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TE WHARE WĀNANGA O TE KURAHUNA
MAHI A ATUA
TĒNEI TE PŌ NAU MAI TE AO- TRANSFORMATION IN ACTION
Mahi a Atua:
Committed to developing indigenous systems for positive community outcomes.

Institutional Racism in Action: Privileging the Integrated Primary Mental Health and Addiction Service Model

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Be brave, be bold, be curious, and embrace the potential of Mahi a Atua and Te Kurahuna!

The pūrākau of Mataora, tells the story of an ariki (high chief) who had believed he was not accountable to anybody. However, guided by the love he had for his wife, Niwareka, Mataora became a kaitiaki for changing attitudes, beliefs and behaviour; firstly his own and then actively influencing changes in those around him. Guided by the knowledge embedded in the pūrākau of Mataora, Te Whare Wānanga o Te Kurahuna understands genuinely addressing equity for Māori requires an uniquely transformative Indigenous approach. Te Kurahuna is the kaitiaki of Mahi a Atua: a 'way of being' which privileges Indigenous knowledge and practice as the basis for addressing institutional racism, strengthening best practice, and realising equitable outcomes for Māori.[1]

Directly responding to evidence presented across multiple reports, inquiries and reviews that institutional racism must be addressed in order to realise equitable outcomes for Māori[2], alongside overtly operationalising the necessary paradigm shift to whānau ora and whānau-centred practice, Te Kurahuna and Mahi a Atua are centrally positioned to realise the systemic innovation and transformation across sectors which has long been called for. This paper, part of the *Tēnei te Po Nau Mai Te Ao - Transformation in Action Series*[3], examines how the privileging of the Integrated Primary Mental Health and Addiction Service Model exemplifies institutional racism in action.

Integrated Primary Mental Health and Addiction Model

Expanding access and choice to mental health and addiction services is the target of substantial government investment in Aotearoa. The integrated primary mental health and addiction (IPMHA) service model favoured for nationwide implementation is centred on a general practice team supplemented with a new workforce of Health Improvement Practitioners (HIPs), and Health Coaches. Originating in a context significantly different to Aotearoa, the IPMHA model is based on the North American Behavioural Health Consultant (BHC) model. With improving efficiency and effectiveness as a

central aim, the BHC model is premised upon the applicability of behavioural science in addressing commonly presenting primary care issues, for example chronic disease management, lifestyle problems, fatigue and stress, alongside what are described as 'sub-threshold' problems such as relationships, parenting, finance, and employment.[4] Integral to this model are HIPs, qualified mental health professionals who have completed specialist training in the integrated primary mental health model, and Health Coaches, who may be a registered or unregistered health practitioner.[5] In some locations, a NGO community worker is also included, providing what is described as a 'culturally responsive connection point'.[6] This new primary care health workforce is intended to maximise access to 'effective, focused, evidence-based psychological strategies' such as talk therapies and brief behavioural interventions; [7] support behavioural or lifestyle changes; promote self-management and goal achievement; and assist in navigating and connecting people to other services.[8]

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There are major concerns about the deployment of the IPMHA model in Aotearoa. Whilst described as 'unique' and able to 'effectively address mental health and wellbeing needs of populations in Aotearoa'[9] the IPMHA model, privileges a bio-medical, GP focused approach, and essentially leaves the wider system untouched. In doing so, the IPMHA model explicitly fails to recognise that widely accepted social and economic determinants of health (determinants which tend to appear under the category of 'commonly presenting issues' or 'sub-threshold' problems in the BHC model) create a level of disadvantage for Māori, even before Māori engage with the health system.[10] The IPMHA model also fails to acknowledge and address the well evidenced conclusion that inequities for Māori are structural, and are underpinned by institutional racism.[11]

Absent Evidence

... little evidence to support the effectiveness of behavioural health consultancy models for Indigenous peoples.

The IPMHA model is promoted as being a "suite of services, based on best available evidence of 'what works', that will enhance the ability of primary and community care to re-orientate towards achieving positive outcomes across health and social need",[12] with HIPs and Health Coaches constantly promoted as having high efficacy.[13] Yet such statements are made despite their being little evidence to support the effectiveness of behavioural health consultancy models for Indigenous peoples.

For example, in one paper reviewing integrative health coaching and behavioural health consultancy models, the only mention of Indigenous people is a footnote indicating a lack of research focused on Indigenous populations in Australia, the US, or Canada.[14] Likewise a review of evidence focused on the development of an integrated primary mental health care model in Aotearoa, whilst acknowledging a need for adaptations when working with Māori, makes no reference to any evidence regarding the effectiveness of IPMHA models for Indigenous peoples.[15] Another paper concludes more research is needed to understand the outcomes effected by the behavioural health primary care model for racial and ethnic minority populations.[16] Similarly, an unpublished proposal to introduce into Aotearoa an UK based model centred on a new workforce of Psychology Wellbeing Practitioners who would undertake tasks similar to that of HIPs, highlighted positive outcomes of this workforce for many people. However, despite projected effectiveness for Māori being a key element of the proposal, it was only in the footnotes

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that poor uptake by minority cultures was acknowledged, suggesting benefits for Māori were most likely heavily overstated.

Ignored Evidence

The IPMHA model ignores the extensive literature base which clearly documents the impacts of differential access and quality for Māori at all levels of health care services, including primary care services.[17] This includes the reality that not only do primary care services fail to provide the same benefits to Māori, in some cases engagement with those services actually serves to increase inequity.[18] For example, evidence presented to the Waitangi Tribunal shows, despite Māori accessing primary care at the same or higher rates as non-Māori, more Māori are diagnosed with cancer in Emergency Departments than within General Practice settings.[19] Past research also shows that although more Māori visits to GPs are graded as urgent, GPs report spending less time with Māori in consultations; order fewer follow-up investigations; recommend lower levels of follow-up visits; and make less referrals for Māori.[20]

Specifically in relation to mental health care, there is evidence that Māori present more often to general practice settings with mental health related problems, however their problems are underdiagnosed.[21] Such findings support the conclusion that although increasing enrolments and utilisation of primary care services may be a positive indicator of engagement, they alone do not sufficiently address issues underpinning inequity for Māori.[22]

Cost has been widely reported as a barrier to accessing a general practitioner.[23] Related to this, whilst the GP may be an important first contact for many people presenting with mental health symptoms, for others it will not.[24] The Initial Mental Health & Wellbeing Commission identifies the importance of ensuring non-medical approaches to supporting whānau in distress are available, emphasising for Māori, primary care often exists not in clinics but in communities.[25]

Supporting this, research has emphasised that whilst economic and geographic barriers to access are relatively easily identified and solved by PHOs, barriers originating from a disconnect between Māori models of health and wellbeing, and the disease-oriented medical model are not.[26] The Waitangi Tribunal heard substantial evidence that those who work in more preventative primary care services are likely to promote a knowledge system that perpetuates racism and contributes to worsening outcomes for Māori.[27] Primary care providers, like other health professionals, may inadvertently provide less care to those with the greatest health needs due to a lack of cultural alignment, with this lack of background or understanding inhibiting the therapeutic relationship, thus impacting the quality of care received.[28]

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Access is being equated with equity in IPMHA model. Yet as the evidence clearly shows, equity cannot be measured solely by access alone. The evidence is in no doubt that institutional racism is critical to address if health inequities for Māori are to be eliminated. Yet there is no evidence the IPMHA model has any focus on institutional racism nor the collection of data which enables equity to be fully assessed and monitored. Likewise, there is no evidence that the normalisation of inequity for Māori is being addressed. Dominant individualised deficit theory,

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language and indicators which sustain the stereotype that inequity results from individual failings as opposed to systemic structural bias, remain prevalent in the IPMHA model.

The experiences of Te Kūwatawata ki Tairāwhiti and Te Kūwatawata ki Hauraki, a Māori-resonant and responsive Single Point of Entry (SPoE) to mental health services, provides valuable information regarding how the GP and bio-medically dominated IPMHA model impacts on addressing inequity for Māori. For example, in Te Kūwatawata ki Tairāwhiti it was found the newly favoured IPMHA models would likely result in less referrals to Te Kūwatawata ki Tairāwhiti from GPs, meaning the SPoE and 'by Māori for all' approach of Te Kūwatawata ki Tairāwhiti would be lost.[30] Of major concern is the IPMHA model is becoming increasingly pervasive, to such an extent that Indigenous designed and led initiatives such as Te Kūwatawata are now being expected to fit within the parameters of the imported IPMHA model.

Whānau Ora: Platform for Transformation

... the Government Inquiry into Mental Health & Addiction was clear whānau ora was the transformative paradigm shift required to effect positive outcomes for Māori.[31]

Alongside the lack of evidence regarding effectiveness with Indigenous peoples, and ignoring evidence documenting the perpetuation of inequity by the current GP dominated primary care system, the IPMHA model also overtly ignores what is known to be effective for Māori. Underpinned by an established evidence base documenting its success, whānau ora and whānau-centred practice, the uniquely Indigenous strengths-based paradigm that recognises the wellbeing of individuals is inextricably linked to the wellbeing of the collective[32], remains the foremost call across health, welfare, social service and justice sectors.[33] In 2018 the Government Inquiry into Mental Health & Addiction was clear whānau ora was the transformative paradigm shift required to effect positive outcomes for Māori.[34]

Despite being overtly 'person-centric'[35], the IPMHA model is promoted as adaptable for Māori in that it is holistic and well integrated, with HIPs and Health Coaches expected to link with local community resources that support wellbeing, including whānau ora services.[36] In addition, the 'culturally responsive connection point' referred to earlier is emphasised; an 'Awhi Ora' NGO worker who works alongside HIPs and Health Coaches.[37] Of note is that although this role is described as a 'key part' of the model, it is not detailed alongside HIPs and Health Coaches as a core element of the IPMHA model, with it stated such a role occurs only where DHB contracts allow.[38] Other references have been made regarding it being unclear how the 'Awhi Ora' worker contributes, with potential overlaps across roles needing to be navigated, particularly in relation to access across general practice teams.[39] That the Awhi Ora role is specifically recommended as an important 'consideration' in future IPMHA roll-outs,[40] further indicates a 'culturally responsive connection point' is not actually an assumed non-negotiable component of the IPMHA model.

Although statements are made in relation to the capacity of the IPMHA model to be adapted for whānau, it is not grounded within the whānau ora paradigm. As has been well documented, whānau ora and whānau-centred practice encompasses significantly more than that of simply delivering to a group.

That models such as IPMHA have been prioritised over Indigenous led and designed paradigms such as Te Kurahuna, Mahi a Atua and Te Kūwatawata which directly target institutional racism ... is of course ironically illustrative of institutional racism ... .

It is the holistic totality of the whānau ora paradigm which makes it successful: an Indigenous worldview in which culturally anchored whānau-centred practice is prioritised; the wellbeing of individuals is inextricably linked with the wellbeing of the collective; rangatiratanga is considered as residing within whānau collectives; and whānau are viewed not only as the foundation of strength and wellbeing with potential for transformative change, they themselves are the agents of that change.[41] As has been emphasised by the Initial Mental Health & Wellbeing Commission, cultural components of a service must not be confused with an entirely culturally-grounded model.[42]

> *... whānau ora and whānau-centred providers are already well positioned to take the lead in the design, development and implementation of services for whānau in distress.*

Despite it having been emphasised for some time that the health system must create opportunities for Māori to exercise rangatiratanga and mana motuhake, particularly in terms of exercising control over systems and models of care grounded within te ao Māori,[43] the implementation of the IPMHA model has ignored the reality that whānau ora and whānau-centred providers are already well positioned to take the lead in the design, development and implementation of services for whānau in distress. A thorough understanding of the whānau ora paradigm and its strengths were a logical first step in determining how any integrated primary mental health and addictions model could effectively impact equity for Māori.

Institutional Racism in Action

Despite clear calls for systemic structural transformation and culturally-led initiatives which address inequity, and despite Te Whare Wānanga o Te Kurahuna, Mahi a Atua, and Te Kūwatawata being widely acknowledged as exemplars of the pathway needed into the future,[44] an imported model, complete with an imported training paradigm, has emerged as the favoured solution for enhancing access and choice to mental health and addiction services in Aotearoa. The Ministry of Health has itself acknowledged the need for whānau-centred services designed, developed and delivered for and by hapū, iwi and Māori communities.[45] Yet paradoxically, in proceeding to mandate what primary mental health care must look like, the Ministry of Health has maintained a somewhat standard practice of importing international programmes with limited or unknown effectiveness for Indigenous and minority peoples.[46]

The primary health care framework in Aotearoa has already been identified as institutionally racist by the Waitangi Tribunal.[47] Significant funding has been allocated to a model with no evidence it is able to successfully impact inequity for Māori. That models such as IPMHA have been prioritised over Indigenous led and designed paradigms such as Te Kurahuna, Mahi a Atua and Te Kūwatawata which directly target institutional racism as the underpinning cause of inequity for Māori, is of course ironically illustrative of institutional racism: lack of action; inappropriate action; and lack of consequence for poor outcomes.

Recognising whānau ora and whānau-centred practice lies at the centre of transformative responses, Te Kurahuna, Mahi a Atua and Te Kūwatawata, in explicitly recognising the wider determinants of health and wellbeing, intentionally seek to effect significantly wider solutions for whānau than that offered by the IPMHA model.

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