



# **SAFETY OF SUBSEQUENT CHILDREN**

**Māori children and whānau**

## **A review of selected literature**

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## Contents

Acknowledgements .....	2
List of tables .....	4
Abbreviations .....	5
Glossary .....	5
<b>Whakarāpopotanga—Executive summary .....</b>	<b>6</b>
Understanding complex problems.....	6
Mauri Ora—Cultural identity.....	6
Treaty of Waitangi .....	6
Welfare policy.....	7
Te Ōranga—Participation in society.....	7
Toiora—Healthy lifestyles .....	7
Parental problems .....	8
Challenging child characteristics.....	8
Family characteristics.....	8
Previous experiences of abuse/neglect .....	8
Te Mana Whakahaere—Service provision.....	8
Prevention and early intervention.....	8
(Re)habilitation .....	9
Kupu whakatepe—Conclusion .....	9
<b>Kupu Whakataki—Introduction.....</b>	<b>11</b>
The project brief .....	12
Māori wellness—Te Pae Mahutonga .....	12
<b>Mauri Ora—Cultural identity .....</b>	<b>13</b>
Treaty of Waitangi .....	13
The child welfare system.....	14
<i>Puao-Te-Ata-Tu</i> .....	15
Children, Young Persons, and their Families Act 1989 .....	17
<i>Te Punga</i> .....	19
The Waipareira report.....	19
Differential Response service pathway.....	19
Whānau Ora.....	20
Summary.....	20
<b>Te Ōranga—Participation in society .....</b>	<b>21</b>
Economic factors.....	21
Social factors.....	22
Community factors .....	23
Summary.....	24



<b>Toiora—Healthy lifestyles .....</b>	<b>25</b>
Parental problems .....	26
Mental health issues .....	26
Poor parenting skills.....	26
Substance abuse .....	27
Intimate partner violence.....	28
Challenging child characteristics .....	28
Family characteristics.....	29
Previous experiences of abuse/neglect .....	30
Summary .....	30
<b>Te Mana Whakahaere—Service provision .....</b>	<b>30</b>
Prevention and early intervention.....	31
Whānau support and parenting programmes .....	31
Parental relationship support .....	35
Support, counselling and rehabilitation for parents.....	36
Community development .....	37
(Re)habilitation .....	38
Grief following child removal .....	39
Rehabilitation .....	39
Where to from here? .....	40
Summary .....	40
<b>Kupu Whakatepe—Conclusion.....</b>	<b>41</b>
<b>Bibliography .....</b>	<b>45</b>
<b>Appendix .....</b>	<b>56</b>
Literature review method.....	56
Literature search .....	56
Inclusion criteria .....	57

#### **List of tables**

Table 1. Socio-economic indicators, age-standardised rates, New Zealand .....	22
Table 2. Issues identified in the delivery of the programme and Māori creative solutions .....	32
Table 3. Key principles in the benchmarking of programmes for Māori protected persons under the Domestic Violence Act 1995 .....	35
Table 4. Incorporating context, culture and historical variables into strategies for preventing child maltreatment in Māori whānau .....	44



### **Abbreviations**

CHILD	Child health indicators of life and development
CYF	Department of Child, Youth and Family Services
CYPFA	Children, Young Persons and their Families Agency
CYP Act	Children and Young Persons Act 1974
CYPF Act	Children, Young Persons, and their Families Act 1989
DSW	Department of Social Welfare
DVA	Domestic Violence Act 1995
ECD	Early childhood development
FACS	Family and community services
FASD	Foetal Alcohol Spectrum Disorder
FGC	Family group conference
NGO	Non-government organisations
MSD	Ministry of Social Development
NZEI	New Zealand Educational Institute
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
WARAG	Women Against Racism Action Group
WHO	World Health Organisation

### **Glossary**

hapū	subtribe
iwi	tribe
kaupapa Māori	by Māori, for Māori, with Māori
maatua whāngai	foster parenting
Puao-Te-Ata-Tu	day break
rangatahi	young people
tamariki	children
tāne	men
wāhine	women
whakapakari whānau	support for, and strengthening of, Māori families
whakapapa	genealogy
whānau	Māori family

## Whakarāpopotanga—Executive summary

Māori children belong to whānau, hapū and iwi and, as such, responsibility for raising children is shared beyond the bounds of their immediate family. The roles and responsibilities of these childrearing networks include the transmission of cultural mores and monitoring of child safety. Unfortunately, and for often complex reasons, not all whānau are safe places for children in their care and Māori whānau are overrepresented in the welfare system, including child-removal statistics. This paper seeks to understand the confluence of factors that place Māori whānau at risk within our society and how these whānau can be supported in their parenting aspirations, especially if they have already had a child removed by Child, Youth and Family (CYF). This paper is part of a larger project being undertaken by the Families Commission; the objectives of which are to consider what could be done to:

- assist families to overcome their complex issues so subsequent children are not at risk
- prevent subsequent children coming into families (while parents are still addressing their complex issues).

The project was initiated in March 2010 when the Minister of Social Development requested that the Families Commission undertake an “international literature review about parents who lose custody of children through a care and protection intervention who then have additional children who may be at risk ... [with particular focus on] ... what could be done with these families to prevent additional children coming into these families and being put at risk while the parents are still addressing their complex issues”.

## Understanding complex problems

A Māori wellness model has been used to understand the conditions that challenge the ability of whānau to fulfil their childrearing roles and responsibilities. Mason Durie’s *Te Pae Mahutonga* (1999a) uses the symbolism of the Southern Cross, with the constellation’s four stars representing: Mauri Ora (access to the world of Māori, cultural identity); Waiora (environmental protection); Toiora (healthy lifestyles); and Te Ōranga (participation in society). The pointer stars represent the context and resources required to achieve these outcomes: Ngā Manukura (effective leadership) and Mana Whakahaere (autonomy). This report examines Mauri Ora, Te Ōranga and Toiora as determinants of Māori whānau wellness. The Māori initiatives that support and strengthen whānau are then explored as an expression of Te Mana Whakahaere.

## Mauri Ora—Cultural identity

### Treaty of Waitangi

Article II of the Treaty of Waitangi affirms the right of Māori to cultural identity and thereby participation in the Māori world (through the protection of Māori values). This right is confirmed in the United Nations Declaration on the Rights of Indigenous Peoples. However, the denial of Māori access to the world of Māori is a root cause of the overrepresentation of whānau within the social welfare system.

## **Welfare policy**

Before the 1960s, Māori child welfare was largely seen as the responsibility of whānau. This changed with growing urbanisation and the involvement of mainstream social welfare services that had little understanding of whānau. This change was reinforced by the legislation of the time. By 1981, Māori made up 12.3 percent of all 0- to 17-year-olds but 53 percent of the 0- to 17-year-olds who were under state guardianship with mainly Pākehā foster parents. Dissatisfaction with the social welfare system's treatment of whānau led to the 1988 publication of *Puao-Te-Ata-Tu* (daybreak) by the Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, and its conclusion that: "At the heart of the issue is a profound misunderstanding or ignorance of the place of the child in Māori society and its relationship with whānau, hapū, iwi structures" (p. 7). *Puao-Te-Ata-Tu*'s first two recommendations were about tackling cultural racism and eliminating deprivation. The other recommendations that followed were about making the social welfare system more responsive to and appropriate for Māori, through true partnership.

Although the New Zealand Children, Young Persons, and their Families Act 1989 responded to *Puao-Te-Ata-Tu* by legally prescribing kinship placements for children in care, welfare budget cuts in the early 1990s shifted the financial burden for this care from the state to whānau. Since this time, structural changes to the welfare system and a rising number of notifications have seen the introduction of a 'differential response' service pathway. Notifications are now triaged; support options are available for those cases that do not enter the care and protection system.

In 2010 the Whānau Ora initiative was launched, affirming again the Treaty of Waitangi and the status of Māori as tangata whenua. The initiative aims to strengthen the support pathways for whānau, helping them to address their needs and achieve their aspirations.

## **Te Ōranga—Participation in society**

Socio-economic determinants are a key driver of whānau vulnerability and inability to participate fully in society, with poverty being a major contributing risk factor for children. Compared to European/others, Māori are more disadvantaged on a range of economic indicators and experience poorer access to, and outcomes from, universal services (eg, health, education). The poverty experienced by many whānau is often intrinsic to the communities in which they live. Twenty-four percent of Māori, compared to 7 percent of non-Māori, live in the most deprived areas of this country. This neighbourhood poverty affects access to goods and services, as well as people's sense of community. Being Māori also increases the vulnerability and risk of exclusion for whānau, possibly because Māori live different lifestyles or because of the prejudice and discrimination experienced by Māori within our society.

## **Toiora—Healthy lifestyles**

The issues faced by vulnerable whānau may intertwine, challenging their ability to parent and, in extreme cases, lead to child maltreatment that results in the removal of their child(ren). These issues include parental problems, challenging child characteristics, family characteristics and previous experiences of abuse/neglect.

## **Parental problems**

Māori are more at risk of mental health problems, substance abuse and intimate partner violence. Mental health problems and substance abuse often co-exist, and both have been linked to distressing life experiences and, like intimate partner violence, may make it difficult for people to provide a stable and nurturing childrearing environment. A fourth parental problem is a lack of parenting skills, which is often associated with unrealistic expectations of child development.

## **Challenging child characteristics**

Māori children aged from 0 to 14 years are more likely than non-Māori children to have a disability (14 percent versus 9 percent). Pre-term infants and disabled children are at increased risk for child maltreatment because parental attachment may be more difficult. In addition, the unequal distribution of social and economic resources within our society means that whānau may have fewer options for coping with, and raising, a baby or child with special needs.

## **Family characteristics**

In 2002 the World Health Organisation described the children of parents who are young, single, poor, unemployed and less well educated as being more at risk of child abuse. Parents who fit this characterisation are more likely to be Māori. These characteristics are also determinants of community social organisation that, in turn, mediates the mechanisms by which poverty affects child maltreatment.

## **Previous experiences of abuse/neglect**

Compared to non-Māori women, Māori women are more likely to have experienced childhood sexual abuse and, as a result, be more vulnerable to intimate partner violence and other violence. Childhood sexual abuse has also been found to be associated with mental health problems later in life.

## **Te Mana Whakahaere—Service provision**

Māori whānau need culturally responsive prevention and early intervention of child maltreatment, and (re)habilitation services to respond to and prevent child maltreatment and meet the needs of whānau who have had a child removed by CYF.

### **Prevention and early intervention**

Evaluations of Māori parenting programmes have focused largely on their cultural acceptability. These programmes have been found to build parents' esteem and confidence, but small sample sizes may limit the generalisability of these findings. Programmes based on international models have been adapted for Māori, both in their organisation (eg, being offered at times that Māori can attend, providing transportation) and pedagogy (eg, using Māori learning styles).

Māori-initiated programmes that teach Māori parenting practices have been found to have a positive impact on participants' parenting skills and confidence. The incorporation of Māori concepts and values into domestic violence programmes and into addictions services for Māori has also been found to benefit participants. Community development approaches to preventing child maltreatment may also be



effective at bolstering community protection mechanisms, along with providing support to whānau who have had a child(ren) removed.

The programmes and services examined tend to be delivered by Māori and:

- address the barriers to Māori engaging and participating in programmes
- include, if not be based within, indigenous cultural traditions, values and beliefs
- address issues of colonisation and racism
- set in a context in which participants are accepted and able to share with other Māori people who are in similar situations
- emphasise whakawhanaungatanga (relationship building)
- based on principles of individual and collective healing, with this requiring time and long-term support.

## **(Re)habilitation**

There is little information on the (re)habilitation needs of Māori parents who have had a child removed because of maltreatment. There is an argument that these parents should continue to receive services after their child(ren) has been removed to address the issues that led to the removal. They should also be helped to cope with the grief of this removal.

## **Kupu whakatepe—Conclusion**

Children are the future of Māori communities and the main function of whānau is the nurturance of children (Walker, 2004). The issue addressed in this paper is how to prevent child maltreatment by whānau who fail in their caregiving roles and responsibilities, and as a consequence have a child removed from their care. None of the literature canvassed dealt directly with the needs of whānau who have had a child removed from their care. Therefore, the paper approaches the issue by using Te Pae Mahutonga, a Māori model of whānau wellness, to examine factors that place whānau at risk of child maltreatment, along with ‘by Māori, for Māori’ prevention and intervention strategies. Table A sets out an agenda for intervening in Māori child maltreatment.

**Mauri Ora:** An understanding of Māori cultural values within the context of the history of this country sets the scene for dispelling any illusion that child maltreatment is acceptable. The resulting policy and community-based initiatives are about raising awareness and building connectedness.

**Te Ōranga:** Inclusion in society is promoted within a context of understanding the social, economic and political barriers to participation. The resulting strategies are about reducing these barriers, especially poverty and racism, through improving whānau access to goods and services.

**Toiora:** Removing the opportunity for child maltreatment is about firstly understanding the lived reality of vulnerable whānau and communities. Prevention initiatives focus on improving whānau and community relationships through ensuring that support and resources are available where needed.

**Te Mana Whakahaere:** The teaching of transformative practices can occur through the provision of appropriate services that develop whānau knowledge, skills and attitudes.

The reduction of child maltreatment, including opportunities for maltreatment to occur within whānau who have already had a child removed, starts from a Māori model of whānau wellness and an acknowledgement of Māori aspirations. This paper adds to the current dialogue that is occurring about Māori child maltreatment and calls for system responsiveness alongside the resourcing of Māori cultural supports and solutions.

**Table A – Summary. Incorporating context, culture and historical variables into strategies for preventing child maltreatment in Māori whānau**

	Context	Strategy	Description	Prevention examples
MAURI ORA	History Cultural values Social change	<b>Dispel the illusion</b> that child maltreatment is acceptable Change individual/community knowledge, skills, attitudes Uphold cultural models Advocate for Māori sovereignty	Increase knowledge, respect, sense of self and belonging in community Build healthy Māori and public policy Move into the future	Building connectedness Community education Decolonisation and anti-racism workshops Raise public awareness Family resource centres School-based curricula
TE ŌRANGA	Economic and social environment Political/judicial systems Geographic isolation	Change the social environment Address barriers to accessing goods and services Enhance understanding of political systems Increase harmony among services	Enhance the cultural responsiveness of institutions Support the development of Māori cultural interventions	Policies to improve Māori access to goods and services Involve Māori in all aspects of service design and delivery Invest in the capacity of Māori providers Raise the cultural competence of staff Reduce community barriers to services
TOIORA	Describe whānau and community circumstances Understand whānau and community strengths and aspirations	<b>Remove the opportunities</b> for child maltreatment Advocate for institutional support of vulnerable whānau Understand communities and build on their strengths	Enhance positive interactions Develop gathering places Create supportive environments Enhance community access to goods and services Strengthen community actions	Whānau navigators Long-term interagency support Support whānau caring for children with disabilities Parent support groups Home visitations Support nurturing and attachment
TE MANA WHAKAHAERE	Develop an understanding of what services and programmes are needed by vulnerable whānau and communities	<b>Teach transformative practices</b> based on Māori cultural knowledge, beliefs and values	Determine culturally appropriate manner to deliver information to individuals and whānau Develop personal skills Reorient social welfare services	Kaupapa Māori services Education on traditional parenting Addiction and mental health services Involve kaumātua Respite and crisis care programmes

## Kupu Whakataki—Introduction

Whānau is defined as “a multigenerational collective made up of many households that are supported and strengthened by a wider network of relation” (Taskforce on Whānau-Centred Initiatives, 2010, p. 13). The whānau values things Māori, including the Māori language and culture. However, Māori whānau are not homogeneous in their economic, social and cultural circumstances and aspirations (Smith, 1995).

Māori children develop within this broad network of familial relationships and attachments, beyond the bounds of their immediate biological family. As with Native American and Alaska Native children, familial bonds can encompass cousins, uncles, aunts and grandparents as well as important others who have effectively been ‘adopted’ into the family (Sarche & Spicer, 2008). These networks can participate in childrearing, monitor child safety and also ensure the transmission of cultural values, beliefs and stories (Baker, 2001). Pitama, Ririnui and Mikaere (2002, p. 93) describe four principles related to the care and upbringing of Māori children:

- the significance of whakapapa
- children belong to whānau, hapū and iwi
- rights and responsibilities for raising children are shared, and
- children have rights and responsibilities to their whānau.

Unfortunately, and for often complex reasons, not all whānau are seen as safe places for the children in their care (Durie, 1999b). Māori whānau are overrepresented in the welfare system, including child removal statistics. For example, Māori make up just over half (51 percent) of the notifications for 0- to 2-year-olds received by CYF (Child, Youth and Family, 2010b). Māori children are also 4.5 times more likely than non-Māori, non-Pacific children to have a finding of neglect<sup>1</sup> (Mardani, 2010).

Around the world, indigenous children are overrepresented in child welfare systems for many reasons: “systemic racism, the application of white, middle-class standards and values to [indigenous] communities, and the intergenerational fragmentation of the family and community structure resulting from past assimilation-oriented government policies with respect to [indigenous] child welfare” (Grier, 2005, p. 436). The high proportion of these children whose families live in deprivation suggests that this overrepresentation can be substantially accounted for by structural risk factors such as poor housing and poverty (Fluke, Chabot, Fallon, MacLaurin, & Blackstock, 2010). In other words, the issue of child maltreatment within indigenous families may be “more reflective of larger society than a microcosm of isolated dysfunction” (Wesley-Esquimaux & Snowball, 2010, p. 391). This analysis has informed the present project, with explanations for and solutions to Māori child maltreatment being sought at multiple levels through the use of a Māori model of whānau wellness, *Te Pae Mahutonga* (Durie, 1999a).

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<sup>1</sup> “Child neglect is a failure to provide for a child’s basic needs or to protect a child from harm or potential harm... Neglect may be physical, emotional, medical, educational or supervisory. It includes exposure to violent environments, community and societal neglect” (Mardani, 2010, p. ix).

## The project brief

In March 2010 the Minister of Social Development and Employment, Paula Bennett, requested the Families Commission undertake an “international literature review about parents who lose custody of children through a Care and Protection intervention who then have additional children who may be at risk ... [with particular focus on] ... what could be done with these families to prevent additional children coming into these families and being put at risk while the parents are still addressing their complex issues”.

The objectives of the Families Commission literature review were to consider what can be done to:

- assist families to overcome their complex issues so subsequent children are not at risk
- prevent subsequent children coming into families (while parents are still addressing their complex issues).

The present paper is a complementary review of selected literature. It explores the needs of Māori whānau, with a focus on how whānau who have had a child removed can be supported in their childrearing roles and responsibilities to develop safe environments for any further children who may come into their care. This paper seeks to understand the confluence of factors that place Māori whānau at risk within our society and how these whānau can be supported in their parenting aspirations.

## Māori wellness—Te Pae Mahutonga

This paper examines the issue of the protection of children within whānau, the nurturing of positive parenting and the support of whānau for whanaungatanga<sup>2</sup> through the lens of a holistic Māori wellness model. *Te Pae Mahutonga* (Durie, 1999a) uses the symbolism of the Southern Cross to describe the interrelatedness of elements of Māori wellness. The constellation’s four stars represent: Mauri Ora (access to te ao Māori and cultural identity); Waiora (environmental protection); Toiora (healthy lifestyles); and Te Ōranga (participation in society). The pointer stars represent the context and resources required to achieve these outcomes: Ngā Manukura (effective leadership) and Mana Whakahaere (autonomy) (Abel, Gibson, Ehau, & Tipene Leach, 2005).

Mauri Ora is about cultural identity, including access to language, cultural institutions, knowledge, practices and services (Ministry of Health, 2008). Durie (1999a, p. 2) describes cultural identity as a ‘critical prerequisite’ of Māori wellness. This paper examines Mauri Ora through an assessment of the Crown’s obligations under the Treaty of Waitangi and the expression of these obligations within the child welfare system that has been constructed within this country.

Te Ōranga is about the ways Māori participate in society. On the one hand, access to goods and services (eg, education, health), as well as having a voice in deciding how goods and services are made available, facilitates participation. A lack of access to

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<sup>2</sup> “The concept of whanaungatanga (the root word of which is whānau, meaning kin group and also to be born) is similarly crucial to Māori existence. It embodies the nature of the Māori person’s relationships to other members of their whānau, hapū and iwi; to other Māori; and to the world around them. It entails a complex web of responsibilities and obligations” (Mikaere, 2002, in Pitama et al, 2002, p. 22).

goods and services, on the other hand, can lead to marginalisation and a lack of participation (Durie, 1999a). Māori social and economic status is described below in an assessment of Te Ōranga.

Toiora is about a healthy lifestyle and the reduction of habits that place wellness at risk. Within Toiora, we examine the multiple issues that may be faced by whānau and how these issues may place whānau at risk for child maltreatment. This part of the report also touches briefly upon the role of the physical environment, or Waiora, by way of the neighbourhoods that whānau may live in. The link between whānau wellness and the land made by Pere (1984), Durie (1994, 1999b) and others is acknowledged, but exploring this was beyond the scope of the present paper.

Te Mana Whakahaere encompasses the development and delivery of solutions for whānau that uphold their cultural identity and facilitate self-sufficiency. Te Mana Whakahaere is about the devolution of power and decision-making to Māori, and the involvement of Māori at all levels of service provision (Ministry of Health, 2008). Ngā Manukura is touched upon below when the Māori providers of these services are showcased and the leading advocates for Māori solutions to child maltreatment are cited.

A holistic approach to Māori wellness, described in *Te Pae Mahutonga*, reflects the need for complex, multilayered and interconnected explanations and interventions when whānau are less than well. This paper works within the framework provided by *Te Pae Mahutonga* to understand the antecedents of child maltreatment in Māori whānau and the solutions being initiated by Māori. An important consideration in this paper is those whānau who have had a child removed and therefore need support to become a safe environment for any further children who may come into their care.<sup>3</sup>

## **Mauri Ora—Cultural identity**

The denial of Māori access to te ao Māori (the world of Māori) is a root cause of the overrepresentation of whānau within our social welfare system. This section first highlights the Treaty-affirmed right of Māori to Mauri Ora: cultural identity. The child welfare system within this country is then examined to assess whether it has upheld this right in the provision of care and protection services to whānau.

## **Treaty of Waitangi**

The 1840 Treaty of Waitangi promised that:

- the values of Māori must be respected and protected (the Article II promise)
- Māori should form part of the new society and feel as much at home in New Zealand and its institutions as other New Zealanders (the Article III promise, reinforced by the Preamble to the Treaty of Waitangi). (New Zealand Law Commission, 1999, p. 1)

Guarantees were therefore made in the Treaty of Waitangi about the right of Māori to cultural identity as well as the right to participate in society (also see Section 5, Toiora, below). Article II of the Treaty affirmed the right of Māori to be Māori and upheld Mauri Ora. The reassertion of this right has occurred throughout the past 170

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<sup>3</sup> The method for the literature search and review conducted for this paper is in the Appendices.

years. For example, Māori leaders at the 1984 Hui Taumata concluded that the denial of the right of Māori to live as Māori, and the resultant cultural and political alienation of Māori, was the primary reason for Māori health disparities (Public Health Commission, 1994).

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), endorsed by New Zealand in April 2010, confirms the right of indigenous peoples, including Māori, to their cultural identity (United Nations, 2007). Article 5 states that:

Indigenous peoples have the right to maintain and strengthen their distinct political, legal, economic, social and cultural institutions, while retaining their right to participate fully, if they so choose, in the political, economic, social and cultural life of the State.

Prior to this, in 1993, New Zealand ratified the 1989 United Nations Convention on the Rights of the Child (United Nations, 1989). Article 30 of this convention speaks to indigenous children's rights to their cultural identity:

In those states in which ethnic, religious or linguistic minorities or persons of indigenous origin exist, a child belonging to such a minority or who is indigenous shall not be denied the right, in community with other members of his or her group, to enjoy his or her own culture, to profess and practise his or her own religion, or to use his or her own language.

The right of Māori, including Māori children, to their cultural identity, and the state's responsibility to protect this right is also found in key documents that this country has acceded to. The next section examines whether this right has been reflected in this country's child welfare system.

## **The child welfare system**

The 'backstop' for the protection of children within this country is the Department of Child, Youth and Family Services (CYF). CYF employs the largest number of social workers of any organisation in New Zealand, and receives notifications (on average, 230 per day) of child abuse and neglect from a wide range of individuals and agencies, including the police (Child, Youth and Family, 2010a). The development of this institution has been shaped by government policies that reflect the wider political, social and cultural context in this country (Kane, 2001).

Prior to the 1960s, Māori child welfare was largely seen as the responsibility of the whānau and there was no forced removal of children, as occurred in Canada, Australia and the US. The movement of Māori to urban centres from the 1960s onwards brought whānau to the attention of mainstream child welfare services that did not recognise the role of the extended whānau in the care and protection of Māori children (Duncan & Worrell, 2000; Libesman, 2004).

The monocultural focus of the Adoption Act 1955, the Guardianship Act 1968 and the Children and Young Persons (CYP) Act 1974 sidelined Māori beliefs and practices. The paramountcy principle in the CYP Act 1974, for example, dictated that those involved in child maltreatment investigations must "treat the interests of the child or young person as the first and paramount consideration" (s.4). This conflicted with the Māori belief that children should never be isolated from their whānau (Pitama et al,

2002). Power was therefore transferred into the hands of professional ‘experts’ (eg, social workers, police, doctors), with families considered, at best, to be unimportant and, at worst, a hindrance to the decision-making process regarding the welfare of the child (Cockburn, 1994).

As a result of the monocultural child welfare system and law during this time, Māori were seriously disadvantaged (Connolly, 2001; Love, 2006; Mikaere, 2002):

Historically, the role of the state in the provision of care for dependent and neglected children has reflected a Eurocentric philosophy undergirding the law and welfare services in New Zealand. At no time were Māori involved in the establishment of the child welfare system, and in no way were the cultural values or social needs of Māori respected. (Duncan & Worrell, 2000, p. 289)

The work of CYF (and its previous incarnations) has been resisted and criticised by Māori for its lack of cultural responsiveness. Culturally non-responsive social work practice has been variously described as poor practice, “institutional abuse” (Gray & Cosgrove, 1985, p. 389) and even “cultural genocide” (Blackstock, Trocme, & Bennett, 2004, p. 902). It is poor practice because social workers do not have the skills, knowledge and resources to address the systemic problems (eg, poverty, disempowerment, loss of parenting practices) and the intergenerational trauma and grief faced by indigenous families in colonised countries. They therefore revert to the removal of indigenous children from families, largely motivated by a political unwillingness to address the “etiological drivers of child maltreatment” (Blackstock et al, 2004, p. 903). In this way, an intervention of last resort (ie, child removal) becomes used on a population-wide basis. The statistics for Māori child removals suggest that this may have become the case within this country. By 1981 Māori made up 12.3 percent of all 0- to 17-year-olds but 53 percent of the 0- to 17-year-olds who were under state guardianship, and they were placed mainly with Pākehā foster parents (McKay, 1981).

In their comparison of Canadian Aboriginal and non-Aboriginal families, Blackstock et al (2004) found that Aboriginal families are more likely to be investigated for child maltreatment, have their investigation substantiated, have their case kept open and have children placed in out-of-home care. Fischler (1985) says there are similar injustices within Native American populations, as a consequence of the misunderstanding by state agencies of indigenous childrearing practices. Blackstock et al (2004, p. 902) attribute this to “the misinterpretation of the conditions experienced by Aboriginal families coupled with the misapplication of EuroWestern values, social work pedagogy, and practice”.

At its heart, the source of tension between CYF and Māori is a clash of worldviews, not unlike that encountered by indigenous groups in North America and Canada. This section provides a short, recent history of government provision of social welfare to Māori in this country, beginning with a Ministerial Advisory Committee set up in 1985 in response to Māori dissatisfaction with the lack of cultural responsiveness within the child welfare system.

### ***Puao-Te-Ata-Tu***

In September 1988 the Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare tabled their report, *Puao-Te-Ata-Tu* (daybreak). In July 1985, the advisory committee, chaired by John Rangihau, was given the task of

advising the minister on the “most appropriate means to achieve the goal of an approach which would meet the needs of Māori in policy, planning and service delivery in the Department” (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988, p. 5). The advisory committee was formed in response to a number of highly publicised reports between 1982 and 1985 that highlighted the monocultural, institutionally racist nature of the department (Duncan & Worrell, 2000). Key among these was the *Report of Women Against Racism Action Group* (WARAG), which uncovered sexism and racism within the Department of Social Welfare (DSW) (Department of Social Welfare, 1985).

In their submissions to the advisory committee, Māori openly challenged the right of Pākehā to make decisions about their political and social future. The views of many Māori contained recurring messages of anger, frustration and resentment (Taki, 1996). “The most consistent call the committee heard around marae was for Māori people to be given the resources to control their own programmes” (Walker, 2004, p. 280).

In the preface to *Puao-Te-Ata-Tu*, the advisory committee identified institutional racism as the key issue facing the department, and our society: “At the heart of the issue is a profound misunderstanding or ignorance of the place of the child in Māori society and its relationship with whānau, hapū, iwi structures” (p. 7). The first two recommendations of *Puao-Te-Ata-Tu* recommended tackling cultural racism in New Zealand, and eliminating deprivation.<sup>4</sup> It was within this wider societal context that the advisory committee then made its recommendations about DSW, including recommended legislative amendments.

*Puao-Te-Ata-Tu* also set out recommendations for a more responsive and appropriate welfare system for Māori, including Recommendation 7, that the “Maatua Whāngai programme, in respect of children, return to its original focus of nurturing children within the family groups” (p. 12). The Maatua Whāngai (‘foster parenting’) programme was launched in 1983 with the objective of substituting DSW interventions in the lives of Māori children and young people with “the traditional caring networks of Māoridom (whānau, hapū, iwi)” (Department of Social Welfare, 1989, p. 2). The Maatua Whāngai pilot programmes, along with *Puao-Te-Ata-Tu*, highlighted the need for DSW to change at fundamental levels if it was to achieve “true partnership with Māoridom in the delivery of social services” (Department of Social Welfare, 1989, p. 9). This change included the development of care and protection plans for Māori children and young people based on the principle of whakapakari whānau (support for whānau); that is:

- (a) Whānau and hapū and, where applicable, iwi make decisions on services and matters affecting their members.

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<sup>4</sup> “Recommendation 1—We recommend that the following social policy objective be endorsed by the Government for the development of Social Welfare policy in New Zealand: ‘Objective: To attack all forms of cultural racism in New Zealand that result in the values and lifestyle of the dominant group being regarded as *superior* to those of other groups, especially Maori, by: (a) Providing leadership and programmes which help develop a society in which the values of all groups are of central importance to its enhancement; and (b) Incorporating the values, cultures and beliefs of the Maori people in all policies developed for the future of New Zealand.’

Recommendation 2—We recommend that the following operational objective be endorsed: ‘To attack and eliminate deprivation and alienation by: (a) Allocating an equitable share of resources. (b) Sharing power and authority over the use of resources. (c) *Ensuring legislation* which recognises social, cultural *and economic* values of all cultural groups and especially Maori people. (d) Developing strategies and initiatives which harness the potential of all of its people, and especially *Maori* people, to advance” (p. 9)



- (b) The Department's principal roles are as funder, facilitator but also 'intervener of last resort'.
- (c) There will be joint planning and negotiation of the provision of services. (Department of Social Welfare, 1989, p. 7)

## **Children, Young Persons, and their Families Act 1989**

*Puao-Te-Ata-Tu* had a major influence on the development of the Children, Young Persons, and their Families Act 1989 (CYPF Act) (Connolly, 2004; Pitama et al, 2002). "The Act represents a shift from British models of legislative authority to intervene in the lives of families to an indigenous construct of family decision-making" (Worrell, 2006, p. 546). The Act included the principles that, wherever possible:

- a child's or young person's family, whānau, hapū, iwi, and family group should participate in the making of decisions affecting that child or young person, and accordingly that, wherever possible, regard should be had to the views of that family, whānau, hapū, iwi, and family group (s.5(a))
- the relationship between a child or young person and his or her family, whānau, hapū, iwi, and family group should be maintained and strengthened (s.5(b)).

The CYPF Act therefore legally prescribed that family, whānau, hapū, iwi are primarily responsible for caring for and protecting children (s.13(b)), thereby responding to Māori dissatisfaction with Māori children in need of care and protection being placed with non-Māori caregivers.

The provision in the Act for the Family Group Conference (FGC) was a mechanism for involving whānau in decision-making about the care of their child. The FGC is a key legal mechanism for addressing child protection alongside the maintenance and strengthening of whānau (Connolly, 2004). Thus the CYPF Act marked a shift in child protection legislation from a model of 'society as parent' to society as 'kinship defenders', accompanied by the acknowledgement that economic and social factors contributed more to child abuse than parental inadequacy (Cockburn, 1994).

Empowerment practice subsequently grew within social work, and social workers were now seen as facilitators of family empowerment rather than 'expert' decision-makers (Connolly, 1999). However, Lupton (1998) noted that 'empowerment' is not a value-free term. For some social workers it may well be "inextricably linked with the wider struggle against an oppressive and 'disempowering' professional practice"; however, it is more commonly a "synonym for 'enabling' users to have their say about the services they receive" (Lupton, 1998, p. 109). It should also not be a surprise that the 'empowerment' of whānau to become more 'self-reliant' occurred at a time of reduced state expenditure on welfare services and therefore a push for less whānau reliance on state support (see below) (Duncan & Worrell, 2000; Lupton, 1998).

In 2005, the Chief Social Worker, Shannon Pakura, commented: "There has been some retreat from full Maori process in family group conferences with Maori. There are fewer such meetings held on marae, for example, and this can diminish the role and status of tribal leaders (kuia and kaumatau) in the problem-resolution process" (p. 117). Further, "Organisationally, we (the Department of Child, Youth and Family Services) made some mistakes in the process of implementing the new law and its procedural requirements" (p. 118).

Under the CYPF Act, non-kin placements were only acceptable when extended family networks had been exhausted (s.13(f)(i)). However, in Duncan and Worrell's (2000) analysis, the CYPF Act was also a cost-cutting measure, as maintaining children in care was economically unsustainable. Soon after the passing of the Act, the expenditure for care and protection services fell more than 20 percent (between 1991 and 1993). One outcome was less funding for the care of children in kin placements, leaving extended families with a financial and emotional burden that had previously been shouldered by the state. Toward the end of the 1990s half of the Māori children in care had been placed with kin, compared with only 22 percent of Pākehā children. In the funding formula used for kin and non-kin placements Māori children in care seem to be an "undeserving population" while Pākehā children in care remain "deserving" largely because Pākehā extended family structures do not live up to the expectations in the Act (Duncan & Worrell, 2000, p. 290).

The CYPF Act provided for the development of iwi social services. The notion of iwi and DSW working in partnership to provide social services to Māori whānau was central to these provisions (Bradley, 1995). Under the CYPF Act it was implied that an iwi social service would:

- provide child-centred social services primarily to their own kin, according to the ideal child welfare customs and values of their iwi
- take priority in the marketplace, or at least exist alongside cultural authorities and child and family support services, so Maori are given choice
- not have to compete against other non-iwi social services for funding to provide social services to their kin
- provide whakapapa-based services and other culturally relevant information and intervention services for non-iwi social services with whom iwi members, or Maori in general, have come to notice—to assist those agencies meet the objects and principles of the Act, and
- be able to access the expertise that other bodies possess through a joint venture or sub-contracting. (Bradley, 1995, p. 30)

The development of the policy and funding framework for iwi social services by DSW was slow (Bradley, 1995). Brown (2000) noted "the funereal progress towards the manifestation of those Maori social service organisations" (p. 79).

In 2002, Pitama et al concluded that "the specialist role of iwi social service agencies ... should be recognised and further explored. Adequate resourcing and the development of clearer relationships between iwi social services, Family Court and the Children, Young Persons and their Families Service would allow whānau and children access to culturally-appropriate services".

The CYPF Act also established the Office of the Commissioner for Children as an independent monitor of child welfare. Māori participants at a 1990 national conference called by the Office of the Commissioner for Children "recommended the appointment of a Māori Commissioner for Children to work in equal partnership with the present Commissioner and to share resources to ensure that whānau, hapū, and iwi are empowered to assume responsibility for their own children" (Ministry of Health, 1996, p. 8). This did not happen.

## ***Te Punga***

In 1994, DSW published *Te Punga*, the department's response to *Puao-Te-Ata-Tu*. Māori were sceptical about *Te Punga*. For many Māori, *Te Punga* symbolised an anchor and the probability that the canoe of Puao-te-ata-tu would not be allowed to move anywhere. According to Taki (1996), *Te Punga* brought iwi to the realisation that the Crown would not deliver on its stated commitment to partnership with iwi or DSW's endorsement of the principle of whakapakari whānau.

## **The Waipareira report**

The 1998 Waitangi Tribunal report on Te Whānau O Waipareira raised several issues for CYF to consider in relation to its service delivery to Māori (Child, Youth and Family, 2001, p. 11):

- The need to develop relationships with Māori communities that are based on the Treaty principles of utmost good faith, mutual cooperation and trust.
- The recognition of new iwi and Māori groupings in an urban environment.
- The need to work with Māori communities in a way that empowers them to develop in their own way.
- The need to resolve the 'piecemeal' approach to social policy and Māori policy.

Te Whānau O Waipareira is one of many pan-Māori organisations that were established in response to the challenges of Māori urbanisation after the 1960s. Urban Māori taura here groups, based on kaupapa whānau, evolved to support each other (Families Commission, 2010).

One year later in 1999, Te Puni Kōkiri interviewed a range of Māori and non-Māori providers delivering social services to Māori about the Children, Young Persons and their Families Agency (CYPFA). It identified the following issues:

- the need for greater support, recognition, and adequate stable funding from the agency (CYPFA) for holistic services, preventative programmes and early intervention services
- the importance of focusing time on service delivery to Māori clients rather than meeting the vastly different funding and monitoring requirements of government agencies, and
- the lack of funding from the agency for Māori provider development (training and administrative support) as well as the lack of networking opportunities that exist for Māori providers. (Te Puni Kōkiri, 2000b, p. 4)

## **Differential Response service pathway**

CYF has also developed a Differential Response service pathway in an attempt to create a less adversarial pathway for parents and families (Waldegrave & Coy, 2005) and respond to a doubling in the number of notifications in the four years to 2006. Under Differential Response, CYF can triage cases to identify those that do not need to enter the care and protection system and then assist these families to get other forms of support (Child, Youth and Family & Ministry of Social Development, 2006). Differential Response therefore allows for more response options that connect with

whānau as early as possible, while enabling CYF to work more closely with other agencies and organisations (Connolly, 2009). This should allow more connectivity between CYF and Whānau Ora providers (see below) as part of CYF's commitment to a *Partnered Response*.

Family and Community Services (FACS), established within the Ministry of Social Development (MSD) in 2004, also helps coordinate government and community activities. FACS focuses on “the delivery of early intervention and prevention services and programmes for families, and activities that strengthen the people and organisations working in communities that support them” (Ministry of Social Development, 2011b). The work of FACS is guided by ngā kaupapa o moemoea (a dream for families). This is compatible with strengths-based, kaupapa Māori approaches to working with whānau. As a funder, FACS contributes to the work many Māori providers undertake with vulnerable whānau. FACS also promotes the community response model, which recognises local knowledge and supports the development of local solutions (Ministry of Social Development, 2011a).

## Whānau Ora

MSD, the Ministry of Health and Te Puni Kōkiri are participating in the Whānau Ora initiative, which was launched in 2010 following the report of the Taskforce on Whānau-Centred Initiatives (2010). The taskforce report (2010, p. 6) states clearly that:

Te Tiriti o Waitangi, the Treaty of Waitangi, remains a key instrument to guide national development. It affirms the unique status of Māori as tangata whenua, the indigenous population, while simultaneously conferring, through Government, the rights of citizenship upon all New Zealanders.

Many Māori providers and community practitioners regard “...a Whānau Ora approach as one that [is] driven by the aspirations, needs and realities of whānau as a whole” (Taskforce on Whānau-Centred Initiatives, 2010, p. 30). Within a Whānau Ora approach, both the wellbeing of individual whānau members and the wellbeing of the whānau as a whole are considered and balanced in a way that promotes their co-existence. Thus, the initiative emphasises the importance of the relational self for Māori whereby aspirations and values (to name but a few aspects) exist within the context of whānau and whanaungatanga (that is, family and familial networks) (Hart, 2007).

## Summary

The negative experience of Māori within the social welfare system has not gone unrecognised over the past 40 or more years. The watershed of *Puao-Te-Ata-Tu* was prompted by Māori concerns as well as evidence from research by social welfare staff, so people within and outside of the system have always had the courage to speak out about the system's lack of responsiveness to Māori. As well as recommending changes within the welfare system, *Puao-Te-Ata-Tu* recommended that action be taken within society to tackle cultural racism and to eliminate deprivation.

Evidence presented in the next section, Te Ōranga, strongly suggests that little progress has been made regarding these recommendations, although both were seen as drivers of Māori marginalisation. Therefore, the mis-fit between social welfare services and Māori has been long recognised, along with the structural solutions that need to be actioned in order for real change to occur.

Some developments have occurred within the welfare system, to increase its responsiveness to Māori. In addition, the Whānau Ora initiative will enable Māori and iwi providers of social services to articulate further a model of practice that embraces and reflects mauri ora. This will undoubtedly provide opportunities for the social welfare system to learn from these innovations.

## **Te Ōranga—Participation in society**

The risk of child maltreatment increases when children and their families face economic disadvantage (poverty, unemployment, poor housing), social disadvantage (racism, discrimination) and community disadvantage (socially excluded, disadvantaged, dangerous), which marginalises them from full participation in society. This section examines how Māori whānau are affected and thus placed at heightened risk. This disadvantage is symptomatic of the unequal distribution of goods and services within our society, whereby Māori experience inequities in both access to, and outcomes from, what are purported to be universal services (eg, healthcare system, education system).

### **Economic factors**

On almost all economic indicators, Māori (and Pacific peoples) are more disadvantaged than European/others (Ministry of Health, 2007b) (see Table 1). The Taskforce on Whānau-Centred Initiatives (2010, p. 15) describes socio-economic determinants as a key driver of whānau vulnerability, both in and of themselves and also because “in response to socio-economic hardship, a range of problems are likely to co-exist within the same household”.

Internationally, indigenous people are more likely than non-indigenous people to live in poverty (Sarche & Spicer, 2008, p. 126). In this country, Māori and Pasifika children experience significantly higher poverty rates than Pākehā children (Fletcher & Dwyer, 2008). Evidence that the risk of poverty increases in sole-parent households and households without paid employment indicates that welfare benefits and assistance (eg, Working for Families) are not an adequate safety net against poverty for many children (Fletcher & Dwyer, 2008; St John & Wynd, 2008).

**Table 1. Socio-economic indicators, age-standardised rates, New Zealand**

Indicator	Males	Females	Total	Ethnicity			
				Māori	Pacific	Asian	European / Other
NCEA Level 2 Certificate gained at school or higher, 15+ years, percent, 2006	62.8 (62.5–63.0)	62.2 (61.9–62.4)	62.5 (62.1–62.6)	42.2 (42.0–42.4)	47.6 (47.2–48.0)	80.6 (80.1–80.9)	64.4 (64.1–64.6)
Unemployment, 15+ years, percent, 2006	3.7 (3.7–3.7)	4.2 (4.2–4.3)	4.0 (4.0–4.0)	6.9 (6.8–7.0)	6.0 (5.9–6.1)	4.8 (4.7–4.8)	3.0 (3.0–3.1)
Low income, 15+ years, percent, 2006	18.8 (18.7–18.9)	28.6 (28.5–28.7)	23.8 (23.7–23.9)	24.2 (24.0–24.4)	30.4 (30.1–30.7)	43.0 (42.7–43.3)	21.2 (21.0–21.2)
No access to a telephone/cellphone, 15+ years, percent, 2006	2.0 (2.0–2.1)	1.6 (1.6–1.7)	1.8 (1.8–1.8)	5.4 (5.3–5.5)	4.4 (4.3–4.5)	1.3 (1.2–1.3)	1.1 (1.1–1.1)
No access to a motor vehicle, 15+ years, percent, 2006	4.3 (4.2–4.3)	5.9 (5.9–6.0)	5.2 (5.1–5.2)	9.7 (9.6–9.8)	8.8 (8.7–9.0)	5.6 (5.5–5.7)	4.1 (4.1–4.2)
Not living in own home, 15+ years, percent, 2006	52.9 (52.6–53.1)	51.5 (51.1–51.6)	52.2 (51.9–52.3)	66.7 (66.3–67.0)	75.5 (75.0–75.9)	62.0 (61.6–62.3)	48.1 (47.8–48.2)
Household crowding, all ages, percent, 2001*	9.3 (9.3–9.4)	9.9 (9.8–9.9)	9.6 (9.6–9.7)	19.1 (19.0–19.2)	38.3 (38.0–38.5)	18.7 (18.5–18.9)	4.2 (4.2–4.2)

\* Household crowding data are not available for 2006.

Source: Ministry of Health (2007b, p. 15)

Family poverty is the major contributing risk factor for children (Miller, 2009). Children’s social exclusion, in particular, has “deep emotional costs” (Egan-Bitrán, 2010, p. 28). Poverty can also take its toll on children before birth through poor foetal nutrition and consequent poor foetal development (Ferguson, et al, 2006). The New Zealand Children’s Commissioner (Children’s Commissioner, 2008, p. 11) noted that poverty increases the risk of “illness and injury; child physical abuse and neglect; impaired cognitive development; poorer adult health; lower future earnings; and the next generation being poor”. Poverty prevents children and their whānau from participating fully in society (NZEI Te Rui Roa, 2011) and the Māori world and, as such, is a breach of this country’s responsibilities under the UN Convention on the Rights of the Child.

## Social factors

Being Māori also increases the vulnerability and risk of exclusion for whānau, possibly because Māori live different lifestyles or because Māori experience prejudice and discrimination from society (Taskforce on Whānau-Centred Initiatives, 2010). The latter explanation is favoured by Māori health researchers and advocates (Reid & Cram, 2004; Reid & Robson, 2007). In this country, racism is recognised as a determinant of health and wellness (Robson, Cormack, & Cram, 2007). Māori are more likely to report being victims of ethnically motivated physical attacks and being treated unfairly because of their ethnicity (Harris et al, 2006). Racism has also been a common thread in the criticisms Māori and others have levelled at the social welfare system of this country.

A review of US research “revealed the extent of racially disparate treatment in child welfare ... [whereby] race [is] one of the primary determinants of decisions of child protective services at the stages of reporting, investigation, substantiation, placement, and exit from care” (Hill, 2006, p. 1). These disparities signal the unequal treatment experienced by children of colour and their families. Public child welfare administrators in the US identified a reluctance to address institutional and structural racism as one of several challenges to meaningfully addressing racial disproportionality.<sup>5</sup> Other challenges included a lack of cultural relevancy of agencies and service providers, a lack of ethnic/racial diversity among child welfare service staff and a lack of cultural competency among white staff (Miller, 2009).

As a counter to racism, whānau inclusion within society can be measured by Māori participation in education (eg, early childhood education, tertiary education), the non-government organisations (NGO) sector (eg, as social service and health providers), in business and in governance (eg, on the boards of public and private organisations). By these indicators whānau inclusion has greatly increased during the past two to three decades. However, “full participation in society and the economy eludes many whānau” (Taskforce on Whānau-Centred Initiatives, 2010, p. 16).

## Community factors

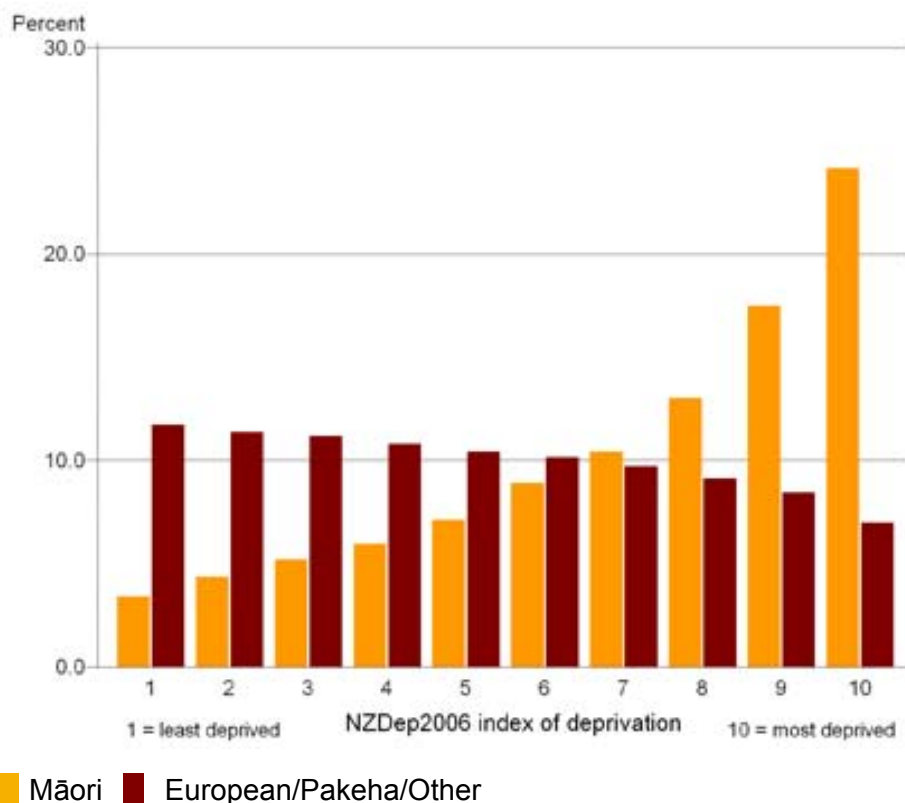
The poverty experienced by some whānau is an intrinsic part of the communities in which they live. NZDep06, a small-area deprivation index based on nine socio-economic variables from the 2006 Census, documents the segregation of whānau within communities that are described as ‘most deprived’ (Figure 1). As noted by Robson et al (2007, p. 26), “there is a significant disparity in the distribution of deprivation in Aotearoa/New Zealand. The proportion of Māori living in very deprived areas is significantly higher ... than for non-Māori, with over half of the Māori population represented in the most-deprived deciles”. In 2006, 24 percent of Māori, compared with 7 percent of non-Māori, lived in decile 10 (most deprived) areas; 3 percent of Māori, compared with 12 percent of non-Māori, lived in decile 1 (least deprived) areas (Ministry of Health, 2010).

This segregation affects their access to goods and services, including transportation and schooling, as well as employment opportunities. Those living in areas of high deprivation and in low-income households are also more at risk of experiencing a mental disorder during their lifetime (Berlyn & Bromfield, 2010). And the rate of identified child neglect is highest for Māori 0- to 4-year-olds living in the most deprived neighbourhoods (Mardani, 2010). Excessive involvement of child welfare services in these deprived communities potentially damages people’s sense of community identity as they may have, or know of others, who have been investigated and possibly had children removed (cf. Hill, 2006).

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<sup>5</sup> “Disproportionality refers to the differences in the percentage of children in a certain racial or ethnic group in the country as compared to the percentage of the children of the same group in the child welfare system” (Hill, 2006, p. 3).

**Figure 1. Deprivation distribution, Māori and European/Pakeha and ‘other’ ethnic groups\*, 2006**



\* 'other ethnic groups' excludes Pacific and Asian ethnic groups

Table created from data sourced from White, et al, 2008

From his review of research on minority disproportionality in the US, Hill (2006, p. 25) suggests “that overrepresentation [of children of colour within the child welfare system] has less to do with the race or ethnicity of the residents [of deprived neighbourhoods] and more to do with the disadvantaged characteristics of the communities in which they reside”. For example, neighbourhoods in Chicago that are now occupied by blacks were occupied by European immigrants 100 years ago and had similarly high rates of child maltreatment then (Testa & Furstenberg, 2002, in Hill, 2006). Hill (2006) describes this issue as the poverty of the neighbourhoods rather than the ethnicity or race of the people who reside there. He states, “Those who desire to reduce racial disparities in child welfare services ... might pay more attention to how the structure and functioning of communities affect child welfare decisions” (Hill, 2006, p. 27).

## Summary

Access to the resources of a society is key to the participation of people within that society. In New Zealand the economic and social disparities experienced by many Māori whānau is a risk factor for social exclusion. Social exclusion, in turn, is both a cause and an outcome of poverty. The reason this sounds like a merry-go-round is



because effectively it is, and macro-level interventions are needed to interrupt its cycle; for example, taxation, welfare, housing, education, labour market and economic management policies (Fletcher & Dwyer, 2008). Such macro-level interventions need to address the misdistribution of goods and services within this society.

## Toiora—Healthy lifestyles

Toiora is the healthy lifestyles outcome in Te Pae Mahutonga (Māori wellness model). Toiora includes the fostering of healthy child development as well as the development of mental health. While some lifestyle factors can be major risks for child maltreatment it is widely acknowledged that these factors are so closely intertwined with deculturalisation and poverty that macro solutions are equally, if not more, important than micro, individually targeted interventions (National Screening Unit, 2004).

This section looks at the lifestyle issues faced by many vulnerable whānau that prevent them from achieving Toiora. These include (Higgins, 2010, p. 3):

- parental problems (mental health, substance abuse, poor parenting skills or family/domestic violence)
- challenging child characteristics (low birth weight, disability or other special needs)
- family characteristics (poor relationships, large number of children, single parenthood or early parenthood), and
- previous experiences of abuse/neglect (of either parents or children).<sup>6</sup>

For example, compared to white families, the caregivers in American Indian and Alaskan Native American families where children were removed by welfare services had greater drug, alcohol and mental health problems (Carter, 2010). Asian and Pacific Islander families in Washington State who were referred to child protective services were more likely to be experiencing higher levels of social and economic stress (Pelczarski & Kemp, 2006). Compared to non-Aboriginal families, Aboriginal families in Canada investigated for child maltreatment had worse socio-economic conditions and reported higher rates of substance abuse (Blackstock et al, 2004).

These risk factors are not separate things that may or may not culminate in child maltreatment; rather, they are intertwined and associated factors that often fall into place along a chain of causality. For example, parenting skills are undermined by substance abuse and mental health problems. Substance abuse has been linked to experiences of childhood sexual abuse that have, in turn, been linked to social welfare policies that were not responsive to indigenous cultural practices and often resulted in the loss of children from indigenous families and communities. This interweaving of ‘risk factors’ within and across the levels explored in this paper is also acknowledged in other indigenous communities and can lead to “hurtful parenting practices and insensitivity to children’s needs by some ... parents” (Dionne, Davis, Sheeber, & Madrigal, 2009, p. 912).

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<sup>6</sup> Measurement of family risk for child abuse includes these areas; for example, the measure used by Duggan et al (1999, p. 67) included: “parents not married; unemployed partner; inadequate income; unstable housing; lack of telephone; less than high school education; inadequate emergency contacts; marital or family problems; history of abortions; abortion unsuccessfully sought or attempted; adoption sought; history of substance abuse; history of psychiatric care; history of depression; and inadequate prenatal care”.

In this section, some of these risks to whānau are examined, and particular attention is paid to describing the nature of the risk to the safety and wellbeing of children within whānau. However, we acknowledge that there is no comprehensive epidemiological study of Māori child maltreatment, so the picture being painted here is piecemeal, at best.

## Parental problems

Many of the personal risk factors for child maltreatment explored below are well established within non-indigenous populations. This section specifically examines the evidence for a relationship between them and child maltreatment within Māori and other indigenous populations. The incidence of these risk factors for Māori is also reported where these data are available.

## Mental health issues

The 2006/07 New Zealand Health Survey found that “Māori adults were nearly twice as likely as non-Māori adults to report they had a high or very high probability of anxiety or depressive disorder” (11.2 percent versus 6 percent) (Ministry of Health, 2010, p. 46). Baxter (2007, p. 121) summarises mental health statistics for Māori, including:

- Just over half of Māori had experienced a mental disorder during their lifetime.
- The most common lifetime disorders for Māori were anxiety (31.3 percent), substance (26.5 percent) and mood (24.3 percent) disorders.
- Mental disorders for Māori were more common in those aged 16 to 24 and 25 to 45 years, those living in low-income households and those living in areas of high deprivation.

Mental health issues are linked to child maltreatment and other complex risk factors. Depression, for example, is linked to substance abuse, lack of social support, low socio-economic status, domestic violence, being married and being female. Maternal depression has been linked to child maltreatment (Ta, Juon, Gielen, Steinwachs, McFarlane, & Duggan, 2009). Mental health issues have also been found to be more prevalent in indigenous women who were abused as children (Duran et al, 2004).

An Hawaiian longitudinal study revealed that, among mothers considered to be at risk for child maltreatment, Asian and Native Hawaiian/other Pacific Islander women were significantly more likely to suffer from depressive symptoms than white women (Ta et al, 2009).

## Poor parenting skills

The importance of parenting outcomes is two-fold: first, parenting plays a special role in the intergenerational transmission of health and health risks at the biological, psychological and environmental levels ... and, second, parenting plays a role in the intergenerational transmission of childhood abuse. (Libby, Orton, Beals, Buchwald, & Manson, 2008, p. 196)

Rokx (1998, p. 1) writes that while Māori parents desire the best for their children, a “lack of knowledge and understanding of Māori child development, and shortcomings in effective parenting methods which maintain and are based on Māori values and ideals, prevent the positive progression of many Māori whānau”.<sup>7</sup>

There is a multitude of reasons for why Māori parents have found themselves in this situation. Generally, parents who maltreat their children may have unrealistic expectations about child development, be less affectionate, responsive and playful, and be controlling (World Health Organisation, 2002). In noting the link between maternal depression and child maltreatment (also see above), Ta and colleagues (2009, p. 43) explain that “depressed mothers are more likely to be hostile, irritable, and coercive towards their children, and, therefore, have negative parent-child relationships”.

Parenting skills for Māori parents have been identified as a priority in consultations about child abuse (Ministry of Health, 1996).

## **Substance abuse**

The abuse of alcohol and other substances is important as “Relationships with family and whānau are often troubled because the relationship with alcohol and other drugs becomes more important than intimate relationships” (Kina Families and Addictions Trust, 2005, p. 4). The findings of the 2007/08 New Zealand Alcohol and Drug Use Survey were that (Ministry of Health, 2010, p. 21):

- Māori and non-Māori adults were equally as likely to have consumed alcohol in the past year (86.1 percent versus 85.2 percent).
- Māori adults were less likely to have consumed alcohol on a daily basis (3.9 percent versus 7.1 percent).
- Of those who had drunk in the past year, Māori were more than twice as likely as non-Māori to have consumed a large amount of alcohol at least weekly.
- Māori adults were more than twice as likely as non-Māori adults to have consumed cannabis in the past year (27.9 percent versus 12.9 percent).

Women with substance abuse issues “may have challenging life circumstances, including severe economic and social problems ... and may have difficulties providing stable, nurturing environments for their children” (Kelley, 1998, cited in Niccols, Dell, & Clarke, 2010, p. 324).

Binge drinking has been linked to childhood sexual abuse among Kanak women aged 18 to 54 years in New Caledonia. This independent association was evident among a sample of 441 women, when social and demographic factors were controlled (Hamelin et al, 2009). This should not be surprising, as “substance abuse has been identified as a means for women to cope with distressing situations in their lives, including emotional pain, distress, violence and trauma” (Niccols, Dell et al, 2010, p. 322).

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<sup>7</sup> Rokx’s comment is also pertinent with respect to interventions and solutions: they must be founded upon a belief that Māori parents want the best for their families and children (rather than some deficit-based notion that Māori parents are fundamentally deficient, bad people who deliberately harm their children).

Parents with substance abuse problems may not parent poorly, but their substance abuse places them at risk for parenting problems (Mayes & Truman, 2002). Although drinking behaviour can have a deleterious impact on parenting, Fischler (1985, p. 101) maintains that “even if parental drinking behaviour cannot be modified, the adverse effects upon children can be mitigated”. This might include, for example, school holiday residential programmes for children that offer children nurturing while giving parents respite from childrearing.

In writing about programmes to support Aboriginal women with substance abuse problems Niccols, Dell et al (2010, p. 326) state that:

Within an Aboriginal worldview, substance abuse is understood within a framework of mental health ... conceptualised as the wellbeing of individuals and their communities, in which understanding an individual apart from her community is not possible. An individual’s wellbeing is understood to be inter-reliant with the wellbeing of the collective (children, family, community, land) and its relation to self identity.

This approach to understanding substance abuse and approaches to supporting the recovery of Aboriginal women is compatible with Māori approaches to health and wellbeing, such as those expressed in the current Whānau Ora initiative (see below). This is also stressed by calls for Māori cultural factors, including the role of whānau, hapū and iwi, to be included in alcohol treatment services for Māori (Ebbett & Clarke, 2010).

### **Intimate partner violence**

Violence in the home is strongly related to child abuse across a wide range of countries and differing cultural environments (World Health Organisation, 2002). In the 2004–06 period, Māori adults were more likely than non-Māori adults to be hospitalised (218.8 versus 61 per 100,000), and to die as a result of intimate partner violence (4.3 versus 1 per 100,000). Māori children are also more likely to be exposed to domestic violence (Ministry of Health, 2010).

In the US, American Indian and Alaskan Native American women are more at risk of intimate partner violence than women from other ethnic groups (Jones, 2008). Research in the US has emphasised the role of alcohol and drugs in intimate partner violence (Jones, 2008); however, this has been disputed as an oversimplification that diverts attention away from issues of subjugation and colonisation (Duran, Duran, Woodis, & Woodis, 2008). Jones (2008, p. 114) writes that:

The reasons for the disproportional occurrence of DV in the Indian community are historical (the legacy of colonialism, subjugation, oppression, and subsequent trauma) and current (high poverty rates, encounters with racism, high rates of abuse of alcohol and drugs, and isolation particularly in rural areas.

### **Challenging child characteristics**

The presence of babies and children with special needs may be part of the mix of childcare challenges for whānau. Special needs may be due to, for example, babies being pre-term, having Foetal Alcohol Spectrum Disorder (FASD) or children having disabilities.

The prevalence of low-birthweight babies is only slightly higher for Māori than for non-Māori (7.18 versus 60.9 per 1,000 live births) (Ministry of Health, 2010). Low birthweight has been associated with unintended pregnancies (World Health Organisation, 2002) and also alcohol consumption during pregnancy (A. Chudley, 2010, personal communication).

Māori children aged 0–14 years are more likely than non-Māori children to have a disability (14 percent versus 9 percent). “The most common disability type experienced by Māori children was special education needs and chronic conditions” (Ministry of Health, 2010, p. 27). The unequal distribution of social and economic resources within our society means that whānau may have fewer options for coping with and raising a baby or child who has special needs (Taskforce on Whānau-Centred Initiatives, 2010). Pre-term infants and disabled children are also at increased risk for child maltreatment because parental attachment may be more difficult (World Health Organisation, 2002).

The term ‘FASD’ covers a range of disorders caused by women drinking alcohol during pregnancy. In Canada the overrepresentation of Aboriginal children in the child welfare system is even greater for children with FASD. The characteristics of the disorder include intellectual and developmental delay, and often behavioural and cognitive difficulties. FASD also brings with it financial costs for the families of these children, as well as the social, health and educational systems that support them (Fuchs, Burnside, Murchenski, & Mudry, 2010). In addition to alcohol during pregnancy, socio-economic status, stress, age of mother (over 30 years) and parity are also contributing factors for FASD (Stuart, 2009). However, Stuart (2009, p. 42) also notes “that many mothers of children with FASD have few or none of these interacting factors”.

The concern in Aotearoa New Zealand is the links between alcohol abuse, FASD and child removal. There are currently no data on the prevalence of FASD in New Zealand (Stuart, 2009). The Ministry of Health 2004 Health Behaviour Survey found that 82.4 percent of pregnant Māori women reported they had stopped drinking (Ministry of Health, 2007a).

## **Family characteristics**

As well as being poor, unemployed and less well educated (see above), “physically abusive parents are more likely to be young [and] single” (World Health Organisation, 2002, p. 67). For Māori, the proportion of children in single-parent households may mean that the responsibility of raising children is falling disproportionately to Māori women who may not have extended whānau support. However, rather than looking at these as individual risk factors, Hill (2006, p. 26) considers them to be determinants of community social organisation. This includes the “concentration of female-headed households, excessive numbers of children per adult residents, household and age-structure, population turnover, and geographic proximity to other poverty areas”. Community social organisation mediates the mechanisms through which family characteristics are associated with child maltreatment.

## Previous experiences of abuse/neglect

In American Indian communities, children who were removed during intensive colonisation and assimilation and placed in boarding schools and non-indigenous foster or adoptive homes often experienced poor parenting or, at its worst, maltreatment at the hands of their caregivers (Fischler, 1985). This created what Fischler (1985, p. 100) describes as “a generation of unparented parents”. The trauma of being separated from their birth family in early childhood, the stress of being raised by a non-indigenous family or in an institution and the abuse that many of these removed or ‘stolen’ indigenous children experienced has had a profound, but perhaps not surprising, impact upon their adult lives. “Individuals exposed to chronic trauma in early childhood experience in adulthood higher rates of mental illness and substance abuse problems, and lower levels of social, emotional and cognitive functioning” (Morgan, 2010, p. 57).

Māori women are more likely than non-Māori women to report an experience of childhood sexual abuse. Women who have experienced child sexual abuse were also found to be more vulnerable as adults to intimate partner violence and other violence (Fanslow, Robinson, Crengle, & Perese, 2007). Childhood sexual abuse has also been found to be associated with mental health problems later in life (Fergusson, Horwood, & Woodward, 2000).

## Summary

Risk factors for child maltreatment include characteristics of parents, children and families. These can be linked in multiple and varied ways. For example, poor parenting skills can be because parents were not well parented themselves. Parents may have experienced childhood maltreatment with this, in turn, linked to adult mental health problems. Family characteristics may lock families into cycles of poverty and segregation in communities that experience the excessive vigilance of child welfare services, which break down personal and community identity.

This section does not insinuate that all whānau who find themselves in difficult circumstances, or experience mental health issues or the challenges of raising a child with disabilities, are potential or actual child abusers. Rather, this section has examined how Māori are more likely to experience complex circumstances which make them more vulnerable, as these circumstances add to socio-economic deprivation and societal racism. It should not be surprising that this layering of societal context, socio-economic disadvantage and difficult personal circumstances might undermine good parenting.

## Te Mana Whakahaere—Service provision

Culturally responsive prevention and early intervention, and (re)habilitation services are needed for Māori whānau to prevent and respond to child maltreatment, and to respond to the needs of whānau when they have had a child removed by a CYF social service provider. This section looks primarily at Kaupapa Māori (by Māori, for Māori) service provision as an expression of Te Mana Whakahaere.

In 2007, more than 114 Māori, representing iwi health and social service organisations, NGOs and government agencies attended the Māori Child Abuse Summit. Key messages from this summit included (Kawerongo, 2007, p. 2):

- It's time for [Māori] to take responsibility and heal.
- Only we can solve the problem and research shows how successful by Māori for Māori approaches are. We have highly qualified experts in all the areas that contribute to child safety.
- Solutions must be inclusive—of wāhine, tāne, tamariki and rangatahi.

Following the summit, the group Te Kahui Mana Ririki was formed to promote the wellbeing of Māori children. Te Kahui Mana Ririki's strategy—responding to the disproportionate and unacceptably high Māori child abuse rates—incorporates the principles of self-determination, the centrality of tradition, Māori strengths, networks and collaborations, whanaungatanga and education and communication (Kaa, 2009). The summit called for Māori cultural solutions to child abuse (Kawerongo, 2007, p. 2).

Kaupapa Māori services and programmes align with this strategy and also with international calls for “culturally appropriate interventions and prevention models” (Fuchs et al, 2010, p. 242), and the legitimisation of “Aboriginal systems of care” (Blackstock et al, 2004, p. 905), “within an honest, relevant, and respectful historical and cultural context” (Dionne et al, 2009, p. 912). Kaupapa Māori programmes (and programmes that have been adapted to a Māori kaupapa) have highlighted what programme ‘success’ means from a Māori perspective. These outcomes include being Māori, using Māori kawa (protocols), using the Māori language, using marae and being creative and innovative (Cargo, 2008).

## **Prevention and early intervention**

There are interventions targeted at caregivers and whānau that help them address risk factors within their domestic arrangements that may have contributed to a child(ren) being removed and/or may place another child(ren) at risk. Four prevention and early intervention areas are explored here: parenting programmes; relationship support; counselling; and the promotion of community development solutions. The first three fall under Higgins' (2010, p. 4) prevention and early intervention category of “intensive family support and parenting programmes”.

### **Whānau support and parenting programmes**

Parenting programmes “generally educate parents on child development and help them improve their skills in managing their child's behaviour” (World Health Organisation, 2002, p. 70). The desired outcome of parenting programmes is often increased child management skills, to reduce the family risk factors for child behaviour problems, along with a reduction of child maltreatment (Herbert, 2001). The New Zealand Government contributed more than \$30 million to parenting programmes in the 2003/04 financial year; these programmes reached more than 14,000 families (Families Commission, 2005). The programmes were diverse and, as part of other support structures (eg, accommodation and income needs), they can make a difference (Families Commission, 2005).

Many of the Kaupapa Māori (by Māori, for Māori) programmes and services that are funded by CYF were included in the 2005 review of targeted programmes. This review endorsed most of these programmes and services as successful (Child, Youth and Family, 2005). The evaluations of these programmes and other programmes adapted for Māori have focused largely on their cultural acceptability. Outcomes from these programmes have included improvements in parents' esteem and confidence. Small sample sizes often mean that generalisable conclusions cannot be made from the evaluations. However, this also reflects the need for programmes to be sourced from, and reflect, local community issues and aspirations that, in the long run, may be more important than generalisability.<sup>8</sup> The impact of these programmes on the reduction of child maltreatment has not been examined in a systematic way. Given that parenting is just one risk factor, it may be misleading to expect that parenting programmes alone can have this impact. Herbert (2001), for example, describes the situation where parents have appropriate parenting skills but are unable to implement them because of their environment. Parenting programmes may, however, help reduce the risk of child maltreatment. This section looks at some of the parenting programmes that have been tailored for, or specifically developed for, Māori.

Cargo (2008) looked at the delivery of the mainstream Incredible Years parenting programme to Māori. From her discussion with the Māori programme facilitators she developed a list of the issues they encountered, and how these were mediated. The barriers for Māori, and how the facilitators responded to them, are replicated in Table 2 below. These barriers are similar to those found in other parenting programmes (Herbert, 2001) and in health services (Jansen, Bacal, & Crengle, 2008), but the organisational (eg, timing of the course) and pedagogical (eg, learning styles) solutions reflect Kaupapa Māori principles (Smith, 1997).

**Table 2. Issues identified in the delivery of the programme and Māori creative solutions**

Issue	Creative solution
Retention	Keep to Māori kawa (protocols) Set up a tuakana-teina (mentoring) system of support Provide regular out-of-session contact and support
Timing	Consider alternatives to daytime when whānau may have other commitments Maybe look at wānanga (conference) style learning over weekends or evenings, with catch-up sessions for whānau who miss a session (so they don't feel whakamaa [reticent]) Look at ways to ensure whānau get the basics if they have to leave early
Support to attend	Provide transportation or funding for petrol Allow support people to attend with whānau
Ability	Keep it creative and know about Māori learning styles
Homework and role plays	Change the wording to home activities and practice as these are more acceptable to Māori Follow up on the phone rather than waiting until the next session

Source: Adapted from Cargo (2008, p. 17)

<sup>8</sup> Randomised control trials of parenting programmes often use waiting control groups. Some researchers have found that by the time the control group is offered a programme, indigenous parents have disengaged and are no longer willing to participate, leading researchers to stress the importance of offering parents a programme when they first make contact for assistance (Turner, Richards, & Sanders, 2009).



Cargo (2008, p. 11) also reported that discussion with Māori about the Incredible Years parenting programmes elicited a “desire to learn traditional Māori parenting practices”:

Many of the whānau we work with tend to be disconnected from a strong Māori identity. So they have never been taught how in traditional Māori communities children were ‘He Taonga’ a treasure. (Cargo, 2008, p. 15)

Rokx (1998) argues that parenting programmes inhibit positive outcomes for Māori parents when they are not based in Māori values and knowledge about childrearing. This includes knowledge of Māori childcare practices pre-colonisation. Herbert (2001) emphasised the role of whakapapa (genealogy) and whanaungatanga (kinship) from her interviews with kaumātua (elders) about Māori parenting practices. Although she found little difference in the outcomes from standard parenting training (SPT) and her culturally adapted Matuatanga model programme, Herbert (2001, p. 146) noted that the SPT “was also marae-based and inevitably included a range of culturally-embedded processes and interactions”.

A two-phase programme for utilising the Incredible Years programme in American Indian communities by Dionne and colleagues (2009) may provide a bridge for enhancing the effectiveness of mainstream programmes for Māori parents. In the motivational phase, the difficulties that families are experiencing are placed within an historical context, in much the same way that the decolonisation component of many Kaupapa Māori programmes do. In the second, intervention phase, the mainstream programme is linked to cultural traditions and values. Preliminary findings supported the efficacy of this approach.

The Hakuitanga, Hakorotanga Māori parenting programme developed by Te Komako (the Māori training unit within Early Childhood Development [ECD]) is a parenting programme for parents “who demonstrate a critical lack of knowledge, understanding and practice in positive parenting” (Cargo & Cram, 2003, p. 5). The programme has been described as addressing “interrelationships within the whānau by examining broader male and female roles within whānau generally, and then considering these specifically within the context of parenting” (Child, Youth and Family, 2005). The programme was evaluated by the Māori Psychology Research Unit (MPRU) in 1999 and was found to have “a high likelihood of long-term positive impact”.

The need for specialist training and capability of Māori service and programme providers dealing with child welfare issues has been highlighted. Programmes such as Te Atawhainga Te Pā Harakeke (Nurture the Family) have been developed by Māori child development specialists and have been successful at training Māori providers of social services (Cargo & Cram, 2003). This training emphasises the personal, professional and spiritual growth of participants. One issue raised in the 2003 evaluation was the need for more Māori men to participate in the training. Atawhainga Te Pā Harakeke captures traditional practices by, for example, encouraging “participants to fully explore the implications of the creation cycle which subsequently goes on to define the creation of the universe and all that is in it, and then evolves to include individual and focused whakapapa” (Rokx, 1998, p. 4). The training principles behind Te Atawhainga Te Pā Harakeke come from *Te Whāriki*, the national early childhood curriculum statement (Cargo & Cram, 2003, p. 21):

- Whānau/Tangata-family and community: the content and delivery are relevant and appropriate to the whānau and communities that providers represent and operate in, and overall to the providers themselves.
- Kotahitanga/holistic development: the premise that development occurs as a result of considering all factors, that for a whānau to progress and develop the bigger picture of their situation must be taken account of.
- Whakamana/empowerment: the commitment to strengthening the capacity for providers to deliver support services to the whānau in their respective communities.
- Ngā Hononga/relationships: the importance of relationships, wider interaction and professional networking to provide all round holistic support to whānau.

Te Korowai Aroha O Aotearoa (2011) also provides specialist training, *Mauri Ora*, for those seeking to become certified as whānau, hapū and iwi kaiwhakaruruhau (mentors and advisors). Kaiwhakaruruhau work in a kaupapa Māori way, particularly in the areas of addiction, suicide, domestic violence, mental health and counselling. This training is based on the Mauri Ora Framework (Kruger et al, 2004).

Whānau Toko i te Ora is a parenting programme developed by the Māori Women's Welfare League. It was initially delivered in three sites, starting at the end of 1999. When the programme was evaluated in 2001 it had expanded to six regions. "Its services are tamariki [child]-centred and whānau-focused, using a holistic approach that integrates Māori tikanga into all aspects of tamariki development, with an emphasis on the first five years" (Livingstone, 2002, p. 1). The programme's objectives are to facilitate positive parenting, confident family functioning and a learning and development environment for children. The programme is delivered through a combination of home visiting, whānau learning, group support and linking whānau to services, which are flexible and responsive to individual whānau. Most of the parents participating in the evaluation of the programme had increased their parenting skills and confidence; however, whānau with substance abuse issues did not make these gains (Livingstone, 2002).

Gifford and Pirikahu (2008, pp. 5–6) implemented and evaluated a Tips and Ideas on Parenting Skills (TIPS) parenting programme for Ngāti Hauiti whānau. Their report makes a number of recommendations about Māori parenting programmes that add to the issues identified by Cargo (2008) above, including:

- Parenting programmes should be included in broader health and social service contracts to enable a holistic approach to strengthen whānau resiliency; this may counter some of the negative connotations associated with parenting programmes that are provided as stand-alone programmes.
- People who have rapport/whanaungatanga with the whānau may be the most appropriate first point of contact for recruitment of Māori whānau for parenting programmes.
- Programmes such as TIPS, that are adaptable to meet the needs of local communities, have previous evaluation data and offer training, can be utilised by Māori communities to strengthen whānau-parenting responses.

The Whānau Ora initiative is based on similar principles to those described above and seeks to facilitate and enable Māori potential as whānau (Taskforce on Whānau-Centred Initiatives, 2010). The strengthening of family and kinship ties (ie, whanaungatanga) is also seen as contributing to the resilience of indigenous communities (Turner et al, 2009).

The current Whānau Social Assistance programme that has been running for just under a year (funded by Te Puni Kōkiri) ascribes to the same principles and is focused on assisting families who are most vulnerable (Sharples, 2009a). Kaitoko Whānau are responsible for providing a planning and navigation service for whānau. They have described the first steps in the engagement with whānau as “building relationships and rapport and establishing trust” (Cram & Paipa, 2010, p. 20). It is anticipated that the programme will enable whānau to begin their journey “pathway towards rangatiratanga and self-reliance” (Sharples, 2009b, p1).

### Parental relationship support

More than 20 years ago, Balzer and McNeill (1988) recommended greater Māori participation in the quest to find solutions to Māori domestic violence from within Māori culture:

Family violence intervention involves male responsibility for their violence whilst ensuring the absolute safety and protection of the women and children victims of this violence. Any rehabilitation process for Māori men must be inclusive of positive Māori self-identity and must promote the family (whānau) as an institution which supports, as well as sanctions, behaviour. (p. 12)

The Programmes for Māori Adult Protected Persons under the Domestic Violence Act (DVA) 1995, for example, are based in Tikanga Māori, incorporating Māori values and concepts. Three key principles underpin the programme: Māori language and culture; Kaupapa Māori (by Māori, for Māori) solutions; and individual and collective healing (Table 3).

**Table 3. Key principles in the benchmarking of programmes for Māori protected persons under the Domestic Violence Act 1995**

Key principles		
Māori language and culture	Kaupapa Māori solutions	Individual and collective healing
<p><u>Ako Māori</u>: Māori pedagogy</p> <p><u>Taonga tuku iho</u>: cultural aspirations</p> <p>Providers (facilitators, counsellors) are Māori</p> <p>Providers have appropriate skills and training</p> <p>Culturally safe use of the Māori language and culture</p> <p>Matching providers and participants</p> <p>Code of ethics and standards</p> <p>Sense of equality between provider and participants</p> <p>Valuing of nurturing and mutually respectful relationships</p>	<p><u>Kia orite i Ngā raruraru o te kainga</u>: mediation of socio-economic and home difficulties</p> <p><u>Kaupapa</u>: collective vision</p> <p>Support Māori cultural aspirations</p> <p>Holistic approach</p> <p>Consultation with whānau, hapū, iwi</p> <p>Access to matauranga Māori (Māori knowledge)</p> <p>Manaakitanga: support and care</p> <p>Social, political, historical and gender analysis of domestic violence</p> <p>Acceptance of and respect for the client as a whole person</p> <p>Supporting women in the legal system</p>	<p>Priority given to participants' safety</p> <p><u>(Tino) rangatiratanga</u>: relative autonomy</p> <p>Participants are listened to and not judged</p> <p>Women share their experiences with others</p> <p>Affirmation, empowerment and choice</p> <p>Building cultural esteem</p> <p>Sense of community and shared responsibility</p> <p>Recognition of Mana Wahine, Mana Tane, Mana Tamariki</p> <p><u>Whānau</u>: support for extended family structure and connectedness</p>

Source: Adapted from Cram, Pihama, Jenkins and Karehana (2002, p. xviii)

The programmes dealt with issues related to colonisation and traditional Māori family values, including the prestige of men and women, as well as issues regarding ensuring safety. The 2002 evaluation of the programmes found that the Kaupapa Māori content was important, as were the women:

being listened to, not being judged, being accepted, and being able to share their experiences with other Māori women who had had similar experiences. (Cram et al, 2002, p. xvi)

Barriers to women's attendance at programmes included lack of transportation and lack of childcare (Cram et al, 2002).

In Canada, initiatives such as the Community Holistic Healing Circle have been developed to provide indigenous communities with a way to address domestic violence and child sexual assault (Cripps & McGlade, 2008). The programme is about the restoration and healing of victims, perpetrators and the community. The path for abusers from the Community Holistic Healing Circle to the point of reconciliation with the victim and their family is a three- to five-year journey. Cripps and McGlade (2008) critically reviewed the outcomes from this initiative with a view to implementing it in Australia. They found that the improvements achieved from this initiative included reduced recidivism, as well as:

happier children and better parenting, more disclosures and empowerment of victims, women feeling empowered, community actions and responsibility, respect, broadening of resources, responsiveness, openness and honesty, strengthening of traditions, harm reduction, and violence being controlled. (p. 248)

Nancarrow (2010) states that indigenous women in Australia have long called for alternatives to the criminal justice system for domestic violence offences. Restorative justice programmes for domestic violence may therefore be a better fit with, and more effective within indigenous communities than, a focus solely on the criminalisation of domestic violence. Such programmes also fit well with community development approaches (see below). Even so, Ptacek (2010) notes that restorative justice programmes remain highly contested and he calls for "hybrid developments" of restorative and criminal justice that work for "safe and just outcomes".<sup>9</sup> From their interviews with 21 Aboriginal family violence programme administrators and service providers in Canada about what are the essentials of an Aboriginal family violence prevention programme, Brown and Languedoc (2004, p. 482) found that successful programmes "must balance traditional history and process with Westernized content and accountability". Such calls for hybridisation and balance may be attuned with calls for domestic violence interventions to be culturally responsive and community controlled.

## **Support, counselling and rehabilitation for parents**

As with parenting programmes and support mechanisms for women experiencing domestic violence, support and counselling services for Māori with mental health

<sup>9</sup> This review has only touched briefly on restorative justice programmes as a full review of these programmes was outside the scope of the present review.

and/or addiction issues also has a wide lens that incorporates the historical and social context within which people and their whānau are living (Pitama et al, 2007). This is similar to other indigenous peoples; for example, “the mental health and recovery of indigenous people in Canada have always been tied to history, identity, politics, language and dislocation” (Lavallee & Poole, 2010, p. 271).

The Kina Families and Addictions Trust (2005, p. 4) has developed practitioner guidelines for Family Inclusive Practice with couples, families and whānau. The principles underpinning their approach reflect an ecological model in that:

- Family and whānau members have a right to participate in and receive services.
- Services are more effective when they involve family and whānau.
- Interventions with clients include broader social issues and services need to respond to these through interagency work.
- Harms associated with addiction (such as marital problems) extend beyond the individual, and these can be addressed effectively.

We now recognise that involving family members in drug and alcohol treatment results in higher levels of subsequent abstinence among clients. Morgan and Freeman (2009) have also found that, in order to be successful, substance abuse programmes for Alaskan Native American and American Indian populations in Alaska need to combine the medical profession’s technical and treatment skills with the cultural strengths of the people being treated.

There is now a growing movement to offer programmes that integrate ante-natal care, parenting and child development, and addiction services to vulnerable women of childbearing age (Niccols, Dobbins et al, 2010). For whānau with complex needs, an integrated service that offers a menu of possible assistance and services may provide the holistic, wraparound support structure that whānau members need to address their issues and achieve their aspirations. The current Whānau Ora initiative holds this possibility.

## **Community development**

There are also community development approaches to preventing the maltreatment of indigenous children (Higgins, 2010). These approaches may also be effective at bolstering the community protection mechanisms and support available to whānau who have had a child(ren) removed. Community development initiatives, such as the Amokura initiative, in Aotearoa New Zealand have targeted family violence (Grennell & Cram, 2008).

Within the Mauri Ora Framework, outlined in the report of the Second Māori Taskforce on Whānau Violence, violence is seen as damaging the Mauri Ora (wellness of the life principle) of both victims and perpetrators: “it creates dis-ease and imbalance which results in a state of kahupō, which can be described as having no purpose in life or spiritual blindness” (Kruger et al, 2004, p. 15). Mauri Ora is restored through a transformative process that “includes contesting the illusions around whānau violence, removing opportunities for the practice of whānau violence and replacing these with alternative behaviours and ways of understanding” (Kruger et al, 2004, p. 16).

If community development is based on the principles in the Mauri Ora Framework for reducing Māori domestic violence then the three fundamental tasks are (Kruger et al, 2004, p. 5):

- a. **dispelling the illusion** (at the collective and individual level) that [child maltreatment] is acceptable
- b. **removing the opportunities** for [child maltreatment] to be perpetrated through education for the empowerment and liberation of whānau, hapū and iwi, and
- c. **teaching transformative practices** based on Māori cultural imperatives.

However, as with the Mauri Ora Framework, this direction needs to also be the product of community consultation and expert guidance. Strengthening Families operates in communities across the country to improve outcomes for at-risk families. The initiative has strong foundations within communities and a commitment to strengths-based, collaborative family case management processes (Ministry of Social Development, 2005).

The Strengthening Families initiative has facilitated formal collaborations between “government agencies and community organisations to work together to improve outcomes for at-risk families ... through: local interagency family case management; addressing gaps and overlaps in available services; [and] the development of local preventative and community-strengthening initiatives” (Ministry of Social Development, 2005, p. 8). Whānau Ora has many of the same initiatives in mind to support whānau to achieve wellness.

A 2001 audit of Strengthening Families concluded that the involvement of Iwi and Māori service providers in the management of the programme needed to be enhanced (Te Puni Kōkiri, 2001). A 2005 review also expressed concern that even though 40 percent of the families involved in the initiative were Māori, local management groups had little engagement with Māori and iwi providers in some areas (Ministry of Social Development, 2005, p. 18). The establishment of a Māori Caucus by Te Puni Kōkiri was one solution, but the lack of local-level engagement could be interpreted as an example of institutional racism operating at a local community level.

There is also a need for long-term investment in Māori whānau and communities, to address social and economic risk factors for child maltreatment. The Whānau Ora initiative will hopefully provide this investment (Taskforce on Whānau-Centred Initiatives, 2010). Like the Strengthening Families initiative, Whānau Ora will facilitate the coordination of government agencies to support whānau. It is acknowledged within this initiative that responding to whānau needs has:

to be based on Māori processes and values and be relevant to the many and varied forms of contemporary Māori familial relationships. (Ministry of Health, 1996, p. 28)

## **(Re)habilitation**

This section asks whether there are programmes and services that specifically address the parenting needs of parents who have had a child(ren) removed, to increase opportunities for whānau ora should they become caregivers again. While we use the term (re)habilitation, we acknowledge that parents who have had a child removed may never have been parented well, or been good enough parents.

From their examination of CYF data, the Families Commission (2011) found that of the 4,238<sup>10</sup> children in out-of-home care<sup>11</sup> in 2010, 1,895 (45 percent) also had siblings who had previously been removed from their parents/caregivers by CYF. Fifty-two percent of the children in CYF out-of-home care were Māori. Of the Māori children who had custody orders taken in 2010, just under half (45 percent) had had a sibling previously removed. Similarly, 48 percent of Pacific children<sup>12</sup> and 42 percent of Pākehā children who had custody orders taken in 2010 also had a sibling who was previously removed by CYF.

However, there is little information on the (re)habilitative needs of Māori parents who have had a child permanently removed. The closest literature is on services and programmes for parents who wish to be reunited with their removed child(ren). However, even this literature focuses largely on the care and support given to children and young people, rather than on what happens with parents. Some literature examines the changes that parents must make.

This section is therefore rather brief and addresses issues related to the grief of child loss when removal happens, followed by what has been said in the literature about therapy and targeted programmes for parents. Much of this literature also relates to general, rather than Māori or indigenous, populations.

## **Grief following child removal**

From their review of a small amount of literature on parents of children taken into care, Panozzo, Osborn and Bromfield (2007, pp. 6–7) report that after a child has been removed, parents experience feelings of sadness, alienation, powerlessness, loss and despair. Their involvement with child protection is described as “both threatening and confusing”.

As the CYPF Act prioritises extended family placements, the removal of a child is less legalistically harsh and may not necessarily end contact, albeit that may be supervised contact, between birth parents and their child(ren). Mothers may also experience the uplifting, or removal, of the child at its birth.

In the US the termination of parental rights (TPR) is a severe legal encroachment on the relationship between parent(s) and child(ren) and has been compared to a death sentence (Hewitt, 1983, in Laufer, 2006). Her argument is based on circumstances when there is no longer contact between children and parents after TPR.

## **Rehabilitation**

The reunification literature finds there are risks in therapy of collusion versus alienation of parents, and therapists must walk this fine line (Panozzo et al, 2007). “O’Neill (2005) commented that what these parents need from professionals is ‘for their stories to be heard without blame; to be consulted about their children’s future; and to be offered the possibility of meeting up with parents who have similar experiences’ (p17)” (Panozzo et al, 2007, p. 7).

Research on out-of-home care for Aboriginal and Torres Strait Islander young people highlighted the importance of parents continuing to receive services after their

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<sup>10</sup> This figure includes children who entered out-of-home care placements prior to 2010.

<sup>11</sup> Out-of-home placements include kin-care placements.

<sup>12</sup> Pacific children made up a very small proportion of the children in out-of-home care.

child(ren) had been removed. This helped to keep the hope for reunification alive, even if the child(ren) were placed in permanent care (Higgins, Bromfield, & Richardson, 2005). As one of the indigenous carers in their study said:

The help should be there for the parents as well as the children. They just look at taking the children away, but don't think about what's left. Later on, that child will go back to that root. So we need to not let that root die. (Higgins et al, 2005, p. 56)

Fariss (2000, p. 81) describes a reunification programme operating in Perth, Western Australia, where issues of safety faced by family and children "require an intensive change-focused approach". During the three months that children lived in residential care their parents were "encouraged and assisted to spend increasing amounts of time learning how to meet their children's needs". The return of children to the parents only happened if the family situation was safe enough in the absence of constant supervision, and outreach support was provided for a further three months following reunification. The reunification rate for the programme was around 30 percent, with the programme being most successful for single parents with one child. Although the author states that one in four children in placement in Western Australia is Aboriginal, there was no mention whether any of the participants in the programme were.

## **Where to from here?**

The literature is virtually silent on what needs to happen with parents who have had a child(ren) removed. This silence creates the impression that once a child is removed the focus of child welfare services is then solely on the child and the parent(s) are somehow forgotten, as if this instance of child removal makes no allowance for them becoming primary caregivers for a child(ren) in the future or continuing their relationship with their child.

Māori cultural beliefs and practices related to whānau therefore need to be taken into account in decisions about the support and monitoring of parents who have had a child removed. More discussion now needs to occur with Māori professionals who work with whānau who have had a child(ren) removed, and possibly with those whānau themselves, about what they need to support them in any future parenting role.

## **Summary**

The principles of effective prevention and early intervention for First Nations, Métis and Inuit communities have been described as 'wise practices', as a counter to 'best practices' that are often Eurocentric. This metaphor is "a long overdue vehicle for lifting up the collective morale of Aboriginal peoples in Canada" (Wesley-Esquimaux & Snowball, 2010, p. 390). In a similar fashion, the Whānau Ora initiative has set out to recognise and value the practices that Māori know work within their communities, for their whānau.

The programmes and services described do not make up a comprehensive listing of Māori interventions. However, they do provide examples of some of the overarching principles of Māori prevention and early intervention programmes. These programmes tend to be delivered by Māori and:



- address the barriers to Māori engaging and participating in programmes
- include, if not be based within, Māori cultural traditions, values and beliefs
- address issues of colonisation and racism
- are set in a context in which participants are accepted and able to share with other Māori people who are in similar situations
- emphasise whakawhanaungatanga (relationship building)
- are based on principles of individual and collective healing, which require time and long-term support.

## **Kupu Whakatepe—Conclusion**

Children are the future of Māori communities and the main function of whānau is nurturing children (Walker, 2004). This paper sought to understand the confluence of factors that place Māori whānau at risk within our society and how these whānau can be supported in their parenting aspirations, especially if they have already had a child removed by CYF. Explanations for Māori not fulfilling their parenting roles and responsibilities have been canvassed within the framing provided by Te Pae Mahutonga, a Māori model of whānau wellness (Durie, 1999a). Mauri Ora—cultural identity—took into account the legacy of colonisation in this country and the denial of Māori sovereignty that infiltrated the provision of social welfare services to whānau. Te Ōranga—participation in society—examined the ongoing segregation of whānau into communities marked by a label of ‘high deprivation’. The risk factors for Toiora—healthy lifestyles—experienced by whānau included parental, child and whānau relationship characteristics.

Since the time when whānau first encountered a monocultural social welfare system, Māori have sought culturally appropriate systems, structures and services that will deliver culturally appropriate child maltreatment prevention and interventions. In 1988, *Puao-Te-Ata-Tu* recognised that a culturally appropriate child welfare system also depended on New Zealand society ridding itself of cultural racism and economic deprivation. The lack of attention to these recommendations reflects the constraints on the social welfare system of the time, which struggled to change when society itself remained fundamentally unreformed.

After the Public Finance Act 1989 established a funder-provider split, Kaupapa Māori services and programmes emerged. This Act coincided with the New Zealand Children, Young Persons, and their Families Act 1989 that reinforced the importance of kinship placements. Māori and iwi providers saw a window of opportunity to provide social welfare services to whānau. However, at the same time, the budget for care and protection services decreased by a fifth, and the issues faced by whānau increased as a result of the economic reforms of the late 1980s and early 1990s (Reid & Robson, 2007).

It has been proposed in this paper that:

- children are often removed from whānau because the whānau is experiencing complex issues
- the support that whānau need in order to prevent additional children being removed, following the removal of one or more children, is similar to the support that whānau experiencing complex issues need

- whānau need additional support when they have had a child removed because of:
  - the configuration of issues that has led to that removal
  - the grief that a whānau experiences following a removal.

Any solution that does not acknowledge and respond to the complex problems whānau experience will likely fail to meet the needs of whānau. In addition it may be that, as well as recognising the common issues that these whānau have, solutions need to be tailored to the particular situation of any one whānau and their support structures. How, then, can these multilayered, intertwined challenges be addressed so that whānau are supported to be the parents they aspire to be, even if they lost that role in the past because of child maltreatment?

DeBruyn, Chino, Serna and Fullerton-Gleason (2001) proposed a public health response to child maltreatment in American Indian and Alaska Native American communities based on violence prevention work undertaken in the US. Their approach has been adapted for the present project and is presented below in Table 4. The three strategies they suggest have been aligned with Te Pae Mahutonga. These four levels have then been placed alongside the three fundamental tasks (called 'Strategies' in Table 4) set out in the Mauri Ora Framework for reducing Māori domestic violence, with these tasks tailored to speak specifically to child maltreatment (Kruger et al., 2004). The description and intervention examples are drawn from the literature described in this paper and the work of DeBruyn and her colleagues (2001). The description also includes six health promotion action themes (in italics) from the Ottawa Charter for Health Promotion (World Health Organisation, 1986), and examples of practice from the Child Welfare Information Gateway (2008) (in blue text). The four levels are described below.

**Mauri Ora—Cultural identity:** Developing an awareness and critique of the historical, political and cultural context of the lives of whānau sets the scene for dispelling the illusion that child maltreatment is acceptable. Upholding Māori self-determination, including Māori cultural values, is imperative for enhancing Mauri Ora in the future. This may be achieved through policy and community-based initiatives that, for example, build connectedness and awareness.

**Te Ōranga—Participation in society:** The context for Te Ōranga is a description of the environment and systems and enhance/prevent whānau from participating in society. Racism and poverty are identified as two key obstacles that need to be combatted. Other strategies include reducing other barriers to service access, enhancing political understanding and increasing the harmony (eg, cooperation and collaboration) among different systems (eg, among Māori NGOs, between Māori NGOs and government agencies). Preventions suggested to facilitate the cultural responsiveness and accessibility of services include policy development, Māori involvement and increased Māori responsiveness of organisations and competence of personnel.

**Toiora—Healthy lifestyles:** Understanding the lives of vulnerable whānau and communities sets the context for Toiora. Strategies revolve around removing the opportunities for child maltreatment and building on community strengths. Supportive and positive environments may be created through initiatives such as whānau navigators, long-term interagency support, parent support groups and home visits.

**Te Mana Whakahaere—Service provision:** The development of appropriate services to support the parenting and caregiving roles and responsibilities of vulnerable whānau is the context for Te Mana Whakahaere. The strategy highlighted is teaching these whānau transformative practices sourced from Māori culture and delivered in a culturally appropriate way. The prevention examples include parent education, respite care and involving kaumātua (elders).

In summary, LeBruyn et al (2001) stress the importance of building understanding about the causes of child maltreatment, alongside developing a body of knowledge about what works, in this case, for reducing Māori child maltreatment and facilitating whānau care and parenting aspirations. Starting from a Māori model of whānau wellness—Te Pae Mahutonga—the present paper has explored international indigenous experiences alongside an analysis of local history, institutional responsiveness, whānau circumstances and interventions that support whānau, to feed into the dialogue occurring within Māoridom about child maltreatment prevention.

**Table 4. Incorporating context, culture and historical variables into strategies for preventing child maltreatment in Māori whānau**

Context	Strategy	Description	Prevention examples
<p><b>Mauri Ora—Cultural Identity</b> Describe the history of the community, cultural values, culture/social change, cultural shame, importance of spirituality, importance of whanaungatanga.</p>	<p><b>Dispel the illusion</b> that child maltreatment is acceptable. Change individual/community knowledge, skills, attitudes that collude with child maltreatment. Uphold cultural models of parenting and childcare. Advocate for Māori sovereignty.</p>	<p>Determine culturally appropriate manner to deliver information to communities; increase knowledge, respect, sense of self and belonging in community. <i>Build healthy Māori and public policy. Move into the future</i> (WHO, 1986).</p>	<ul style="list-style-type: none"> <li>• Building community and social connectedness: whanaungatanga.</li> <li>• Community education on prevention of child maltreatment and revitalisation of cultural values of parenting and caregiving.</li> <li>• Decolonisation and anti-racism workshops.</li> <li>• <b>Raise public awareness</b> (eg, promote healthy parenting, reporting child abuse).</li> <li>• <b>Family resource centres</b>, collaborative ventures with communities to meet their needs.</li> <li>• <b>School-based curricula</b>, teaching children safety and protection skills to prevent sexual abuse.</li> </ul>
<p><b>Te Ōranga—Participation in Society</b> Describe the economic and social environment. Include racism, poverty, healing systems, political/ jurisdictional systems and other barriers to access and participation.</p>	<p>Change the social environment by combatting racism and poverty. Address barriers to Māori accessing goods and services. Enhance understanding of political systems. Increase harmony among services.</p>	<p>Enhance the cultural responsiveness of institutions that deliver universal services to Māori. Support the development of Māori cultural interventions. <i>Enhance community access to goods and services</i> (WHO, 1986).</p>	<ul style="list-style-type: none"> <li>• Develop policies to improve Māori access to goods and services.</li> <li>• Involve Māori in all aspects of service design and delivery.</li> <li>• Increase the capacity of institutions to respond to Māori needs and aspirations.</li> <li>• Invest in the capacity of Māori to provide goods and services to communities.</li> <li>• Raise the cultural competence of non-Māori staff providing goods and services to Māori.</li> <li>• Reduce community barriers to service access (eg, transport, distance).</li> </ul>
<p><b>Toiora—Healthy lifestyles</b> Describe the circumstances that vulnerable whānau and communities are experiencing and the interrelatedness among these circumstances. Develop an understanding of the strengths of whānau and communities.</p>	<p><b>Remove the opportunities</b> for child maltreatment to be perpetuated by supporting whānau to address risk factors; advocate for institutions and agencies to support vulnerable whānau. Understand communities—build on their strengths and add supports.</p>	<p>Enhance positive interactions by improving whānau and community relationships. Develop gathering places for positive whānau and community interactions. <i>Create supportive environments. Strengthen community actions</i> (WHO, 1986).</p>	<ul style="list-style-type: none"> <li>• Whānau navigators to advocate for access to services and entitlements (eg, Kaitoko Whānau initiative).</li> <li>• Long-term interagency support for whānau considered at risk of child maltreatment (food, clothing, housing, transportation and access to essential services that address whānau specific needs; eg, childcare, healthcare, mental health services).</li> <li>• Support for whānau caring for children with disabilities or special conditions.</li> <li>• <b>Parent support groups</b>, where parents work together to strengthen families and networks.</li> <li>• <b>Home visitations</b>, for pregnant mothers and families with new babies or young children (eg, Ōranga Whānau initiative).</li> <li>• <b>Help build and support nurturing and attachment.</b></li> </ul>
<p><b>Te Mana Whakahaere—Service provision</b> Develop an understanding of appropriate services and programmes needed by vulnerable whānau and communities to support them in their parenting and caregiving roles.</p>	<p><b>Teach transformative practices</b> based on Māori culture; enhance individual, whānau and community knowledge, skills and attitudes that support caregiving roles and responsibilities.</p>	<p>Determine culturally appropriate manner to deliver culturally appropriate information to individuals and whānau. <i>Develop personal skills. Reorient social welfare services</i> (adapted from WHO, 1986).</p>	<ul style="list-style-type: none"> <li>• Kaupapa Māori and other culturally appropriate services and programmes.</li> <li>• Education on traditional/good parenting, <b>child and youth development (parent education)</b>.</li> <li>• Addiction and mental health services.</li> <li>• Involve kaumātua as appropriate.</li> <li>• <b>Respite and crisis care programmes</b>, offering temporary relief to caregivers in stressful situations.</li> </ul>

Source: Adapted from DeBruyn et al (2001)

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## Appendix

### Literature review method

We did not find any literature on what Māori parents who have had children removed from them need to be supported, so that they can safely care for other child(ren) who come into their care. Therefore, this paper looked at the historical context of child welfare in New Zealand to understand the underlying causes of Māori whānau coming under the intense scrutiny of mainstream child welfare services.

### Literature search

The literature search that informed this paper began with the terms that the Families Commission used for their paper on the topic. These terms did not produce much information about Māori whānau, especially the needs of those whānau who had experienced the removal of a child(ren). We then undertook five approaches to the literature search (using Google, Google Scholar and the University of Auckland library: PsychINFO and PUBMED databases).

1. Narrow search terms were broadened to encompass topics that might talk about this specific issue within a context of wider concerns. The search terms used were:
  - Māori/indigenous/Aboriginal child maltreatment
  - Intervening Māori/indigenous/Aboriginal child maltreatment
  - Māori/indigenous/Aboriginal child care protection/child welfare
  - Risks Māori/indigenous/Aboriginal parenting
2. The phrase 'what works' was used to search for interventions and solutions, especially meta-analyses. The topics searched were those that had come to prominence as risk factors for child removal for Māori and indigenous parents. The search terms used were:
  - What works Māori/indigenous drugs alcohol
  - What works Māori/indigenous parenting
  - What works Māori/indigenous child maltreatment
  - What works Māori/indigenous child welfare
3. Prominent journals specialising in child and family, abuse, services, social work were searched for specific Māori and indigenous content. These journals were:
  - *Child Abuse & Neglect*
  - *Child & Family Social Work*
  - *Children and Youth Services Review*
  - *Child Maltreatment*
  - *International Social Work*
4. Key authors and their work were searched for to find instances where they had been cited in work that was also relevant to the topic. These authors were:
  - Catherine Love
  - Durie-Hall & Metge



- Cindy Blackstock
5. Key references in the papers that were read were also followed up when these had not already been pinpointed in the searches undertaken in 1–4 above.

### **Inclusion criteria**

Journal articles, government reports and reports from indigenous child welfare organisations were highlighted and downloaded from the initial searches. These were then read for relevance to the topics outlined in this present report.