1.0 Introduction

The current COPMIA project identifies as its aim increasing the capability of health professionals to identify, and attend to the needs of children of parents with mental illness and/or addiction in all aspects of service delivery, with a particular focus on the primary and secondary mental health and addiction sectors. Consistent with the Rising to the Challenge: The Mental Health and Addiction Service Development Plan (SDP) (Ministry of Health, 2012) directive to contribute to Whānau Ora initiatives, this paper:

1) Articulates the interface between Whānau Ora and COPMIA;

2) Identifies important areas where current conceptualisations of COPMIA differ from the underlying principles of Whānau Ora and whānau-centred best practice, and specific factors needing to be taken into account when considering the needs of children and young people impacted on by whānau mental illness and/or addiction; and

3) Identifies future key areas of focus to guide the effective integration of COPMIA within Whānau Ora.

The children of parents who experience mental illness and/or addiction are often referred to as ‘hidden’ (Maybery & Ruepert, 2009; Mental Health Commission, 2007). As is common internationally, national data regarding the parental status of people accessing mental health and addiction services is not routinely collected, and in cases where it is collected, it is neither stored, or able to be extracted electronically (Goodstadt, 2013). This makes it difficult to accurately identify the extent of this issue for the general population let alone Māori.

However, findings from Te Rau Hinengaro (Baxter, 2008) show high mental health and addiction prevalence rates for Māori, gendered patterns of disorder. These are consistent with the Mental Health and General Practice Investigation study (MaGPIE Research Group, 2005), particularly in relation to the relatively high prevalence of common mental disorders among Māori general practice attendees. These findings combined with the relative youthfulness of the Māori population (NZ Statistics, 2006) and higher fertility rates for Māori (Cormack, 2007), suggests that issues associated with children and young people living with parents with mental illness and/or addiction-related issues is of high importance for Māori whānau.

A range of literature sources have been used to inform the writing of this paper. However, it is important to note the near absence of a literature base specific to Māori whānau. Nevertheless the sources cited are useful to highlight the existing evidence base which supports the importance of taking a Whānau Ora and whānau-centred best practice approach. The work of the Māori Addiction Workforce Strategy Reference Group has also informed the writing of this paper.
One final comment needs to be made in relation to the use of the term ‘COPMIA’. To facilitate consistent understanding, the term COPMIA is utilised in this paper. However, it is important to acknowledge that, while this term may be useful in differentiating the specific needs of a particular group, within a Whānau Ora paradigm, there is no need to ascribe a label such as COPMIA to children and young people. First and foremost, they are simply whānau.

2.0 Whānau Ora and Whānau Centred Best Practice

2.1 Whānau
Whānau are the foundation of Māori society. A principal source of connection, strength, support, security and identity, whānau plays a central role in the wellbeing of Maori individually and collectively (Ministry of Health, 2002). Durie (1994) observed that potentially there are multiple definitions of whānau including: whānau as kin; whānau as shareholders-in-common; whānau as friends; whānau as a model of interaction; whānau as neighbours; whānau as households; and virtual whānau. Whānau describes those who share common descent, kinship and collective interests that generate reciprocal ties, aspirations, obligations and responsibilities. Whānau as kin is permanent, and is more than an extended family network (Lawson-Te Aho, 2010; Irwin, Davies, Werata, et al., 2011).

Many use the term ‘kaupapa whānau’ to describe those whānau not linked by whakapapa. Te Aho-Lawson (2010) described kaupapa whānau as a collective of people who associate for a common purpose and may have shared identity, roles and aspirations, obligations and responsibilities. They may include members who are affiliated through whakapapa, however their key link is the kaupapa which pulls them together (Lawson-Te Aho, 2010).

Importantly, it is up to each whānau and individual to define for themselves who their whānau are (Ministry of Health, 2002). Understanding how to ascertain who occupies the role of whānau, in what context, and for what purpose, is critical for engaging in effective whānau-centred best practice and realising Whānau Ora outcomes. However, whilst whānau configurations may differ, whānau as a fundamental construct in Māori society remains the same. Prioritising collective wellbeing, whānau provides an environment where security, connection, support, belonging and identity can be nurtured (Irwin, et al., 2011).

2.2 Whānau Ora and Whānau-centred Best Practice
The Government’s expectation for Māori health development is Whānau Ora: Māori families supported to achieve their maximum health and wellbeing (Ministry of Health, 2002). The Government has as a key priority reducing inequalities that affect Māori, and acknowledges the special relationship which exists between Māori and the Crown via the Treaty of Waitangi. This relationship is based on:

**Kawanatanga: Partnership:** Working together with iwi, hapū, whānau and Māori communities to develop strategies for improving outcomes for Māori.

**Tino Rangatiratanga : Participation:** Involving Māori at all levels of the policy, planning, development and delivery of services put in place to improve outcomes for Māori.

**Oritenga: Protection:** Ensuring Māori wellbeing is protected and improved, as well as safeguarding Māori cultural concepts, values and practices.
Over the past decade Whānau Ora and whānau-centred practice has emerged as the primary vehicle across a range of sectors for realising Maori health and wellbeing aspirations, and improving outcomes. Whānau Ora rests on a foundation of realising whānau potential and giving effect to the collective aspirations of the whānau by building on the strengths and capabilities that are already present within whānau (Taskforce on Whānau-centred Initiatives, 2009).

**Whānau-centred best practice** is the mechanism by which Whānau Ora is realised. Solid foundations have been laid to realise the Government’s expectation of Whānau Ora. Whānau-centred practice as best practice for realising good outcomes for Māori continues to be developed. However, whānau-centred best practice is firmly founded on long accepted best practice methodologies derived from holistic Māori models of health and wellbeing, for example Te Whare Tapa Whā (Durie, 1985), Te Pae Mahutonga (Durie, 1999), and Te Wheke (Pere, 1984).

Whānau Ora simultaneously describes an **overarching philosophy; a process of service delivery and/or model of care; and a desired outcome**. There are various models, interpretations, and applications of Whānau Ora and whānau-centred practice, however all are founded on a set of distinctive principles. It is the combined application of these underpinning principles which distinguishes whānau-centred best practice from other primarily therapeutically focused family inclusive approaches (e.g. family/whānau inclusive practice).

As an overarching **philosophy**, Whānau Ora and whānau-centred best practice explicitly:

- **Prioritises the collective wellbeing** and autonomy of whānau: The interdependence and interconnectedness of whānau is central to wellbeing, both individually and collectively. Although underpinned by a philosophy of collective wellbeing, Whānau Ora and whānau-centred best practice explicitly recognises and encompasses the diverse needs of all population groups, across the life span, particularly developmentally specific needs of pepi, tamariki, and taiohi.

As a **process of service delivery or model of care**, Whānau Ora and whānau-centred best practice explicitly:

- **Maximises all opportunities** to facilitate sustainable change for whānau: All points of contact with whānau are utilised as an opportunity to contribute to the long term wellbeing of whānau. Both individual and collective needs can be addressed within a wider framework of sustainable whānau development.
- **Utilises the collective resources** of whānau to facilitate good outcomes for individuals and whānau as a whole: Interactions with individuals can be converted into opportunities for whānau enablement via the provision of knowledge, skills, and resources which enable whānau to support individual whānau members and facilitate sustainable change.
- **Recognises the value and validity** of Māori concepts and frameworks in practice.
- **Transcends sectors** and weaves resources together into an integrated package of care.

As a **desired outcome**, Whānau Ora and whānau-centred best practice can be expected to contribute to the following broad dimensions of whānau wellbeing, as determined by whānau:

- Self-managing
- Living healthy lifestyles
- Participating fully in society
2.3 Contributing to Whānau Ora

Whānau Ora recognises the wide range of potential opportunities to contribute to overall whānau wellbeing which present across the life course of all whānau members. Although COPMIA is focused on the needs of children of parents who have mental health and/or addiction-related issues, there are a range of settings and services, other than mental health and addiction, that parents and their children have contact with. These include primary health care organisations, educational institutions (preschool, primary, secondary), Māori/iwi health and social services, justice services, housing services, labour and social development services, and primary social services such as food banks, budget advisory services, and community legal services. Given this, diverse and interconnected workforces have the potential to impact on outcomes for whānau with mental health and/or addiction-related needs, each with a responsibility and role to play in either facilitating access pathways to services; and/or delivering interventions of benefit to whānau.

Findings from Te Rau Hinengaro identified high unmet mental health needs; many Māori with mental health needs do not receive mental health care (Baxter, 2008). Also of relevance is that, of those who did have contact, general medical services (mainly general practices) were the group Māori were most likely to have contact with for mental health needs (Baxter, 2008). These findings emphasise the importance of taking a broad perspective in relation to identifying workforces who have the potential to contribute to Whānau Ora via addressing the needs of children and young people impacted on by parental or whānau mental illness and/or addiction.

Although commonly associated with dedicated Whānau Ora service providers, responsibility for contributing to Whānau Ora via whānau-centred best practice is not dependent on being part of a Whānau Ora collective or being a dedicated Whānau Ora provider. Of critical importance is that whānau-centred best practice crosses workforce groupings and sector boundaries, and can be applied and operationalised to some extent in any service, service configuration or context. He Korowai Oranga (Ministry of Health, 2002) and SDP (Ministry of Health, 2012) emphasise the importance of all whānau receiving timely, high quality, effective and culturally appropriate services.

Specific workforce groups relevant to COPMIA include general practitioners, nurses, teachers/educators, youth workers, community support/health workers, health promoters, social workers, midwives, whānau/cultural workers, Whānau Ora practitioners/navigators, budget advisors, counsellors, community corrections, and prison officers. Specifically in relation to the mental health and addiction workforce, whānau are likely to come into contact with psychiatrists, psychologists, nurses, community mental health workers, peer support workers, whānau/cultural workers, alcohol and drug practitioners, problem gambling practitioners, and co-existing problem practitioners.
Effectively identifying and addressing the needs of children of parents with mental illness and addiction requires that all relevant workforce groups have the attitudes, knowledge and skills, within the context of whānau-centred best practice, to identify how whānau mental health and/or addiction issues impact on children and young people, and to play their role as part of an integrated response to addressing those issues. The precise knowledge and skill mix required will differ across workforce groups.

Whānau-centred best practice can be conceptualised as existing on a continuum, influenced by the specific needs of workforce groups and sectors. At one end, the level of attitudes, knowledge and skills may be general and consist primarily of recognising the principles of Whānau Ora and whānau-centred best practice, with this providing a context in which the relevance and necessity of exploring the broader whānau context is understood. Fundamental to operationalising whānau-centred best practice is genuine acceptance of the premise that the collective wellbeing of whānau is impacted on by the wellbeing of each individual whānau member. At the other end of the continuum are dedicated Whānau Ora providers, specialists in the delivery of culturally congruent interventions which go beyond, and often times convert, crises into opportunities for meaningful and sustainable change which contributes to realising of whānau potential. Wherever the various workforce groups are positioned on the continuum, the fundamentals of whānau-centred best practice provide a common foundation for all workforce groups.

3.0 Whānau Ora and COPMIA

Much of the current discussion regarding COPMIA is contextualised within the space of children of parents who have mental health or addiction problems being vulnerable to a range of poor outcomes, particularly a higher risk of developing subsequent mental health and/or addiction related problems. COPMIA therefore appears to be primarily conceptualised as a preventative strategy focused on reducing the incidence and prevalence of mental disorders in future generations.

With its focus on pepi, tamariki, and taiohi within the broader context of parents who have mental health and/or addiction-related issues, COPMIA has a natural alignment with the concept of Whānau Ora. However, there are some important areas where current conceptualisations of COPMIA differ significantly from the underlying principles of Whānau Ora and whānau-centred best practice. Some of these differences are relevant to all children and young people, whilst some impact specifically on Māori whānau. Understanding the underlying paradigm is important as this directly influences the types of interventions which will result from a COPMIA strategy, and the outcomes such interventions are trying to influence. Key issues discussed are collective wellbeing; a potentials focus; and systemic barriers.

3.1 Collective Wellbeing

A Whānau Ora paradigm views the whānau as a whole, and automatically considers the needs of all whānau members impacted on by another whānau member’s mental health and/or addiction-related issues. Fundamental to operationalising whānau-centred best practice is the understanding that the collective wellbeing of whānau is impacted on by the wellbeing of each individual whānau member. However, the way COPMIA is currently constructed tends to presents the needs of children and young people as being independent of, and separate to the needs of their parents.
There are a number of ways the notion of collective wellbeing and interrelated needs is relevant to meeting the needs of whānau impacted on by mental ill health and/or addiction. For example, it has been argued that addressing the needs of children and young people is integral to the recovery process itself. A lack of recognition of parenthood and its associated needs potentially impacts on, and exacerbates the mental health concerns of many service users (Boursnell, 2007; Hargreaves, Bond, O’Brien, Forer, & Davies, 2008). Acknowledging concerns regarding the individualistic frameworks which tend to underpin the concept of resilience, the literature base also identifies the resilience of the family as a whole, in terms of their adaptability and ability to deal with challenges, obstacles and change, as the key to realising resilient outcomes or gaining protection from developing negative outcomes (Greeff, Vansteenwegen, & Ide, 2006; Fraser & Pakenham, 2008). Viewing the needs of children and young people as independent to those of their parents and whānau means that important, and at times immediate, needs such as housing, transport, childcare, education, healthcare, financial and emotional are not considered (Nicholson, Hinden, Biebel, Henry, & Katz-Leavy, 2007). However, these needs are all essential for the collective wellbeing of whānau.

A significant issue for children and young people dealing with whānau related mental health and/or addiction is the extent to which those children are likely to be undertaking caring and other significant responsibilities in the family home (Hargreaves, et al., 2008; Polkki, Ervast, & Huupponen, 2005). Research has identified that this can result in a range of consequences, including anxiety, socioeconomic disadvantage, isolation, low levels of health and emotional wellbeing, impaired psychosocial development, limited friendships, difficulties developing intimate relationships, low participation and achievement at school and in employment, difficulties making the transition to independence, and a lack of opportunities and choices (Hargreaves, et al., 2008). It is also argued that if young carers were supported and their needs met, the negative effects associated with their caring roles could be significantly reduced (Hargreaves, et al., 2008). Although understanding the needs of young carers and how services can respond to those needs is important, linking with the point made earlier regarding positioning the needs of children and young people as integral to the recovery process for parent/s, it is critical that a focus is maintained on how to prevent this situation occurring in the first place (Hargreaves, et al., 2008).

Associated with the issue of caring responsibilities is literature which identifies the important caring roles played by other whānau members, particularly grandparents, when parents/caregivers are unwell. The wellbeing of children and young people in these cases is dependent on the wellbeing of other whānau members who are caring for them (Cowling, Seeman, & Gopfert, 2010; Worrall, 2009). However, the role these whānau play is considered to be somewhat hidden, notably in terms of not accessing financial or any other supports (Cowling, et al., 2010).

International research has identified a lack of information for grandparents regarding the programs and support available to them, as well as a general insensitivity to their situation, stereotyping and a lack of advocacy on their behalf (Cowling, et al., 2010). Whilst not specific to parents who are unwell with mental health and/or addiction-related issues, it has been reported that the number of grandparents and other whānau members who are assuming full responsibility for raising their grandchildren continues to increase in New Zealand (Worrall, 2009).
3.2 Whānau Ora: Potentials Focused

COMPIA as it is currently presented has an explicit preventative focus. However, this tends to exist within an individual model of care focused on preventing adverse outcomes. It also tends to, despite its preventative orientation, take a primarily deficit approach. That is: being part of a whānau in which parents/whānau have mental health and/or addiction issues places children and young people ‘at risk’.

Deficit theorising and frameworks have been described as ‘cul-de-sac’ theories in that they do not offer pathways out that are acceptable to Māori (Bishop, Berryman, Tiakiwai, & Richardson, 2003). Such frameworks result in the individualisation of issues. Risk factors are conceptualised or pathologised in terms of individual and/or family deficiencies and dysfunction, with these provided as explanations for increased susceptibility to poor outcomes (Bishop, et al., 2003; Riele, 2006). Issues are considered independently of each other, with little consideration given to their interconnectedness and inter-relatedness. Deficit focused frameworks also preclude analysis of the broader variables which impact on whānau and the options available to them. Of particular relevance to COPMIA are well established patterns of differential access to mental health, addiction and other health services, and inequalities in socioeconomic positions which contribute to Maori mental health needs (Baxter, 2008).

It has been suggested that a narrow focus on the link between parental mental illness and/or addiction-related harm and poorer outcomes for children and young people is simplistic and fails to account for the range of intersecting variables, such as family composition (particularly in relation to whether children have access to a well parent or other whānau); illness/issue severity and duration; family disruption; social isolation, and financial stress (Maybery, Reupert, Patrick, Goodyear, & Crase, 2005; Mordoch & Hall, 2008; Nicholson, Biebel, Hinden, Henry, & Stier, 2001). Research has also identified a wide range of issues which potentially impact on social and emotional wellbeing, physical and emotional nurturing, and security for children and young people (Robinson, Rodgers, & Butterworth, 2008). However, of importance is that they often exist within a broader context of reduced engagement and disconnection from family, peers, school and the wider community (Hargreaves, et al., 2008; Maybery, et al., 2009; Polkki, et al., 2005), as well as other illness related consequences such physical shifts, job loss, and financial problems (Mordoch & Hall, 2008).

Other important issues often not given a voice in COPMIA discussions include that despite the identification of an association between parental mental illness and child outcomes, there is also literature which suggests that not all children and young people are at inevitable risk of harm. Not all children will experience negative outcomes simply on the basis of their parents’ mental illness, and nor will there necessarily be a negative impact on parent–child relationships (Aldridge, 2008). Similarly, research has found that children and young people can identify positive elements of their family; that is, the presence of mental illness is not the sole defining feature by which they characterise their family or their parents (Mordoch & Hall, 2008). Although their lives, particularly for young carers, can be difficult, positive experiences can also result. For example, children and young people can receive positive feedback regarding their maturity and caring role and their ability to develop coping strategies (Aldridge, 2008; Polkki, et al., 2005).
It has also been found that children, both younger and older, who are living with parental mental illness, become experts in the identification of wellness, and un-wellness. Through observing, listening and sensing any signs of irregularity, they become very astute at predicting parental behaviour and making necessary adjustments to their own behaviour, environment, and ways of interacting with their parents to minimise impacts on themselves and other family members (Mordoch & Hall, 2008). Whilst not always positive in terms of outcomes, the presence of such skills can be interpreted positively within a strengths-based framework.

The Whānau Ora paradigm is very consistent with literature which emphasises the importance of addressing issues for children and young people impacted on by parental mental health and/or addiction issues within the context of their everyday lives. For example, it has been identified that facilitating stability and routine are important for children and young people, with this contributing to a sense of predictability, facilitating less uncertainty and more control (Mordoch & Hall, 2008). Facilitating involvement and success in everyday activities, such as school and different interests, which are not specifically therapeutically focused, are important avenues for building self esteem and coping skills (Polkki, et al., 2005). Strategies to facilitate stability, routine, and success may be as simple as ensuring children can still attend school or participate in activities important to them; providing opportunities to complete homework at school because the home environment is not conducive to this; or providing opportunities for fun activities such as sports and games outside of the home which provide temporary respite from a stressful home environment (Mordoch & Hall, 2008).

Strong relationships with trusted adults, positive peer relationships and external support systems on which to draw, along with a willingness to utilise such support systems have been identified as important mechanisms for coping (Boursnell, 2007; Mordoch & Hall, 2008; Ostman, 2008). Providing opportunities for children and young people to talk about their experiences with trusted others in safe environments has been linked to validating experiences and decreasing feelings of isolation (Mordoch & Hall, 2008; Polkki, et al., 2005). Polkki et al (2005) found that younger children were more likely to share information with other family members, with extended family often able to provide support and help children to understand the problems associated with their parent’s illness. Linked to the preceding points is that the resources available to whānau, both financial and human, play a large role in the extent to which children and young people are able to maintain normal routines and facilitate stability.

Mordoch and Hall (2008) underline the importance of this issue, suggesting that resources to assist in the maintenance of normal family routines comprise an important part of treatment plans for mental health service users. Mordoch & Hall (2008) also advocate taking a strengths based view of families to enhance existing family relationships and resources in order to better address the needs of children and young people.

It can be argued that the identification of ‘at risk’ groups facilitates the prioritisation of resources to those most in need. While this is important, deficit based frameworks contradict the foundations of Whānau Ora. Whānau Ora explicitly focuses attention on realising whānau potential, and building whānau strengths and capabilities.
Within a Whānau Ora paradigm, the needs of children and young people are not exclusively located within a screening, care or treatment framework, and the interrelated needs of all whānau members are considered. Whānau Ora will encompass primary prevention in the context of seeking to prevent adverse mental health and addiction outcomes; however, it is not the primary focus.

3.3 Systemic Barriers

It is reported, both here and internationally, that health professionals are often unaware that their service users are parents (Maybery & Ruepert, 2009). Specific to New Zealand, data regarding the parental status of people accessing mental health and addiction services is not routinely collected, and in cases where it is collected, is not stored, or able to be extracted electronically (Goodstadt, 2013).

It has been suggested that the lack of routine data collection regarding parental and family status both contributes to, and is reflective of a culture within mental health systems that either do not recognise, or fail to acknowledge, the importance of parenthood for clients with mental health issues (Boursnell, 2007). This is wholly consistent with a recent New Zealand survey which found that one of the most frequently identified barriers to COPMIA development was difficulty engaging adult mental health services to change their practice from narrow patient-oriented individualistic models of care to collaborative family based approaches (Goodstadt, 2013). Specific issues which appear to impact on this include unhelpful attitudes such as a tendency of mental health workers to view the service user, not the family, as their client; considering issues relating to children and young people as lying outside of the boundaries of the mental health system, their professional training and core business; and adopting a deficit-based approach when working with parents by focusing on problems as opposed to capacities, including viewing the family primarily as a source of stress (Maybery & Ruepert, 2009).

The above points are not intended to characterise the mental health and addiction workforce as being wholly resistant. Research has identified the mental health workforce lack knowledge and appropriate skills to work with and implement effective solutions for the complex issues which children and families face (Maybery & Reupert, 2006; Polkki, et al., 2005). For example, the majority of nurses in an Australian study considered it was part of their role to discuss parenting with their clients, and speak to children, however over a quarter of them reported barriers to doing so, such as being ill prepared to do so, unaware of resources, and lack of wider systems to support them to do this (Thompson & Fudge, 2005).

As alluded to in the a previous point, wider systems in which services, including mental health and addiction and other cross-sector services, support the continuation of an approach which isolates parents from their wider family context. For example, the dominance of clinical risk management frameworks and professional role boundaries, alongside boundaries that exist between services, and the points at which services are funded to provide responses to families, have all been identified as impacting on the ability of mental health workers to address parenting issues (Maybery & Reupert, 2006; Stallard, Normand, Huline-Dickens, Salton, & Crib, 2004). Similarly, in New Zealand, recent research has identified fragmented, uncoordinated services, with compartmentalised inflexible funding pathways as key barriers to COPMIA (Goodstadt, 2013).
There is an abundance of international research that identifies these barriers and negative impacts of a siloed approach to funding (Aldridge, 2008; Hinden, Biebel, Nicholson, Mehnert, 2005; Mordoch & Hall, 2008; Nicholson, Biebel, Hinden, Henry, & Stier, 2001). The issue of stigma is also relevant. While addressing the stigma associated with mental illness has been a focus in New Zealand for some time, it has been reported that adults with mental illness are often presumed to be incapable of parenting successfully, and are at high risk for child welfare involvement and custody loss (Mental Health Commission, 2005). Research has clearly identified that stigma, particularly a fear of deficit-focused punitive actions from child protection services, has a range of impacts. Of high importance is the extent to which stigma contributes to families and children becoming isolated, in many cases from those most able to provide vital support, such as family, teachers, and primary care providers (Mordoch & Hall, 2008; Polkki, et al., 2005; Maybery & Reupert, 2009; Ramchandani & Stein, 2003). Addressing stigma, including that which is perpetuated from within the workforce itself, is an important element of ensuring the needs of whānau impacted on by mental illness and/or addiction can be effectively met.

3.4 Concluding Comments
The way issues are described and constructed heavily influences the types of responses considered appropriate (Cunningham, 2011; Reid & Robson, 2007; Riele, 2006). A narrow understanding of the issues, leads to a narrow range of interventions being considered, and thus a narrow range of outcomes being realised. Interventions become problem and deficit focused, as opposed to solutions and strengths based. It can be suggested that the current narrow conceptualisation of COPMIA may do little to address a key barrier to ongoing COPMIA development; that is challenging an individually oriented mental health and addictions system. At worse, it presents as further reinforcing that barrier.

Realising an effective interface between Whānau Ora and COPMIA requires the overall focus is broadened to consider parents and their children within the wider context of collective wellbeing, with a focus on better understanding the wide range of interrelated issues which impact on realising whānau potential.

4.0 Future Key Areas of Focus
Four key areas are identified as requiring ongoing action for COPMIA to be effectively integrated within Whānau Ora. Described in more detail below, these are:

1) Whānau-centred Best Practice
2) Whānau-centred Systems Orientation
3) Whānau-centred Education, Training and Professional Development
4) Whānau-centred Knowledge Base

4.1 Whānau-centred Best Practice
As outlined earlier in this paper, Whānau Ora is realised through whānau-centred best practice. Whānau Ora recognises the wide range of potential opportunities to contribute to overall whānau wellbeing which present across the life course of all whānau members. Whānau Ora expects a systems approach to wellbeing, with a shift in focus from individual care to sustainable change which contributes to strengthening the collective wellbeing of whānau as a whole. Whānau Ora is of relevance to all agencies, services, and institutions that have the potential to impact on whānau wellbeing (Durie, 2013).
The link between Whānau Ora and the importance of a collective approach to improving outcomes for Māori is not new. For example, The Health Practitioners Competence Assurance Act 2003, Addiction Intervention Competency Framework (Addiction Practitioners Association Aotearoa, 2011), Let’s Get Real: Real skills for people working in mental health and addiction (Ministry of Health, 2008), and Real Skills Plus CAMHS (The Werry Centre, 2008) are all explicit in their expectations that competent mental health and addiction practitioners will demonstrate the ability to contribute to Whānau Ora for Māori.

The mental health and addiction workforce, both clinical and non-clinical, and including primary mental health and addiction, have a key role to play. It is imperative that mental health and addiction services: 1) routinely identify whether service users are parents; and 2) clearly assess the implications this has in terms of providing, or enabling access to pathways which both support service users in their role as parents, and address the needs of their children, within the broader context of the collective wellbeing of whānau.

Placing COPMIA within the context of Whānau Ora and whānau-centred best practice provides the context by which the relevance and importance of both asking these questions and taking actions are made clear. Reflecting the notion of whānau-centred best practice existing on a continuum, the mental health and addiction workforce are not being asked to address issues outside of their professional boundaries and expertise. They are, by implementing whānau-centred best practice, being asked to effectively play their role in contributing to Whānau Ora.

While the mental health and addiction workforce is an important focus, workforces (both regulated and non-regulated), across a range of other sectors (for example, education, justice, corrections, social development, labour, housing) have significant opportunities to contribute to maximising potential of children and young people, and effect meaningful and sustainable change for whānau.

As identified by recent New Zealand research, significant potential exists in primary health, a broad range of NGOs, education, community centres, and marae, as well as other agencies that have contact with families or children (Goodstadt, 2013). Services such as Child, Youth and Family, Group Special Education, and the Department of Corrections also have significant opportunities, via their close contact with whānau, to contribute to identifying and enacting access to pathways which address wider whānau impacts of parental mental illness and/or addiction.

A whānau-centred health and cross-sector workforce will have the capability to identify and respond appropriately, according to their specific settings, to the needs of children and young people. This requires a shared understanding of Whānau Ora, whānau-centred best practice, and the issues which specifically impact on children and young people affected by parental or whānau mental illness and/or addiction. In relation to COPMIA specific information, there is limited local research to draw off, and even less Māori-centred research. However, international research does highlight valid points of alignment with Whānau Ora. Any reviews of the workforce attitudes, knowledge and skills required to fully adopt COPMIA principles need to be undertaken within the context of seeking to realise a whānau-centred workforce.
Within whānau-centred best practice, issues such as those raised in previous sections will broaden the focus of COPMIA from a narrow and limiting mental illness and addiction prevention focus to one of realising whānau potential. The development of whānau-centred best practice models which integrate COPMIA competencies for application across the Māori and Non-Māori mental health, addiction, health and cross-sector workforces is an important area of further work. Such models should build on the developments already made in whānau-centred best practice, and explore the integration and implementation of whānau-centred best practice models within existing cultural competency frameworks.

**Whānau Ora Workforce and Kaupapa Māori COPMIA Interventions**

As previously emphasised, the expectation of a whānau-centred workforce is not that all members of the workforce have the capacity to address whānau needs, but that all members of the workforce play their part in contributing to the realising of whānau potential by enabling or providing access to pathways that support Whānau Ora. A key element of meeting the needs of children and young people impacted on by parental or whānau mental illness and/or addiction is the availability of services whānau can be referred to.

As is indicated by the recent DHB Survey 2012-2013 (Goodstadt, 2013), COPMIA specific initiatives in New Zealand are scarce, with much of the work that is undertaken carried out by NGOs. DHBs have reported variable interfaces with NGOs, ranging from no involvement to strong pathways of communication and referral. It is unknown how many of these referral pathways are specifically to Māori providers, or the level of capacity within Māori providers to address the needs of children and young people who are impacted upon by whānau members mental illness or addiction.

The dedicated Whānau Ora workforce provides culturally appropriate services by those skilled in working with whānau. Whānau Ora practitioners exemplify the combined application of all principles of Whānau Ora and whānau-centred best practice. Their focus and practice explicitly recognises whānau as a collective entity; endorses a group capacity for self-determination; has an intergenerational dynamic; is built on a Māori cultural foundation; asserts a positive role for whānau within society; and can be applied across a wide range of social and economic sectors (Durie, 2013).

Explicitly focused on facilitating a transformative process for whānau, Whānau Ora practitioners originate from a wide range of backgrounds, including community work, social work, nursing, health promotion, public health, and youth justice. They are expert practitioners able to go beyond crisis intervention to build skills and strategies that contribute to maximising outcomes for whānau as a whole. They are highly skilled in ascertaining whānau aspirations, mediating whānau tensions, and brokering opportunities for whānau to ensure whānau have access to the best possible services and resources (Durie, 2013).

Whānau Ora providers are optimally placed to meet the needs of children and young people impacted on by parental or whānau mental illness and/or addiction. Of importance is a focus on providing support which enables them to facilitate access to services which meet both generic and immediate needs, as well as the development of programmes designed to meet needs specific to children and young people impacted on by parental or whānau mental illness and/or addiction. There is limited local COPMIA specific research to draw off, and even less research which specifically identifies issues of importance for Māori.
However, the international research does highlight real points of alignment with Whānau Ora. Building Whānau Ora provider capacity in terms of growing the Māori specific COPMIA knowledge base and integrating this with Māori paradigms, practices and models is an important focus. The involvement of service users and whānau are critical to guide practice and resource development in this area.

4.2 Whānau-centred Systems Orientation
Developing and sustaining a workforce who contribute to Whānau Ora via addressing the needs of children and young people impacted on by parental or whānau mental illness and/or addiction requires systemic change within and across sectors. The effective implementation of whānau-centred best practice which integrates COPMIA competencies requires a flexible and integrated system of service delivery between primary and secondary service settings, as well as across different sectors where whānau present.

A whānau-centred systems orientation will: deliver flexible and sustainable funding streams which align with the total range of needs of children, young people and their whānau; facilitate effective communication and collaboration between agencies and across sectors, including clear referral pathways; and remove current service configuration disincentives for addressing the wider needs of whānau.

Achieving necessary systems change requires a focus on leadership across the policy, management, funding, planning and practice spectrum which is cognisant of the enhanced outcomes which result from supporting whānau centred best practice. This leadership will champion Whānau Ora and effectively communicate across communities, services and stakeholders expectations for whānau-centred best practice. Included within this is fully understanding how each component of the workforce can add value and support Whānau Ora.

Leadership should also support the development and effective application of consistent whānau-centred best practice models which integrate Māori paradigms, practices and models with COPMIA specific competencies.

Identifying effective mechanisms for building whānau-centred best practice leadership capacity is essential. Areas to further explore include: identifying the potential for existing Māori health leadership programmes to integrate content focused on whānau-centred best practice; identify the potential for existing generic health leadership programmes to integrate whānau-centred best practice as a key mechanism for addressing responsiveness to Māori; and supporting professional/regulatory bodies and workforce organisations to build leadership capacity which will support the integration and application of whānau-centred best practice across their workforces. Leadership which facilitates the implementation of education, training and professional development pathways to support whānau-centred best practice is also essential.

4.3 Whānau-centred Education, Training and Professional Development
Enhanced education, training and professional development pathways at all levels, and including those delivered by professional organisations and workforce regulatory bodies, underpin the development of whānau-centred workforces who have the capability to identify and respond appropriately, according to their specific settings, to the needs of children and young people impacted on by parental or whānau mental illness and/or addiction.
Areas for future activity include: reviewing relevant workforce education, training and professional development pathways to identify how they can be enhanced to better contribute to the development of a whānau-centred workforce; and reviewing existing competency frameworks to identify how they can be enhanced to better contribute to the development of a whānau-centred workforce able to address the impacts of COPMIA. Education, training and professional development pathways which explicitly integrate Māori specific COPMIA knowledge with Māori paradigms, and support development for Whānau Ora providers is also essential.

4.4 Whānau-centred Knowledge Base

There is limited research regarding the needs of children and young people who are impacted on by parental or whānau mental illness and/or addiction. In addition, research has tended to concentrate on deficits as opposed to strengths (Maybery et al, 2009), and be more focused on explaining areas of risk, as opposed to identifying sources of strength (Nicholson, et al., 2001). The views of children and young people themselves have been primarily invisible, and when they have been heard, have tended to be in isolation from the perspectives of the wider family. It has been identified internationally that there is a need for providers, consumers, and family members to be engaged as partners in generating evidence regarding the work they do, and in infusing that evidence into their ongoing activities (Nicholson, 2009).

With very little New Zealand specific literature, and an almost total absence of literature exploring this issue for Māori whānau, there is critical need to build a Māori-centred knowledge and evidence base as it relates to whānau-centred best practice and the needs of children and young people impacted on by parental or whānau mental illness and/or addiction. Understanding specific whānau needs, referral pathways, and the level of capacity within Māori providers to address the needs of children and young people are important areas.

Evaluation is a key element of building the knowledge base. Utilising a practice informed approach can contribute to growing the knowledge base of whānau-centred best practice, Whānau Ora service provision models, and the demonstration of outcomes relevant to Māori. It is recognised that operationalising an outcomes focus continues to be a challenge for a system based on the measurement of outputs. Data collection requirements must support whānau-centred best practice, and the ability to measure long term outcomes.

There should be a high emphasis on realising maximum utility from any research or evaluation activities via effective knowledge dissemination and application. Nicholson (2009) recommends researchers and evaluators build innovative research frames around practices or solutions generated in the community, as well as disseminate their research findings as quickly and creatively as possible to inform community efforts.

A whānau-centred knowledge base is explicitly underpinned by the following principles:

- is related to being Māori;
- is connected to Māori philosophy and principles;
- takes for granted the validity and legitimacy of Māori;
- takes for granted the importance of Māori language and culture; and
- is concerned with autonomy over our own cultural wellbeing as Māori (Smith, 2004).
Of note, is that a shared commitment to the collection of data able to inform the development of whānau-centred best practice across all relevant sectors is required. National data collections and publicly funded research must add value and result in positive outcomes for Māori. Incomplete datasets, particularly in relation to NGO service provision, and dominant analytical frameworks which adjust for difference or use population comparisons as key indicators do not serve to fully maximise opportunities to inform ongoing whānau-centred best practice.
References


Appendix 1

Documents reviewed to inform the development of this paper are listed below. It should be noted that the objective of reviewing these documents, particularly the DHB Annual, Regional, and Māori Health Plans, was to gain a broad indication of how Whānau Ora is being conceptualised and integrated across the health sector. It was not undertaken with the intent of making any comparisons between DHBs, nor to make any judgements on the specific activities or progress being made by DHBs.

Policy Documents Reviewed

- He Korowai Oranga: Māori Health Strategy (Ministry of Health, 2002)
- Report of the Taskforce on Whānau-centred Initiatives (Taskforce on Whānau-centred Initiatives, 2010)
- Ministry of Health Statement of Intent 2013-2016 (Ministry of Health, 2013)
- Youth Forensic Services Development (Ministry of Health, 2011)
- Healthy Beginnings: Developing Perinatal and Infant Mental Health Services in New Zealand (Ministry of Health, 2011)
- Addressing the Drivers of Crime (Ministry of Justice, 2009; 2011; 2012)
- Prime Minister’s Youth Mental Health Project (Ministry of Health, 2013)

DHB Annual, Regional and Māori Health Plans

- Northern District Health Board Annual Plan 2013-2014
- Northland Māori Health Annual Plan 2013/14
- Auckland District Health Board Annual Plan 2012-2013
- Auckland District Health Board Māori Health Plan 2013-2014
- Waikato District Health Board Annual Plan 2013/14
- Waikato District Health Board Māori Health Plan 2013/14
- Midland District Health Boards Regional Service Plan 2013/14
- Bay of Plenty District Health Board Annual Plan 2012-2013
- Tairawhiti District Health Board Māori Health Plan 2013/14
- Hawkes Bay District Health Board Annual Plan 2012/13 and Statement of Intent 2012-15
- Central Region District Health Boards Regional Māori Health Plan 2011
- Southern District Health Board Māori Health Plan 2013/14
- Nelson Marlborough District Health Board Annual Plan and Statement of Intent 2013/14
- Canterbury Māori Health Action Plan 2013-2014
## Appendix

### Table 1: Summary of Whānau ora/ COPMIA interface recommendations for workforce development initiatives

<table>
<thead>
<tr>
<th>Area of workforce Development</th>
<th>Type of Workforce Development</th>
<th>Audience</th>
<th>Focus</th>
<th>Responsibility</th>
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<td>Infrastructure Development</td>
<td>● Policy development</td>
<td>All</td>
<td>All</td>
<td>● Ministry of Health Te Kete Hauora Sector Capability/Implementation.</td>
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<td></td>
<td>● National COPMIA/Whānau Ora direction clearly articulated</td>
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<td>● Ministry of Health Te Kete Hauora Sector Capability/Implementation.</td>
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<td>● Resources</td>
<td>Leaders and managers</td>
<td>Legislation</td>
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<td>● Workshops</td>
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<td>Models of care</td>
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<td>● Seminars</td>
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<td>Leading collaboration and partnership working</td>
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<td>Tumu Whakarae</td>
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<td>Recruitment and retention</td>
<td>Training and Development</td>
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<tr>
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<td>Workshops Seminars Leadership and managers</td>
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<th>Practitioners Supervisors Leaders and managers</th>
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<td>Four workforce development centres</td>
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<tr>
<td>Tumu Whakarae</td>
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<tr>
<td>District Health Boards</td>
<td>District Health Boards</td>
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<tr>
<th>Topics addressed in organisational development and training and development</th>
<th>Whānau Ora / Whānau centre best practice</th>
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<td>Advocacy for Family and child-sensitive practice in education support to recruit practitioners</td>
<td>Parenting</td>
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<tr>
<td>Child abuse and neglect</td>
<td>Legislation and policy</td>
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<tr>
<td>Family work</td>
<td>Risk and Safety</td>
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<tr>
<td>Talking to children</td>
<td>Referral pathways</td>
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<td>Child’s Resilience Plan</td>
<td>Children’s Action Plan</td>
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<tr>
<td>Partnership and collaboration</td>
<td>FASD etc</td>
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| Information, Research and Evaluation | Evaluation  
Data collection with tangata whaiora, whānau and providers | Ministry of Health  
Workforce Centres  
Leaders and Managers | Review of initiatives whānau centred best practice  
Gaps analysis  
Data Collection | Four workforce development centres  
Ministry of Health  
Te Kete I-Auora |