrel Mob in a modern-day setting enacting the traditional protocols of tangihana (death) and a response that showed reciprocal understanding and respect.

The issues of cultural safety, cultural competency and cultural fluency, all expected to improve Māori health, have been raised first in the context of Māori rights, articulated through the Treaty of Waitangi and integrated into health policy such as *He Korowai Oranga – the Māori Health Strategy* ([Ministry of Health, 2014](https://www.health.govt.nz/)).


Findings of *Te Rau Hinengaro survey* ([Baxter, Kingi, Tapsell, Durie, & Mcgee, 2006](https://www.health.govt.nz/)) provided landmark information on mental disorders in Aotearoa and continues to be the most comprehensive mental health survey. The prevalence of disorder in the 12month period prior to the survey was higher for Māori than any other ethnic group. Māori were identified as having the greatest burden of mental health problems.

The *Tatau Kahukura: Māori Health Chart Book 2015* presents a snap shot of the health of Māori compared with non-Māori ([Ministry of Health, 2015](https://www.health.govt.nz/)). The chart book presents key indicators relating to the socioeconomic determinants of health, risk and protective factors for health, health status, health service use and the health system. Māori continued to have
the highest burden for many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma (Ministry of Health, 2015) So, these disgraceful statistics are politically and morally unacceptable and must be addressed. Durie (2001) stated a health-oriented reasoning recognises and builds on cultural realities, if not offered then these opportunities for gains in Māori health may never be realised and will continue to be a challenge to Māori health and wellbeing.

The discussion of cultural safety, cultural competence and cultural fluency has been raised at different times and included in government health policy focusing on the capacity of the health workforce to improve health status by integrating culture into what might present in the clinical context.

The concept of cultural safety arose from the colonial context of Aotearoa and the poor health status of Māori and the insistence by Māori nurses that health service change was necessary. Nursing and Midwifery organisations moved to support cultural safety which then became a requirement for nursing and nursing courses in 1992 (Papps & Ramsden, 1992). The New Zealand Nursing Council promoted cultural safety as related to the experience of the recipient of nursing service and extended beyond cultural awareness and cultural sensitivity.

The concept of ‘cultural competence’ was established in health care to better meet the needs of increasingly culturally diverse populations, and in response to the growing evidence of disparities in the health of ethnic minority groups. The Health Practitioner’s Competence Assurance Act HPCAA (Ministry of Health, n.d.) sets the standards of cultural competence to be observed by health practitioners. This is included under section 118 (i) of the Act. However professional registration bodies for the health and disability workforce in Aotearoa have each defined cultural competence in different ways because the HPCAA does not give a clear definition of the term.

In 2004, the Nursing Council¹ began approving Professional Development and Recognition Programmes (PDRPs) as recertification programmes under section 41 of the HPCAA 2003. The intention was to allow nurses who were already demonstrating continuing competence through PDRPs to be exempt from the recertification audit. PDRPs are developed by employers and professional organisations to recognise and support individual nurses. Their assessment processes are based on the submission of a practice portfolio.

The Huarahi Whakatū² offered through Te Rau Matatini, Māori Health Workforce Centre, is a Nursing Council accredited Professional Development and Recognition Program (PDRP) specifically tailored by and for Māori Registered Nurses. The program is coordinated by a Māori Registered Nurse, guided by a cultural and clinical governance board with access to Mentors and Māori Assessors.

Improving cultural competence and creating culturally safe environments for both patients and doctors is the aim of a new joint project between the Medical Council of New Zealand

¹ www.nursingcouncil.org.nz
² http://www.nz cmhn.org.nz/Maori-Caucus/Huarahi-Whakatu-Programme
(Council)\(^3\) and Te Ohu Rata o Aotearoa (Te ORA)\(^4\), the Māori Medical Practitioners Association. The joint project is a key element of Council’s strategic direction to protect the public by supporting doctors to improve their cultural competence, increase partnership with Māori, create greater health equity and improve health outcomes for Māori.

How cultural competency is assessed is an ongoing matter though in line with the problem-based approach to all health education, a case could be made for it to be closely linked to clinical problem solving, rather than treated as a separate subject that stands outside a health framework. By emphasising the clinical-cultural link, the rationale for cultural competency is clearly based on health objectives rather than political imperatives such as the Treaty of Waitangi, although these must never be forgotten. While the two levels of justification must not be separable, the more cultural competency is perceived as an issue outside of the health environment, unfortunately the less it is likely to be given value or integrated into practice (Durie, 2001).

Preparing a Mental Health and Addiction Workforce that can meet the challenges of the future is an essential component of the Mental Health and Addiction Workforce Action Plan (2017-2021 (Ministry of Health, 2018). One of its key priorities is for a workforce that is competent and capable. Ensuring the workforce is culturally competent and competency frameworks form the basis for all recruitment, training and professional development is a key action to this priority.

The set of competencies determined by the Psychologists Registration Board\(^5\) addresses the knowledge, skills and attitudes involved in providing culturally safe practice. The practice of psychology in Aotearoa /New Zealand reflects paradigms and worldviews of both partners to te Tiriti o Waitangi /the Treaty of Waitangi. Cultural competence requires an awareness of cultural diversity and the ability to function effectively and respectfully when working with people of different cultural backgrounds. Cultural competence requires awareness of the psychologist’s own cultural identities and values, as well as an understanding of subjective realities and how these relate to practice.

The cultural competencies offered by psychologist go some way to address better health outcomes for Māori. Although the following example from the Child and Adolescent Mental Health sector which is nearly 10 years old offers some of the insights that can present if cultural values are not known or appreciated.

Te Tomokanga, a national research project, was conducted with whānau of Māori Rangatahi (Youth) who had been referred to a Child and Adolescent Mental Health Service (CAMHS) in the 2000 – 2006 years to gain their understanding of the notion of culturally appropriate services (McClintock, Moeke Maxwell & Mellsop, 2011). The mother who supported access to a CAMHS articulated frustration with continuing having to clarify the cultural context for the psychologist because of his lack of cultural knowledge and language.

\(^3\) [https://www.mcnz.org.nz/](https://www.mcnz.org.nz/)
Durie (2001) articulated that cultural competency is about the acquisition of knowledge required to achieve better understanding of members of other cultures. Culture and language are inseparably bound but if the language of the culture is not well known then there must be at least an appreciation of the values upon which culture is based. Cultural competence is essentially another relationship that can provide additional information necessary for better health outcomes.

The Western Approach
A psychological approach of maintaining a distant relationship is at odds with the Māori process of whakawhanaungatanga. This Māori process seeks to establish a sharing of personal details, to establish a personal connection crucial to ensuring positive clinical outcomes for Māori. Therefore, in stating the above Bennett (2018) agrees with the mother (McClintock, Moeke Maxwell & Mellsop, 2011) when she said “He didn’t introduce himself! no whanaungatanga!” (relationship building) which is important to Māori, no telling us who he was, nothing about Te Ao Māori. And not giving us much time to say who we were. Yeah RUDE! All leading to a failed relationship.

Several affirmative action cultural fluency programmes to build clinical and cultural competency for Māori working in health have been implemented over the years. Te Rau Puawai programme, Massey University and Te Rau Matatini Māori Health Workforce Organisation are two such initiatives.

Te Rau Puawai began towards the end of 1997 through the motivation of Māori psychology personal from Massey University who brought their concerns about low numbers of Māori enrolled in Psychology to the attention of the Professor of Māori Studies. The possibility of scholarships for Māori students in health qualifications was suggested as a way forward and a goal of 100 graduates over a five-year period was set – hence the name Te Rau Puawai. By the beginning of the 1999 academic year the first scholars had been selected and by 2004, 104 Te Rau Puawai scholars had graduated (Durie & Durie, 2018).

The success of Te Rau Puawai over the past 20 years has been spectacular – as measured by the academic accomplishments of successive waves of students at undergraduate and postgraduate levels. A strong argument to retain the same focus and the same approach could be made with ample justification. But as a proven champion for Māori mental health, Te Rau Puawai might also be expected to be a leader in the promotion of mental health in those areas that will be critical for Māori in the future (Durie & Durie, 2018).

The second example is Te Rau Matatini6
Established in 2002 Te Rau Matatini aims to:

1. Be the lead agency to improve Māori Health and Indigenous Wellbeing via health workforces, strategies and systems that implement Pae Ora (Ministry of Health, 2014).
2. Strengthen health workforces to decrease Maori inequity and increase Māori wellbeing and potential.

6 http://teraumatatini.com/our-purpose
Te Rau Matatini prefer the concept of ‘cultural fluency’ over cultural competence, which is the ability of health professionals to operate in various spaces, places and settings. The idea of being able to operate in differing places, with the ability to apply varying levels of knowledge in practice is more relevant to a diverse workforce and their need to be agile and adaptable according to their roles and practice with differing groups of people and in differing contexts (Te Rau Matatini, 2018). Cultural fluency implies knowing how things are done in everyday life such that one’s conscious or non-conscious culture-based expectations typically match situations as they unfold, an almost automatic response. How to predict that a hallmark of this culture-based expectation to situation match is the experience of cultural fluency (Inoue, 2007).

Te Rau Matatini has a suite of cultural competency towards cultural fluency programmes which are delivered in workshops and wānanga. The cultural fluency programmes focus on addressing Māori inequalities in the mental health and addiction sector for Māori and non-Māori workforces. Participants complete a workshop or wānanga and will receive a certificate of completion with professional development points or hours. Te Rau Matatini will work across the health sector to advance the cultural competency toward cultural fluency of health workforces, organisational systems and responses to address Māori mental health and addiction need (Te Rau Matatini, 2018).

Conclusion

_Tuku iho Tuku iho, Culture in Māori Health Service Provision_ has provided detailed understanding of the notion of culture, cultural safety, cultural competency and cultural fluency especially central to Māori health service provision in Aotearoa. The passage of this development has been influenced by the impetus provided by legislative imperatives and addressing equities for Māori.

The experiences and research which enunciates a clarity of understanding through both a Māori voice and Māori worldview have been interspersed within this account, supportive of the sourced literature. In addition, the support of registration boards such as the Nursing Council, Medical Council and Psychologist Board adds sector weight to this discussion.

The cultural fluency examples of Te Rau Puawai and Te Rau Matatini are innovative indigenous examples that will not only resonate with Māori working in and those about to enter the health workforce but also with the indigenous global community where cultural health imperatives are of similar value.

Introduction

This publication _Tuku Iho, Tuku Iho: Culture in Māori Health Service Provision_, provides critical understanding of the notion of culture, cultural safety, cultural competency and cultural fluency especially central to Māori health service provision in Aotearoa (New Zealand). Interspersed within this account, supportive of the sourced literature, are experiences and research which enunciate a clarity of understanding through both a Māori voice and Māori worldview.
United Nations Education, Scientific and Cultural Organization
In 2001, the United Nations Education, Scientific and Cultural Organization (UNESCO, 2001) promoted the definition of culture as “the set of distinctive spiritual, material, intellectual and emotional features of society or what a social group encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs”. This definition embraces the notion that culture comprises not only the physical artefacts around which group identity emerges, but also the conventions that frame their sense of reality. The United Nations Education, Scientific and Cultural Organization stated that though the shared values of cultural contexts are complex, understanding them is critical to health and well-being and the development of appropriate health services.

World Health Organisation
In 2015, upon acknowledging the importance of culture to health and well-being, the World Health Organisation (WHO) convened its first expert group on the cultural contexts of health and well-being (WHO, 2015). This came as a response to a growing body of evidence demonstrating that the best medical care in the world remains limited if its provision does not align with the priorities and perceived needs of those it seeks to serve. Indeed, Napier (2014) argued that “the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide”.

Aotearoa
Durie (2001) describes culture essentially as ways members of a group understand each other and communicate that understanding. Often the differences of meaning are generated by behaviour rather than words, and much of the interaction between members is determined by shared values operating at an unconscious or taken for granted level.

A Personal Account
The other day I experienced the cultural behaviour - ALERT red patches on their backs, as my daughter quickly pointed out! - of a 25plus group of Mongrel Mob gang members, alongside cars parked up on grassed areas. They were in our neighbourhood standing in the middle of an arterial road in my suburbia. Yes, mostly big young Māori boys - I call them boys because they all looked at least 10 years younger than my 30ish daughter. They were facing sideways to the direction we were coming from and oblivious to us, about to invade their space.

I quickly scanned the scene for any reason why they would be here and yes just to the far right of us, on the right side of a house was a garage clothed in greenery and the colour black, that have been symbols of mate (death) tangihana (funeral) to honour our tūpāpakū (dead) for as long as I can remember. But only then did I recognise the group not as Mongrel Mob gang members but as mourners in grief, Māori who had experienced the loss of a loved one, all waiting in quiet respect to enter the realm of Hine-nui-te-po, our Goddess of Death, all waiting patiently for the tikanga (protocols) to be performed to allow them entry into the sanctum of the whānau pani (bereaved family).

My daughter and I recognised their solemnness, their heads bowed in grief, in respect and of respect for our protocols of death, of standing to be called into the realm of Hine-nui-te-po, to share the loss with the whānau pani. So, we pulled to the side, stopped our car and waited in

7 (K.K McClintock, personal communication, 25 September 2018)
the in a suburban street! Heads turned slowly and looked at us, my daughter and I, and then without any words being spoken and fuss being made they moved aside to let us pass. Why did they do that? They did that NOT because they knew they were holding us up but without doubt because they knew we had understood their grief and had respected them and they knew too there was time for them to move aside for these two Māori women who had momentarily honoured their loss by stopping.

As I passed i tangi tōku ngākau, I silently wept for their tūpāpakū, their deceased not known to me, but whose spirit was about to be sent to the final resting place of all Māori, a farewell to send the tūpāpakū to Hawaiki nui, Hawaiki roa, Hawaiki pamamao ki te okiokinga o te tangata. I tangi hoki tōku ngākau, I also silently wept overjoyed that in the middle of suburbia in 2018 our tikanga relating to tūpāpakū, to tangihanga still had value for Māori of all generations and from all walks of life!

In retrospect I pondered what would have happened if we were ignorant and just saw the group as Mongrel Mob members in our way, causing a barrier for us in getting home; if we hadn’t scanned the scene in search of a reason for them being there; if we hadn’t recognised the Māori symbols acknowledging death; if we didn’t know the protocols of the tangihana; and most importantly of all if we hadn’t shown respect? This meeting of them and us had the potential to be a risk, a clash of differences, unsafe for my daughter and I and just as importantly unsafe for our Mongrel Mob boys. But because both our groups knew and respected our cultural beliefs and values, our tikanga and honoured them, courtesy and respect were easily reciprocated.

The Treaty of Waitangi
In Aotearoa the issues of cultural safety, cultural competency and cultural fluency, all expected to improve Māori health, have been raised first in the context of Māori rights, articulated through the Treaty of Waitangi and integrated into health policy such as He Korowai Oranga – the Māori Health Strategy (Ministry of Health, 2014). The Treaty of Waitangi principles of Partnership, Participation and Protection that underpin the relationship between the Government and Māori are:

- **Partnership** involves working together with iwi (tribes), hapū (subtribes), whānau (family) and Māori communities to develop strategies for Māori health gain and appropriate health and disability services.
- **Participation** requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services.
- **Protection** working to ensure Māori have at least the same level of health as non-Māori, and safeguarding Māori cultural concepts, values and practice

He Korowai Oranga – the Māori Health Strategy (Ministry of Health, 2014) places further:

- Emphasis on building a competent, capable, skilled and experienced Māori health and disability workforce by increasing the number and developing the skill base of Māori in the health and disability workforce and enabling equitable access for Māori towards training opportunities; and
• The overarching framework to guide the government and the health and disability sector to achieve Pae Ora – healthy futures for Māori and supporting this direction by aligning to the:
  - New Zealand Public Health and Disability Act 2000;
  - Treaty of Waitangi; and
  - Māori health outcomes and equity.

The United Nations Declaration on the Rights of Indigenous Peoples
In 2010, the Aotearoa Government, became a signatory to the United Nations Declaration on the Rights of Indigenous Peoples (Survival International, 2010; United Nations, 2008). In doing so the government committed to working towards meeting its obligations to Māori. Two articles are critical to Māori health.

Article 23
Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24
Indigenous peoples have the right to their traditional medicines and to maintain their health practices including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without discrimination to all social and health services.

The inclusion of these rights for Māori is a political health debate which unfortunately has largely been ignored. But the health argument continues to demand attention because it is also built on the health equity issue given that Māori are disproportionately represented in most health statistics (Baxter et al., 2006; Ministry of Health, 2015).

Te Rau Hinengaro
Findings of Te Rau Hinengaro survey (Baxter et al., 2006) provided landmark information on mental disorders in Aotearoa and continues to be the most comprehensive mental health survey. The prevalence of disorder in the 12 month period prior to the survey was higher for Māori than any other ethnic group. For disorders that were noted in the 12 months of the survey, the prevalence was 29.5% for Māori, and 19.3% for Others, which indicates that Māori have a greater burden of mental health problems.

After adjusting for sociodemographic correlates no ethnic differences in the prevalence of anxiety disorders were apparent as with, major depression after adjustment, Māori and Others have very similar prevalence (5.7%, 5.8%). But even with adjustments the prevalence of bipolar disorder was higher for Māori (Māori, 3.4% and Others 1.9%), as was substance use disorder higher for Māori (Māori 6.0% and Others, 3.0%; Baxter et al., 2006).
Tatau Kahukura
The *Tatau Kahukura: Māori Health Chart Book 2015* presents a snap shot of the health of Māori compared with non-Māori (Ministry of Health, 2015). The chart book presents key indicators relating to the socioeconomic determinants of health, risk and protective factors for health, health status, health service use and the health system. The chart book shows that Māori have higher rates than non-Māori for many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma (Ministry of Health, 2015).

These shameful Māori health statistics are in the context of an Aotearoa government that has guaranteed Māori health and wellness at least equivalent to their non-Māori counterparts. This assurance has existed since 1840 when Māori signed the Treaty of Waitangi as Treaty partners with the Crown. Also, as recent as 2010, the government articulated a commitment to Māori wellbeing when Aotearoa became a signatory to the *United Nations Declaration on the Rights of Indigenous Peoples* (United Nations, 2008).

So, these disgraceful statistics are politically and morally unacceptable and must be addressed. Durie (2001), stated a health-oriented reasoning recognises and builds on cultural realities, if not offered then these opportunities for gains in Māori health may never be realised and will continue to be a challenge to Māori health and wellbeing.

The discussion of cultural safety, cultural competence and cultural fluency has been raised at different times and included in government health policy focusing on the capacity of the health workforce to improve health status by integrating culture into what might present in the clinical context.

Cultural Safety
The concept of cultural safety arose from the colonial context of Aotearoa and the poor health status of Māori and the insistence by Māori nurses that health service change was necessary. Nursing and Midwifery organisations moved to support cultural safety which then became a requirement for nursing and nursing courses in 1992 (Papps & Ramsden, 1992). The New Zealand Nursing Council promoted cultural safety as related to the experience of the recipient of nursing service and extended beyond cultural awareness and cultural sensitivity. It aimed to provide consumers of nursing services with the power to comment on practices and contribute to the achievement of positive health outcomes and experiences. It also enabled them to participate in changing any negatively perceived or experienced service (Nursing Council of New Zealand, 2011).

The New Zealand Nursing Council’s definition of cultural safety is: “The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.”

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on.
his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual” (New Zealand Nursing Council, 2011, p.7).

Cultural Competence

The concept of ‘cultural competence’ was established in health care to better meet the needs of increasingly culturally diverse populations, and in response to the growing evidence of disparities in the health of ethnic minority groups. The benefits of delivering culturally competent health care (Stewart, 2006) were noted as improved:

- access and equity for all groups in the population;
- consumer ‘health literacy’ and reduced delays in seeking health care and treatment;
- communication and understanding of meanings between health consumers and providers, resulting in better compliance with recommended treatment or clearer expectations or reduced medication errors and adverse events or improved attendance at ‘follow-up’ appointments o reduced preventable hospitalization rates o improved consumer satisfaction;
- patient safety and quality assurance;
- ‘public image’ of a health service; and
- Good business practice and better use of resources.

Conversely, it follows that there are substantial risks that are likely to incur costs if healthcare provision is culturally incompetent.

The Health Practitioners Competence Assurance Act 2003 (HPCAA)

The Health Practitioners Competence Assurance Act 2003 HPCAA sets the standards of cultural competence to be observed by health practitioners. This is included under section 118 (i) of the Act. However professional registration bodies for the health and disability workforce in New Zealand have each defined cultural competence in different ways because the HPAAA does not give a clear definition of the term. The following details acknowledge, the cultural competence definition and standards prescribed by two Registration Boards: the Nursing Council and the Medical Council.

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8 www.moh.govt.nz/hpca
Cultural Competence Definition and Standards

Table 1

<table>
<thead>
<tr>
<th>The Nursing Council of New Zealand⁹</th>
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<tbody>
<tr>
<td>In 2004, the Nursing Council began approving Professional Development and Recognition Programmes (PDRPs) as recertification programmes under section 41 of the Health Practitioners Competence Assurance Act 2003. The intention was to allow nurses who were already demonstrating continuing competence through PDRPs to be exempt from the recertification audit.</td>
</tr>
<tr>
<td>PDRPs are developed by employers and professional organisations to recognise and support individual nurses. Their assessment processes are based on the submission of a practice portfolio.</td>
</tr>
<tr>
<td>PDRP requirements are usually different from the requirements of the recertification audit. This is because these programmes usually look at more than simply competence to practice. They may seek to support individual nurses to develop their practice and to recognise additional contributions made by nurses to the workplace. The assessment tools used by PDRPs may also be different, as the nurse usually supplies more evidence in a portfolio than is required for audit.</td>
</tr>
<tr>
<td>The criteria for advancement through these programmes are determined by the organisation and not by the Nursing Council. Council approval means that the programme has met the Nursing Council standards for PDRPs and the Council is satisfied that nurses assessed by the programme meet the Council's continuing competence requirements (as well as other organisational requirements).</td>
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Huarahi Whakatū¹⁰

The Huarahi Whakatū offered through Te Rau Matatini, Māori Health Workforce Centre, is a Nursing Council accredited Professional Development and Recognition Program (PDRP) specifically tailored by and for Māori Registered Nurses. The program is coordinated by a Māori Registered Nurse, guided by a cultural and clinical governance board with access to Mentors and Māori Assessors.

What’s unique?

The Huarahi Whakatū promotes the philosophy of ‘dual competency’, that is clinical and cultural competencies. Clinical competencies are drawn from Nursing Council of New Zealand, whereas cultural competencies are informed by Te Ao Māori. This provides a framework with four domains of clinical competencies, and six domains of Māori cultural concepts. These were developed accumulatively with Māori as being integral to practice by and for Māori, and for the achievement of Whānau ora.

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⁹ www.nursingcouncil.org.nz
¹⁰ http://www.nzcmhn.org.nz/Maori-Caucus/Huarahi-Whakatu-Programme
The six cultural domains offer a range of Māori concepts and values categorised as Wairuatanga, Pupuri ki te Arikitanga, Te Reo me ona Tikanga, Tuakiri, Whānaungatanga and Hauora Māori.

What can the Huarahi Whakatū provide?

- Provide a framework for Māori nursing professional growth and development.
- Recognise, reward and advance cultural and clinical aspects of a Māori nurses practice.
- Assist to identify areas for ongoing professional and personal development.
- Enhance responsiveness to client and whānau ‘whole of health’ needs.
- Raise the profile of Māori nursing practice, advancement and leadership.

Who is it for?
Registered nurse with a current annual practicing certificate who identifies as Māori and is currently employed.

What’s involved?
The Huarahi Whakatū is comprised of:

- Regional wānanga
- Resources
- Self-paced programme
- Compiling a professional portfolio
- Online Mentors
- Links to Māori Registered Nurses

Clinical understandings of health are based on a scientific method substantiated by years of study and scientific evidence that satisfies the criteria of scientific proof. However cultural competence is more about recognising another belief systems as a legitimate way of looking at the world. One approach should not negate the other, clinical staff may need to share the healing platform with others who do not base their interventions on clinical scientific evidence but on their own unique cultural beliefs system and evidence (Durie, 2001).

There is also the notion that a culturally competent doctor will see opportunities for collaboration with traditional healers and wellbeing approaches to produce better health outcomes rather than regarding them as not valid nor evidence based. Ignoring the cultural reality as if it were of little consequence will lead to missed opportunities for offering positive interventions (Durie, 2001).
Improving cultural competence and creating culturally safe environments for both patients and doctors is the aim of a new joint project between the Medical Council of New Zealand (Council) and Te Ohu Rata o Aotearoa (Te ORA), the Māori Medical Practitioners Association.

The joint project is a key element of Council’s strategic direction to protect the public by supporting doctors to improve their cultural competence, increase partnership with Māori, create greater health equity and improve health outcomes for Māori.

A national symposium to consider the challenges and opportunities for improvement was held in June 2017 as a first step in the initiative. Council has commenced a review of the resource *Best health outcomes for Māori: Practice Implications* and will engage with stakeholders about this in the future as work continues on this important strategic direction.

### Cultural competence, partnership and health equity

The cultural competence, partnership and health equity strategic direction relates to all strategic goals however Goal three is highlighted within this report:

#### Goal three: Promote good regulation of the medical profession by providing standards of clinical competence, cultural competence and ethical conduct and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.

A doctor’s culture and world view influence the way that they interact with patients and the way they understand health, healthcare and wellness. They can also impact upon the doctor-patient relationship. Patient’s cultures and world views can influence the way they interact with the health system and how they respond to healthcare interventions. A doctor’s approach to patients with a cultural identity that differs from their own can influence the way a patient accesses care.

Medical regulators and colleges have a responsibility to support doctors in the further development of a culturally competent workforce. Developing the cultural competence of doctors is a method of improving the experiences for Māori within the health system and reducing the unacceptable inequities in health that exist between the indigenous Māori and the Pākehā population.

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11 [www.mcnz.org.nz](http://www.mcnz.org.nz)
Key outcomes

Improved health outcomes and reduced health inequity for Māori and other ethnic groups, through Council’s role as the medical regulator responsible for professional standards and ensuring doctors’ competence.

How we will achieve our outcomes:

Strengthening Cultural Competence

- Develop resources for Council staff to improve understanding of tikanga Māori and Te Reo.
- Develop a cultural competency framework that identifies clear expectations and standards of cultural competence for doctors and the related competencies which can be used for assessment of doctors and included in standards for prevocational medical training, vocational training and recertification programmes.
- Collaborate with colleges and employers about the importance of cultural safety, focusing on the experiences of the patient to improve the quality of care.
- Review Council’s statements and resources so that they are written in both Māori and English and reflect the standards of cultural competence.
- Engage with colleges and other stakeholders to influence an increase in the number of Māori doctors entering and completing vocational training.
- Improve understanding of the outcomes of care and the causes of health inequities.
- Work collaboratively with medical colleges and employers to ensure cultural competence is embedded in all prevocational, vocational and recertification programmes.
Registration and Review

As suggested earlier in this publication, to produce the best possible health outcomes, cultural competence should be assessed both for registration and as part of an ongoing professional education requirement. New Zealand graduates, have since the 1970s had some exposure to the impacts of culture on health in undergraduate years. But introductory lectures and experiences, by themselves, are insufficient for Best Practice Health Outcomes (Durie, 2001). As evidenced in this document some specialist colleges such as Nursing and Doctors are clear about requirements for cultural competency in post-registration situations. Cultural competency is regarded as a necessary skill and therefore be included in all ongoing education and assessment for all health professions.

How cultural competency is assessed is an ongoing matter though in line with the problem-based approach to all health education, a case could be made for it to be closely linked to clinical problem solving, rather than treated as a separate subject that stands outside a health framework. By emphasising the clinical-cultural link, the rationale for cultural competency is clearly based on health objectives rather than political imperatives, although these must be never forgotten. While the two levels of justification must not be separable, the more cultural competency is perceived as an issue outside of the health environment, unfortunately the less it is likely to be given value or integrated into practice (Durie, 2001).

Treatment plans which are developed without involvement or appreciation of whānau and community cultures, are more likely to fail, not because they are professionally and technically unsuitable but because the community’s cultural beliefs and values are more likely to be associated with different aspirations, priorities and procedures. A culturally competent doctor must therefore have clinical knowledge and information about the cultural communities serviced by the practice. This enables a more accurate picture to be drawn about the full opportunities for health, as well as the health risks (Durie, 2001).

Mental Health and Addiction Workforce

Preparing a Mental Health and Addiction Workforce that can meet the challenges of the future is an essential component of the Mental Health and Addiction Workforce Action Plan (2017-2021) (Ministry of Health, 2018). One of its key priorities is for a workforce that is competent and capable. Ensuring the workforce is culturally competent and competency frameworks form the basis for all recruitment, training and professional development is a key action to this priority. The New Zealand Psychologist Board articulates cultural competence as follows:
The set of competencies determined by the Psychologists Registration Board addresses the knowledge, skills and attitudes involved in providing culturally safe practice. The practice of psychology in Aotearoa /New Zealand reflects paradigms and worldviews of both partners to te Tiriti o Waitangi /the Treaty of Waitangi. Cultural competence requires an awareness of cultural diversity and the ability to function effectively and respectfully when working with people of different cultural backgrounds. Cultural competence requires awareness of the psychologist’s own cultural identities and values, as well as an understanding of subjective realities and how these relate to practice. Cultural mores are not restricted to ethnicity but also include (and are not limited to) those related to gender, spiritual beliefs, sexual orientation, abilities, lifestyle, beliefs, age, social status or perceived economic worth. (Reference must also be made to the Board’s “Cultural Competencies” document). The psychologist will be able to demonstrate a range of knowledge and skills.

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness and knowledge of their own cultural identity, values, and practices.</td>
<td>• Exploration of their own and others’ assumptions with respect to cultural differences (e.g. beliefs, practices and behaviours).</td>
</tr>
<tr>
<td>• Understanding of Māori models of health (e.g. Te Whare Tapa Whā).</td>
<td>• Respect for cultures and languages (e.g. culturally appropriate behaviour in Māori settings and taking care with pronunciation of names and other common words in Te Reo Māori).</td>
</tr>
<tr>
<td>• The cultural beliefs and values situated within tikanga Māori.</td>
<td>• Work from a non-prejudicial and affirming stance.</td>
</tr>
<tr>
<td>Awareness and knowledge of the cultural identity, values and practices of clients, and particularly:</td>
<td>• Alleviation of distress associated with stigma, discrimination and social exclusion (based upon ethnicity, gender, sexual orientation, disability, or religious beliefs).</td>
</tr>
<tr>
<td>Knowledge and awareness of the cultural bases of psychological theories, models, instruments, and therapies.</td>
<td>• Sensitivity to diversity.</td>
</tr>
<tr>
<td>Knowledge of diversity, individual differences and abilities.</td>
<td></td>
</tr>
<tr>
<td>Knowledge of the importance of different cultural approaches to assessment, intervention and other areas of psychological practice.</td>
<td>• Active inclusion of others' understandings in practice, including data collection, analysis and intervention design.</td>
</tr>
<tr>
<td></td>
<td>• Recognition and application of the differing requirements for cultures in approaches to assessment, intervention, consultation and other areas of psychological practice.</td>
</tr>
<tr>
<td></td>
<td>• Consultation with culturally knowledgeable people.</td>
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</tbody>
</table>

12 [www.psychologistsboard.org.nz](http://www.psychologistsboard.org.nz)
The cultural competencies offered by psychologists go some way to address better health outcomes for Māori. Although the following example from the Child and Adolescent Mental Health sector which is nearly 10 years old offers some of the insights that can present if cultural values are not known or appreciated.

A Mother’s account of psychological assessment for her tama (son):
Te Tomokanga, a national research project, was conducted with whānau of Māori Rangatahi (Youth) who had been referred to a Child and Adolescent Mental Health Service (CAMHS) in the 2000 – 2006 years to gain their understanding of the notion of culturally appropriate services (McClintock, Moeke-Maxwell, & Mellsop, 2011). The following is the near full transcript from one of the interviews with a mother who supported access to a CAMHS.

Mother

*My tama (son) well his kura (school) regarded him as disruptive and non-compliant excluding him and refusing to have him back until he had had a psychological assessment completed and appropriate treatment if needed. So, we agreed to this process to help our tama get back into his kura.*

*But at home, he was a respected role model to all his siblings and his cousins within our extended whānau (family). When he left home he had mana (status, authority through leadership) and he knew he was loved.*

*Unfortunately, the kura only saw disruptive leadership, particularly a bad influence on his extended whānau who was always with him. They would listen to him, challenging kaiako (teachers) who he perceived as bullying his whānau and kaiako saying to him he was a trouble maker, leading others astray.*

*So, we agreed and turned up for the scheduled appointment with the psychologist? Well he didn’t say what he was! He didn’t introduce himself! no whanaungatanga! (relationship building) which is important to Māori, no telling us who he was, nothing about Te Ao Māori (Māori world). And not giving us much time to say who we were. Yeah RUDE!*
His first question was to my tama, tell me what you’re good at? That was surprising but I thought respectful wanting to know my tama’s strengths. But there is a saying in Te Ao Māori Kaore te kūmara e kōrero ana mō tōna ake nei reka, the kūmara doesn’t talk about his own sweetness. So, the doctor didn’t get a response from my tama which the doctor probably perceived as non – compliant behaviour - just like the kura reported!

So, I took charge and said, my tama (doctor had no trouble with understanding the word tama) spends a lot of time at our marae ... the doctor asked what is a marae?... so I had to educate him for the next 20 minutes. It is a place where all our whānau (doctor had no trouble with whānau) meet regularly to connect with each other and enjoy who we are and our histories... doctor confirmed his understanding ..oh like a place to socialise... yes I partly agreed with him.

We also have manuwhiri who arrive ..... the doctor asked what are manuwhiri? Another language lesson, well they are distinguished visitors, whānau perhaps who have arrived for a special occasion, a birthday, a wedding or the marae fundraiser and we organise the pōwhiri followed by a hākari. Same line of questioning from the doctor ...what is a powhiri? and what is a hakari?. By this time, I was hoha (annoyed). I wanted to kōrero (talk) about my tama and what he was known for at our marae! Not give the doctor a cultural language lesson!

So, I said proudly, ok my tama gives awhi (helps) in the kitchen leading his siblings and the other Rangatahi (Youth) from within our extended family to make sure that there is enough miti (meat) hua whenua (vegetables) paraoa (bread) for the ringawera (cooks) to make the hākari (feast). Yes, now putting in the Pakeha (English) words for the doctor to stop the 100 questions.

Sometimes less manuwhiri arrive than expected which is never a problem but when the crowd is bigger my tama rounds up everyone very quickly to make sure all our manuwhiri will be fed because that is important to us, manaakitanga (looking after people). He works closely with the ringawera (mostly his elders, aunts and uncles) calculating time, quantity and of course the quality of the kai (food).

Now how did the doctor respond to what I had just shared about my beautiful tama? Well he said thank you for that, that’s a lovely story, but can you tell me what your tama (he gave the word a go) is good at? So how did I respond?!! Well I got my tama and we were out of there!

So, that kura and that Child and Adolescent Mental Health Service were of no help to my tama and our whānau, they had NO understanding. So, my tama continued his kura amongst his Fielding whānau in a Māori Boarding School that we knew would cherish him for the mana he showed and we knew he always had!

What can be learnt from this mother’s contact with a Child and Adolescent Mental Health Service?
Positives: Māori values were shared:
Mana: Leadership
Whanaungatanga: Relationships
Manaakitanga: Care
Te Reo Māori: Māori language
Awhi: Help

Negative: Providing on the spot education for clinical staff in a situation that caused frustration and annoyance.

Clinical staff wanting to understand culture:
Positive: Learning Māori culture through understanding Māori language
Negative: Unfortunately, this contextual learning was probably wrongly timed and as in this case provided limited time to provide understanding.

This left the whānau frustrated with helping the imposed learning task. The staff member was unaware of missing valuable cues and information to make a true assessment based on what was culturally important to the whānau.

Durie (2001) articulated that cultural competency is about the acquisition of knowledge to achieve better understanding of members of other cultures. Culture and language are inseparably bound but if the language of the culture is not well known then there must be at least an appreciation of the values upon which culture is based. Cultural competence is essentially another relationship that can provide additional information necessary for better health outcomes.

Excerpt from Maia te toi ora, Māori Health Transformations, Transforming psychological services for Māori: Mita (Bennett, 2018)

Against a backdrop of whānau violence and abuse, estranged from whānau and having experienced failed intimate relationships by the age of 56, Mita reluctantly sought support from the Mental Health Services after being referred by his GP.

Transformation through whakawhanaungatanga
The Western approach of maintaining a distant relationship is at odds with the Māori process of whakawhanaungatanga. This Māori process seeks to establish a sharing of personal details, to establish a personal connection crucial to ensuring positive relationships that in this case would lead to positive clinical outcomes for Māori.

Therefore, Bennett (2018) is in total agreement with the mother (McClintock, Moeke Maxwell & Mellsop, 2011) in stating the above when she said He didn’t introduce himself! no whanaungatanga! (relationship building) which is important to Māori, no telling us who he was, nothing about Te Ao Māori. And not giving us much time to say who we were. Yeah RUDE! All leading to a failed relationship.

Bennett (2018) utilised whakawhanaungatanga with Mita finding a whakapapa (genealogical) connection that was able to be built on. The knowledge they both contributed to their sessions was able to form a positive foundation for their relationship as client/therapist that progressed healing.
Affirmative Action: Cultural Fluency

Several affirmative action programmes to build clinical and cultural competency for Māori working in health have been implemented over the years. Te Rau Puawai programme, Massey University and Te Rau Matatini Māori Health Workforce Organisation are two such initiatives.

Case Study One: Te Rau Puawai

Te Rau Puawai began towards the end of 1997 through the motivation of Māori psychology personal from Massey University who brought their concerns about low numbers of Māori enrolled in Psychology to the attention of the Professor of Māori Studies. The possibility of scholarships for Māori students in health qualifications was suggested as a way forward and a goal of 100 graduates over a five-year period was set – hence the name Te Rau Puawai. By the beginning of the 1999 academic year the first scholars had been selected and by 2004, 104 Te Rau Puawai scholars had graduated (Durie, 2018).

Four key success factors were identified: an underlying sense of whānaungatanga; the development of a whānau approach; and a collective commitment to make a difference to Māori health. The fourth success factor has been the application of tikanga Māori to all aspects of Te Rau Puawai. Included in the scholarship application forms are items relevant to Māori culture and heritage and the compulsory hui (stay-overs) Māori language, whakawhanaungatanga, waiata, haka and karakia. The involvement of kaumātua (elders) at hui added a unique aspect that provided both assurance and traditional wisdom (Durie, 2018).

The factors of academic excellence, monitoring and mentoring, whānau cohesion, accountability to Māori, and tikanga Māori – are the hallmarks of Te Rau Puawai. Although the priorities for scholarships may change, those factors will need to remain key to understanding the Te Rau Puawai approach. They are expected to remain valued in the future, even if the scope of the scholarships changes (Durie, 2018).

The success of Te Rau Puawai over the past 20 years has been spectacular – as measured by the academic accomplishments of successive waves of students at undergraduate and postgraduate levels. A strong argument to retain the same focus and the same approach could be made with ample justification. But as a proven champion for Māori mental health, Te Rau Puawai might also be expected to be a leader in the promotion of mental health in those areas that will be critical for Māori in the future (Durie, 2018).

Durie and Durie (2018) states mental health as distinct from mental ill health will likely become part of the future agenda for Te Rau Puawai. How that agenda is promoted and implemented will depend on many variables including University priorities, the readiness of the major funder to extend the current portfolio into new areas, and the wider acceptance that mental wellbeing is integral to Māori social, economic, cultural, and environmental advancement.
Table 4  Results Te Rau Puawai (Maxwell-Crawford & Richardson, 2018)

<table>
<thead>
<tr>
<th>Contract</th>
<th>Year</th>
<th>Goal</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1999 – 2003</td>
<td>100 graduates by 2003</td>
<td>70 Undergraduates: cert</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>34 Postgraduates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total = 104 graduates</td>
</tr>
<tr>
<td>2</td>
<td>2004 – 2006</td>
<td>50 additional graduates by 2006</td>
<td>50 Undergraduates: 43 certs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>18 Postgraduates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total = 68 graduates</td>
</tr>
<tr>
<td>3</td>
<td>2007 – 2009</td>
<td>30 additional graduates by 2009</td>
<td>34 Undergraduates:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>20 Postgraduates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total = 54 graduates</td>
</tr>
<tr>
<td>4</td>
<td>2010 – 2012</td>
<td>30 additional graduates by 2012</td>
<td>24 Undergraduates:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>38 Postgraduates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total = 62 graduates</td>
</tr>
<tr>
<td>5</td>
<td>2013 - 2015</td>
<td>30 additional graduates by 2015</td>
<td>30 Undergraduates:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>36 Postgraduates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total = 66 graduates</td>
</tr>
<tr>
<td>6</td>
<td>2016 - 2017</td>
<td>1-year variations during Mental Health &amp;</td>
<td>18 Undergraduates:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Addictions Review</td>
<td>14 Postgraduates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total = 32 graduate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total = 386</td>
</tr>
</tbody>
</table>

Case Study Two: Te Rau Matatini Māori Health Workforce.
Vision
To improve Māori Health through leadership, education, research and evaluation, health workforce development and innovation and systemic transformation.

Mission
Strengthen Māori Health through nationally navigated and locally led solutions.

Aims
3. Be the lead agency to improve Māori Health and Indigenous Wellbeing via health workforces, strategies and systems that implement Pae Ora (Ministry of Health, 2014).
4. Strengthen health workforces to decrease Maori inequity and increase Māori wellbeing and potential.

Strategic Focus Areas
- Increased Māori Capacity and Capability
- Strategic and Sustainable Relationships
- Future Focused
- Meaningful Learning Opportunities
- Research Excellence
- Sector Leadership
- Strong Governance (Te Rau Matatini, n.d)

Te Rau Matatini prefer the concept of ‘cultural fluency’ over cultural competence, which is the ability of health professionals to operate in various spaces, places and settings. The idea of
being able to operate in differing places, with the ability to apply varying levels of knowledge in practice is more relevant to a diverse workforce and their need to be agile and adaptable according to their roles and practice with differing groups of people and in differing contexts (Te Rau Matatini, 2018).

Cultural fluency implies knowing how things are done in everyday life such that one’s conscious or non-conscious culture-based expectations typically match situations as they unfold, an almost automatic response. How to predict that a hallmark of this culture-based expectation to situation match is the experience of cultural fluency (Inoue, 2007).

Returning to the cultural experiences that were articulated earlier in this publication, the encounter with death for Māori, symbols of tangihana, black and greenery, waiting for the call to enter, respectful protocols continue to be a mark of knowing, whether operating in the traditional space of the marae (cultural and social centre) or wherever whānau can provide a private and respectful space for their tūpāpakū to be honoured and farewelled as in the case reported, in a suburban garage (K. K. McClintock, personal communication, 25 September, 2018).

The colour of black and greenery continues to signal to Māori the tikanga of an important hui, a tangihana. is underway, the traditional rituals of death are still being enacted, fluent in 2018. Those who are wanting to enter to show their sorrow know they must be invited to be with the whānau pani and tūpāpaku (K. K. McClintock, personal communication, 25 September 2018).

Once inside the sanctum of the tūpāpākū and whānau pani acknowledgements are made. There is great admiration that this unhindered process continues, the last and most treasured bastion of Māori being. The tangihana allows the flow of tears and release of pain. Once that has occurred there is the sharing of food, of humour and the laughter, automatic responses of uplifting everyone. How strange that must be to other cultures that restrict their emotions, stand without noise and don’t cry, to experience the rituals of the tangihana, the depths of grief and the roar of laughter openly shared, automatic and reciprocated almost in the same space and without offense (K. K. McClintock, personal communication, 25 September 2018).

The second example is an illustration of cultural disfluency. The genuine but failed attempt of a clinical staff member to understand the culture of a Māori whānau and Rangatahi. Firstly, Māori want to know who they are talking to and expect a time to reply. Too many questions frustrate Māori possibly influenced by a cultural view that people should learn by listening. Māori also don’t like to talk about what they are good at. The other and obvious barrier is, when language understanding is not shared then there is a challenge to the process, what is being said and frustration for the recipients.

The final example of a culturally fluent situation presented by Bennett (2018) embraces the value of whakawhanaunga of knowing who you are and the connection to the wider community. How that process affirms relationships and sets solid foundations to ensure better health outcomes.
Te Rau Matatini’s framework of cultural fluency responds to addressing Māori inequalities and includes the pedagogy of Kaupapa Māori which includes knowledge specific to a Māori worldview yet applicable to any workforce aiming to be better helpers to Māori at the frontline. What is important is the application of knowledge and the reflection of it upon practice (Te Rau Matatini, 2018).

Te Rau Matatini has a suite of cultural competency towards cultural fluency programmes which are delivered in workshops and wānanga. The cultural fluency programmes focus on addressing Māori inequalities in the mental health and addiction sector for Māori and non-Māori workforces.

Participants complete a workshop or wānanga and will receive a certificate of completion with professional development points or hours. Te Rau Matatini will work across the health sector to advance the cultural competency toward cultural fluency of health workforces, organisational systems and responses to address Māori mental health and addiction need (Te Rau Matatini, 2018).

The purpose is to:

- Formally recognise culturally competent practitioners following completion of the Te Rau Matatini cultural fluency programmes. Three of the programmes are presented below

Māori Models of Practice

He Puna Whakaata

In 2016, Te Rau Matatini with the support of Andre McLachlan released He Puna Whakaata. Since this date over 300 mental health and addictions staff across the country have received training. He Puna Whakaata refers to a reflective pool and promotes the need for practitioners to be reflexive and in balance. It is a resource integrating Māori thought and knowledge for use in the clinical context. The therapeutic activities described in He Puna Whakaata are discrete activities; each with its own focus, however, there is a logical flow between them. Activities within the resource draw heavily on principles of motivational interviewing and a Te Whare Tapa Whā framework approach to make some aspects of mātauranga Māori more accessible to whānau engaged in change.

He Puna Whakaata is positioned within Te Hau Marire Strategy 2015-2015 (Te Rau Matatini, 2015), which brought together the knowledge and experiences of Māori in the addiction treatment sector to provide guidance for the development of a competent workforce that will contribute to the minimisation of addiction-related harm and the achievement of Whānau Ora. An understanding of motivational interviewing and proficient reo Māori pronunciation are the minimum requirements to attend a workshop.

Tiaki Te Ahuru Mowai

Centring practice on Māori woman, and her whānau

The rates of Māori women taking their lives has increased by 3.5 times over the past decade, the disparity is greater for females as Māori females are more than twice as likely as non-Māori females to take their lives. Family violence in New Zealand is a serious public health issue which disproportionally has affected whānau. Traumatised women who seek help or safety maybe at greater risk of self-harm or suicide attempts. Screening of whānau and intimate partner violence occurs in health and social service settings yet there is insufficient evidence to suggest its effect on outcomes like the early detection and prevention of self-harm or suicidality or the level of harm that may arise from screening.

The potential risk is suicide may go unrecognised and mental health problems (including the effects from trauma) go untreated as methods of risk assessment and intervention at the frontline may not be that helpful to women and their whānau.

Frontline professionals and help groups do their best to assist their communities, yet most do not provide level of response needed due to differing contractual arrangements and limited resources. Thus, potentially placing help seeking women at heightened risk for emotional distress and subsequent risk of self-harm.

In 2015-16 alongside Māori women refuges, a working framework was developed by Kia Maia Ltd on behalf of Te Rau Matatini. Its intention is to promote and support joined-up practices, services and methods across agencies to be more helpful to women. In addition, to providing women a tool for self-help. The framework has been established, supported by a needs analyses of frontline workforces and the development of a training programme to support the framework. Workshops and training that was provided in October 2016 informed the development of a specific training programme to frontline workforces to centre the needs of wāhine with their tamariki and whānau in all approaches.

Te Ihi Ora Māori Suicide Prevention

Ki muri ki mua Ka whakaora ai tou haere Using the treasures of the past today, can keep you well. Te Ihi Ora is a wānanga delivered programme by Te Rau Matatini as a proactive response alongside Māori to the challenging issue of suicide.

The wānanga draws on an in-depth Te Ao Māori perspective to learning and strategy, is informed and guided by mātauranga Māori and kaumātua and kuia kōrero, to prevent suicide. The facilitation team, have experience in suicide prevention, mental health and addiction treatment with Māori.

14 http://wakahourua.co.nz/tiakina-te-ahura-mowai-w%C5%81nanga
15 http://wakahourua.co.nz/te-ihi-ora-w%C4%81nanga
Conclusion

*Tuku iho Tuku iho, Culture in Māori Health Service Provision* has provided detailed understanding of the notion of culture, cultural safety, cultural competency and cultural fluency especially central to Māori health service provision in Aotearoa. The passage of this development has been influenced by the impetus provided by legislative imperatives and addressing equities for Māori.

The experiences and research which enunciates a clarity of understanding through both a Māori voice and Māori worldview have been Interspersed within this account, supportive of the sourced literature. In addition, the support of registration boards such as the Nursing Council, Medical Council and Psychologist Board adds sector weight to this discussion. The cultural fluency examples of Te Rau Puawai and Te Rau Matatini are innovative indigenous examples that will not only resonate with Māori working in and those about to enter the health workforce but also with the indigenous global community where cultural health imperatives are of similar value.
Glossary

Aotearoa - New Zealand
Awhi – Help support
Hapū - Subtribe
Hine-nui-te-po - Goddess of Death
Hawaiki nui, Hawaiki roa, Hawaiki pamamao – To great Hawaiki, to long Hawaiki, to distant Hawaiki
Hauora Māori – Māori Health and Wellbeing
Haka – Traditional War Dance
Hākari – Feast
Hoha - Annoyed
Hua Whenua - Vegetables
Hui - Meeting
I tangi tōku ngākau – My heart wept
Iwi - Tribes
Kai - Food
Kaiako - Teachers
Kāore te kūmara e kōrero ana mō tōna ake nei reka - The kūmara doesn’t talk about its own sweetness.
Karakia – Prayer
Kaumātua - Elders
Kaupapa Māori – Māori Approach
Ki muri, ki mua, ka whakaora ai tou haere - Using the treasures of the past today, can keep you well
Kōrero - Talk
Kuia – Elderly Women
Kura - School
Māori – Indigenous New Zealanders
Manuwhiri – Guests
Mana - Status, Authority
Manaakitanga – Care
Marae - Cultural and Social centre
Mātauranga Māori - Māori knowledge
Mate - Death
Miti - Meat
Pākehā – English
Paraoa - Bread
Pōwhiri - Welcoming
Pupuri ki te Arikitanga – Hold on to aristocratic rank
Rangatahi - Youth
Ringawera – Cooks
Tama - Son
Tamariki - Children
Tangihana - Death
Te Ao Māori - Māori World
Te Ohu Rata o Aotearoa (Te ORA) - The Māori Medical Practitioners Association.
Te Reo Māori – Māori Language
Te Reo me ona Tikanga – Māori Customs
Te Tiriti o Waitangi - The Treaty of Waitangi
Tikanga - Protocols
Tuakiri - Personality
Tūpāpakū - Dead
Wāhine – Female / Women
Waiata – Song
Wairuatanga - Spirituality
Wānanga – Workshop
Whānau - Family
Whakapapa - Genealogical
Whakawhanaungatanga - Relationship Building
Whānau ora – Family Health
Whānau Pani - Bereaved Family
References


