Whakaora, Pae Ora: Health Principles and Psychotherapy

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Abstract

The *Health Practitioners Competence Assurance Amendment Act 2019* and the *Pae Ora (Healthy Futures) Act 2022* have had major implications for the delivery of health services in Aotearoa New Zealand, especially with regard to equity of provision and delivery and to engaging and working with Māori as tangata whenua. As part of the previous New Zealand government's restructuring of the health service, the *Pae Ora Act* set out certain principles for the health sector which this article discusses and applies to psychotherapy, and, specifically, with reference to two ethical codes and the standards of ethics for psychotherapists working in Aotearoa New Zealand. Notwithstanding the fact that the current New Zealand Parliament, dominated by the coalition government elected in October 2023, has repealed that part of the *Pae Ora Act* that established a separate Māori Health Authority as a way of delivering better outcomes, its principles remain in place and are important for psychotherapists practicing as health practitioners in this country.

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Whakarāpopotonga

Mai i te *Hau Ora Ture Tikanga Mātanga Whakahou Ture 2019* me te *Ture Hau Ora 2022* kua ara ake he raruraru tē taea pai ai te whakarite ratonga hau ora i Aotearoa,tuatahi tonu ki tērā e pā ana ki te taurite o te tohatoha rawa te whakauru me te mahi tahi i te taha o tangata whenua. I runga i tētahi wāhanga o te whakahounga o te ratonga hau ora a te kāwana o mua, i whakatakotoria ētahi mātāpono mā te wāhanga hau ora i roto i te *Ture Hau Ora* te take whakawhitinga kōrero pā atu ki te whakaora hinengaro, tōtika tonu ki ngā matatika e rua me ngā whakaritenga tikanga mā te hunga whakaora hinengaro e mahi ana i Aotearoa Niu Tīreni. Hāunga te take kua whakakorea te wāhanga me noho motuhake te Manatū Hauora Māori e te Pāremata o Aotearoa o nāianei, e ngarengarehia nei e ōna hoa kāwana i kōwhiria i te marama o Whiringa ā-nuku 2023, hei tohatoha whāinga pai ake, e noho tonu ana aua mātāpono ā, he mea tino rangatira mā ngā kaiwhakaora hinengaro e mahi mahi hau oranga i tēnei motu.

Keywords: *Health Practitioners Competence Assurance Amendment Act 2019*; *Pae Ora (Healthy Futures) Act 2022*; health principles; equity; Māori; psychotherapy; ethics.

Introduction

This article discusses the implications for psychotherapy of the *Health Practitioners Competence Assurance Amendment Act 2019* (hereafter "the *HPCA Amendment Act*") and the *Pae Ora (Healthy Futures) Act 2022* ("the *Pae Ora Act*"). It begins by giving some background to the practice and profession of psychotherapy in this country with reference to engagement with health and, specifically, Māori health. This is followed, in the second part of the article, by a discussion of the background to the *Pae Ora Act*. The third and final part of the article discusses psychotherapy in terms of the health principles outlined in the *Pae Ora Act*, and offers an analysis of the requirements of the *Pae Ora Act* with reference to the codes of ethics of both the Association of Psychotherapists Aotearoa New Zealand (APANZ), formerly the New Zealand Association of Psychotherapists (NZAP) (NZAP, 2018) and the New Zealand Association of Child and Adolescent Psychotherapists (NZACAP) (NZACAP, 2018), as well as *Ngā Taumata Matatika mā ngā Kaihaumanu Hinengaro | Psychotherapist Standards of Ethical Conduct* issued by the Psychotherapists' Board of Aotearoa New Zealand (PBANZ) (PBANZ, 2022). Although the current New Zealand Parliament, reflecting its control by the new coalition government elected in October 2023, has disestablished the Māori Health Authority, under the *Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill* 2024 (which was passed under urgency on 27 February 2024, completing all its Parliamentary stages in one day and receiving Royal Assent on 5 March 2024), the principles set out in the *Pae Ora Act* remain in place. It is therefore important that their significance is not lost in the noise relating to the removal of the Māori Health Authority and related problems caused by a government that has a focus on cutting public expenditure and which speaks of equality rather than equity. This article is the latest in a series of publications on psychotherapy in relation to the law in Aotearoa New Zealand, i.e., Tudor (2011a, 2017/2020, 2021), Tudor and Gledhill (2022), and Shaw and Tudor (2023).

Psychotherapy in Aotearoa New Zealand

Psychotherapy has been practiced in Aotearoa New Zealand for over 100 years. The first recorded reference to this practice appeared in the *Manawatu Standard* on Tuesday 31 May 1906 in a short advertisement titled "'Psycho-Therapy.' What is it?". The advertisement answered the question by quoting various overseas experts and concluding that:

> The above quotations cannot fail to convince the most sceptical that Psycho Therapy is a scientific and effective way of treating disease and should be tried by all who suffer, especially if OTHER MEANS HAVE FAILED. Try Psycho Therapy and GET WELL (Goodman & Goodman, p. 2)

In their excellent article, O'Connor et al. (2022) trace the history of references to psychotherapy in this country, framing them with reference to discourses of science, medicine, and psychoanalysis. Although the practice of psychotherapy was not widespread — writing in 1950, Beaglehole estimated that "at present there are probably no more than a dozen qualified medical psychologists and lay psychotherapists in private practice" (p. 41) — there had been enough interest to establish the the New Zealand Association of Psychotherapists three years earlier, in 1947. The fledging Association was very influenced by medicine: the original constitution stipulated that at least three of the seven Council members be medically qualified (see Dillon, 2017/2020; Manchester & Manchester, 1996). Moreover, there is no evidence, either prior to the establishment of the NZAP (as it was then) or in the early years of the Association, that psychotherapists in New Zealand were thinking about health in terms of te ao Māori, let alone mātauranga Māori. The first published mention of Māori is a reference to a paper/session at the 1986 Annual Conference titled "Understanding the Maori" (Manchester & Manchester, 1996, p. 86). Over the next eight years, the language — and, presumably, the thinking — changed; summarising the year 1994, Manchester and Manchester (1996) note that: "Haare Williams joined the [Council] meeting for a period for informal discussion of ways in which Council and the Association could move towards an increased bicultural awareness and commitment" (p. 104).

The subsequent history of this increased awareness and commitment to engagement with Māori is represented in a number of publications:

- On Māori involvement with psychotherapy theory and practice — Manawaroa Gray (2003), Morice (2003), Woodard (2008), Huata (2010), Morice and Woodard (2011), Shepherd and Woodard (2012), Woodard (2014), Morice et al. (2017/2020), and Williams (2018).
- On biculturalism and Māori involvement with and in the APANZ, including the development and establishment of Waka Oranga as the APANZ's Treaty partner — Bowden (2000, 2005), von Sommarunga Howard (2007), Carson et al. (2008), Hall et al. (2012), Hall & Poutu Morice (2015), and articles in O'Connor & Woodard (2020).
- On the engagement of Western psychotherapy and its different theoretical modalities with te ao Māori — Tudor et al. (2013), Palmer (2020), Tudor (2021), and O'Connor et al. (2022).

For as long as the APANZ has existed, there have been debates about the recognition and regulation of the profession of psychotherapy, and the regulation and registration of its practitioners and practice (for a summary of which, see Dillon, 2017/2020). After some debate over some years, in 2000 a majority of members of the then NZAP voted to pursue "Occupational Registration through Parliamentary Regulation" (NZAP, 2000, p. 100). Although psychotherapy was not included as one of the health professions under the *Health Practitioners Competence Assurance Act 2003* ("the *HPCA Act*"), after further lobbying, it was included in 2007, and, from 15 October of that year, the term "psychotherapist" became regulated and by statute and thus protected. Since then, only those practitioners who are registered with the responsible authority, i.e., PBANZ (or 'the Board"), may call themselves a psychotherapist. There were — and still are — arguments for and against state registration, arguments which are summarised and discussed in various contributions in Tudor (2011b, 2017/2020), not least regarding the fact that the *HPCA Act 2003* does not refer to Te Tiriti o Waitangi (Morice & Woodard, 2011; Tudor, 2011a), an omission that led Waka Oranga as a rōpu to oppose the state registration of psychotherapists, though it supports individual members' choice to register with the Board. This omission was the subject of a number of submissions to the 2012 review of the 2003 Act — from the Combined Counselling Associations of Aotearoa/New Zealand (2012), Dunedin Community Law Centre (2012), the NZAP (2012), the New Zealand Nurses Organisation (2012), Ngā Ao e Rua (2012), and the first author (Tudor, 2012) (see also Crockett et al., 2010). Notwithstanding these arguments, it is clear that psychotherapists in this country have positioned themselves as health practitioners and, as such, have obligations primarily under the *HPCA Act 2003* but also under the *HPCA Amendment Act 2019*, the implications of which with regard to cultural competence are discussed by Tudor (2021) and Shaw and Tudor (2022).

The background to *Pae Ora (Healthy Futures) Act 2022*

Since enactment, the *Pae Ora Act* has governed the public health system in Aotearoa New Zealand; until 2024, as explained above, delivery was through Health New Zealand (also known as Te Whatu Ora) and the Māori Health Authority (also known as Te Aka Whai Ora). These two national agencies replaced a system of regional District Health Boards.

It has become a feature of legislation in the country to have te reo Māori names as the lead of a statutory name. For example, the main statute relating to the care of children, which started life as the *Children, Young Persons and their Families Act 1989*, became the dually-named *Oranga Tamariki Act 1989/Children and Young People's Well-being Act 1989* as a result of the *Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017*, section 5 of which changed the name.

The *Oranga Tamariki Act 1989* also incorporates another feature of modern New Zealand statutes, namely the inclusion of principles that guide those exercising powers or otherwise operating under a statute. The *Oranga Tamariki Act* as enacted referenced such principles as maintaining links with "family, whanau, hapu, iwi, and family group" (section 5) and involving them in decision-making. Over time, these principles have been supplemented and amended, but remain in place, now including reference to matters such as rights under the *United Nations Convention on the Rights of the Child 1989* and the *Convention on the Rights of Persons with Disabilities 2006* — and now using macrons present in written te reo Māori.

The Pae Ora Act follows this model. The words "pae ora" in the health context take their meaning from the government's *He Korowai Oranga: Māori Health Strategy* (2014). This sets "pae ora" as the ultimate aim. In *The Guide to He Korowai Oranga: Māori Health Strategy* (Ministry of Health, 2014), it is noted that:

> Pae ora is a holistic concept and includes three interconnected elements: mauri ora — healthy individuals; whānau ora — healthy families; and wai ora — healthy environments. All three elements of pae ora are interconnected and mutually reinforcing, and further strengthen the strategic direction for Māori health for the future. (p. 3)

Noticeably, the policy document also prioritises te reo Māori in its name: the 2014 version was delivered during a government that was led by the National Party, which is again the lead party in the current coalition government.

The 2022 Act replaced the *New Zealand Public Health and Disability Act 2000*; this statute did not have a "principles" section, but it did set out purposes and also noted the importance of compliance with the Treaty of Waitangi (as it was referred to in the Act). The latter was contained in section 4, which noted that the statute contained mechanisms (in its Part 3) to have a Māori voice in decision-making and in service delivery. The purposes, set out in section 3, contained unsurprising provisions such as that of improving health outcomes and inclusion in society of persons with disabilities. There was also specific reference to the need to "reduce health disparities by improving the health outcomes of Maori and other population groups" (in section 3(1)(b)).

The structure of a system making some form of differential provision is long-established in New Zealand. The *Health Act 1920*, which established the Department of Health and provided for the appointment of a Minister for Health, included within the structure of the Department a separate "Division of Maori Hygiene" (section 4(2)(g)). (The *Health Act 1956* did not have such a Division.) The *Health and Disability Services Act 1993*, which introduced models of purchasing of health services, set out purposes relating to the improvement of health, but also mentioned in relation to the objectives of the Crown that these included reflecting the "special needs of Maori and other particular communities or people" (section 8(1)(e)).

The long-standing recognition of "special needs" can perhaps be seen as a short-handed reflection of the problem of differential outcomes. There is a right to health: this is expressed in the leading international standard, the *International Covenant on Economic, Social and Cultural Rights 1966* (*ICESCR* or "the *Covenant*"), as the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (article 12(1)). This includes obligations on the state to include "the creation of conditions which would assure to all medical service and medical attention in the event of sickness" (article 12(1)(d)). The more general obligation of states under the *ICESCR* is that steps be taken "to the maximum of its available resources, with a view to achieving progressively the full realization of" the rights set out in the *Covenant* (article 2(1)). This allows developing countries to accept the obligations in the *ICESCR* before they can afford to implement them in full. However, there is an additional point to note in that Article 2(2) of the *Covenant* requires that rights should be guaranteed without discrimination: this is not subject to resources, such that equality of outcome in terms of enjoying the “highest attainable” standard of health is not something that can only be required once resources permit.

The primary enforcement mechanism for the *ICESCR* is a regular review of actions of the relevant state to implement its obligations, leading to recommendations from the relevant UN expert committee. In its most recent review of New Zealand, the Committee on Economic, Social and Cultural Rights (2018) noted that:

> ### Right to health
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> 44. The Committee is concerned about the persistent gaps in the enjoyment of the right to health, with Māori and Pasifika experiencing the worst health outcomes. It is in particular concerned that Māori have higher rates of chronic diseases, experience higher disability rates and are negatively overrepresented in suicide and mental health statistics (art. 12).
> 45. The Committee recommends that the State party intensify its efforts to close the gaps in the enjoyment of the right to health by improving the health outcomes of Māori and Pasifika, in close collaboration with the groups concerned. In particular, the Committee recommends that the State party reinstate the Māori health plans, increase its investment in customary Māori public health systems and ensure that the groups concerned are represented and empowered in decision-making processes in health and disability policy, design, planning and delivery. It draws the State party’s attention to its general comment No. 14 (2000) on the right to the highest attainable standard of health.

“General comments” are the way that the relevant UN expert body sets out standards that are generally applicable, often informed by comments that are made repeatedly in concluding observations to specific states. In its General Comment no. 14, which relates to the right to the highest attainable standard of health under the *ICESCR* (Committee on Economic, Social and Cultural Rights, 2000), the Committee asserted that it was “useful” for it to provide guidance on implementing the right to health for indigenous peoples, and noted that steps to take included “the right to specific measures to improve their access to health services and care”, which includes such services and care being “culturally appropriate”. It also noted the specific requirement that “States should provide resources for indigenous peoples to design, deliver and control such services so that they may enjoy the highest attainable standard of physical and mental health” (para 27).

This General Comment is based on the prevalence in settler societies of worse outcomes for indigenous people. That this is the case in Aotearoa New Zealand is well-established. The correctness of the view of this Committee has been demonstrated comprehensively by the Waitangi Tribunal in its report, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Waitangi Tribunal, 2019). The Waitangi Tribunal’s conclusions and recommendations included:

1. That, as the *New Zealand Public Health and Disability Act 2000*, even with its policy of "partnership, participation and protection" (set out in He Korowai Oranga: Māori Health Strategy, from 2002 and updated in 2014), was not compliant with the obligations arising from the Treaty of Waitangi (See para 9.3.1 and ch 5), there be stronger language as to Treaty compliance and that a series of Treaty principles be adopted for the primary health care system (para 9.3.1).
2. That language reflecting a commitment to reduce inequalities or disparities be replaced by the need to achieve equity of outcomes (para 9.3.2).
3. That, as a reason for ongoing problems was that the Crown led operations, an independent Māori Health Authority (as an independent Crown entity) be established, and that there be discussion between the Crown and the claimants to discuss its structure (section 9.4). (At para 9.5.3, the Tribunal recommended interim improvements so as to redesign partnership arrangements to secure better outcomes, pending the creation of a separate authority.)
4. That the Crown and the claimants agree how to assess the extent of underfunding of Māori providers of primary health care, including compensation for historical underfunding (para 9.5.1).
5. That there be a stronger mechanism to secure accountability for any ongoing failure to secure equity in health outcomes, components of which should include data collection, annual plans, and a co-designed research agenda (para 9.5.2).

Note that an updated version of this report from 2023 is now what is available on the Tribunal's website, though the 2019 version is the one that was available when reform was proposed and initially implemented.

At the same time as the proceedings in the Waitangi Tribunal, the Health and Disability System Review was ongoing (Manatū Hauora | Ministry of Health, 2020). Its final report was produced in June 2020, and recommended that there be a Māori Health Authority and a new national body, Health New Zealand, to coordinate the delivery of services (with regional entities added to the existing District Health Boards). It also noted the importance of strengthening population health measures, making them foundational and integrated within the entire health system; and taking steps to ensure improved equity through better engagement with communities and an improved Te Tiriti relationship. There was specific reference also, and recommendations made, as to improved support for persons with disabilities.

The Government response was to introduce into Parliament the *Pae Ora (Healthy Futures) Bill* in October 2021. The Explanatory note to the Bill indicates that the Government accepted the need identified in the Health and Disability System Review to restructure the system so as to build healthy futures for all and do so with a particular eye on equity and giving effect to Te Tiriti. The latter required principles of the sort suggested by the Waitangi Tribunal. In short, the reforms proposed by the then-government rested on expert advice external to the Ministry of Health. However, in one important respect, there was a difference in that the Bill proposed the removal of District Health Boards, leaving Health New Zealand and the Māori Health Authority as the relevant bodies, with any regionalisation being a matter of organisation for them rather than being set out in the statutory framework.

Section 6 of the *Pae Ora Act 2022* as passed by the legislature requires that the Minister of Health, the Ministry of Health and "all health entities" are "guided by the health sector principles", and sets out the improvements designed to secure better compliance with Te Tiriti (along with such steps as the creation of the Māori Health Authority and various other bodies). The "health entities" are those bodies below the Ministry of Health who are responsible for delivery, namely Health New Zealand, the Māori Health Authority and three bodies that already existed and have continued in the new structure, namely the Health Quality and Safety Commission, Pharmac (the Pharmaceutical Managements Agency), and the New Zealand Blood and Organ Service. Whilst the new government has arranged for the legislative removal of the Māori Health Authority, section 6 still applies to the remaining structures. In addition, the *Pae Ora (Disestablishment of Māori Health Authority) Amendment Bill* 2024 amends the *Pae Ora Act* to require Health New Zealand to have systems to engage with and report back to Māori. A requirement in the 2022 Act to have a ministerial Hauora Māori Advisory Committee remains in place (with some modifications), as do obligations to have iwi-Māori partnership boards. (See sections 29–31 and 89 of the 2022 Act after amendment by the 2024 Act.)

Having given the background to this legislation, we now turn to the health sector principles.

Health sector principles

In this part of the article, we consider the principles as outlined in section 7 of the *Pae Ora Act* (reproduced in the Appendix); discuss these with reference to the discipline of psychotherapy; and compare these with existing principles and other considerations enshrined in the codes of ethics of the two main professional psychotherapy associations in Aotearoa New Zeland, i.e., the APANZ and the NZACAP, and the regulatory body for psychotherapists, the PBANZ.

From the first clause of Section 7 of the *Pae Ora Act*, and its 14 sub-clauses, we identify 11 principles: equity, respectful engagement, Māori autonomy, choice, cultural safety, representation, Māori-centredness, protection, promotion, collaboration, and prevention.

In relation to these principles, there are instances where the legislation refers to both Māori and other groups, but somewhere the reference is solely to Māori. The context is that the purposes set out in section 3 are to "protect, promote, and improve the health of… and build towards pae ora (healthy futures) for all New Zealanders" (sections 3(a) and (c)), but also to "achieve equity in health outcomes among New Zealand's population groups, including by striving to eliminate health disparities, in particular for Māori" (section 3(b)). In short, the overarching aims are to secure good health for all, which requires equitable outcomes for all groups but with particular attention for Māori needs.

Importantly, there are rules that govern how legislation is interpreted: section 10(1) of the Legislation Act 2019 requires that the meaning of statutory language involves reviewing the text, purpose and context of legislation. Hence section 7 is to be read in conjunction with section 3: but the context is clearly that the *Pae Ora Act* was a response to calls for equity and compliance with Te Tiriti because of failures in that regard.

This is akin to the principle well-established in the context of discrimination law that steps taken to counter existing inequalities are not discriminatory against the groups *not* mentioned because those groups are not behind. For example, Article 1(4) of the International Convention on the Elimination of All Forms of Racial Discrimination 1965 (ICERD) (United Nations 1965) indicates that "racial discrimination" is not made out by "[s]pecial measures" which are aimed solely to advance the interests of particular groups or individuals in light of their ethnicity "in order to ensure … equal enjoyment or exercise of human rights and fundamental freedoms". This standard has provisos: the steps are (i) "necessary", (ii) "do not … lead to the maintenance of separate rights for different racial groups" and (iii) cease once their "objectives … have been achieved".

This makes express what is implicit in the definition of racial discrimination in Article 1(1): this refers to differences in treatment based on ethnicity "which has the purpose or effect of" precluding the realisation of rights "on an equal footing". Bringing up towards equality those who are behind by offering additional steps not available to those already ahead is not discriminatory against those who are ahead. The context of this implicit and express allowance of differential treatment for those groups who are subject to existing inequality is that ICERD records in its preamble the reasons for its adoption. These include ongoing "manifestations of racial discrimination still in evidence in some areas of the world" and the need to "speedily" end them and give effect to the equality in dignity and rights on which the human rights regime is based.

Accordingly, there is nothing problematic in statutory principles that refer to certain ethnicities so long as they are designed to overcome existing inequalities: indeed, they are required for that purpose. The principles that include reference to "Māori and other population groups" are:

1. the general requirement for equitable access, levels of service and outcomes, and equity more generally (section 7(1)(a));
2. engagement in developing and delivering what is needed (section 7(1)(b), which also applies to "other people", no doubt designed to capture the needs of groups not delineated by ethnicity);
3. "choice of quality services" (section 7(1)(d))

The principle that applies to Māori alone is that "decision-making authority on matters of importance to Māori" (section 7(1)(c)): this continues to apply despite the abolition of the Māori Health Authority. Finally, population health and preventive approaches are required to protect all people's rights to health (section 7(1)(e), though section 7(1)(e)(ii) specifically requires such measures to protect Māori).

However, there is a problem in the way that these principles, including those that apply to specific groups, are operationalised. This is done through section 7(2), which requires health entities to be guided by them (the strength of which requirement is discussed above), but with the caveat that this is "as far as reasonably practicable, having regard to all the circumstances, including any resource constraints". As we have noted above, the right to health as set out in the *ICESCR* is subject to gradual realisation to the extent that resources permit, albeit that the maximum of available resources must be applied. However, the right to non-discrimination is not resource dependent. We have touched on this briefly above, but will reiterate and expand this.

The *ICESCR* requires in its Article 2(2) that the guaranteeing of the rights set out “will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status”: this does not contain any reference to gradual realisation or restriction according to resources. Indeed, Article 26 of the International Covenant on Civil and Political Rights 1966 requires that the state ensure that

> All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

This is supplemented by the language in documents such as ICERD about the need to have special steps taken to correct inequality that rests on ethnicity.

In summary, the allowance made in section 7(2) of the *Pae Ora Act* for resources to override the correction of inequity is inconsistent with international obligations to counter discrimination.

There are two other general matters to note before we turn to the details of the principles. One is to consider the strength of a requirement to “be guided by” the principles. This can be gauged by considering alternative phrases. For example, a requirement to “take into account” principles — which, for example, is the requirement of section 8 of the *Sentencing Act 2002* in relation to various principles which the legislature has established on how persons convicted should be sentenced — is an obligation to consider them but not necessarily to follow them. Lawyers speak of “mandatory relevant considerations” when referring to matters that must be considered but need not govern. The obligation to be “guided by” principles is a higher level of obligation. It suggests that the outcome must be consistent with the principles. The principles are therefore governing: admittedly, this will be somewhat fact specific in that it may be suggested that in a particular setting, one or more principles do not apply, or that one principle leads to a different direction to another, such that compromise is needed.

But what of the fact that the statutes express them to be binding on the “health entities” only? This does not mean that they are not relevant to individual practitioners who work within the health sector. On the contrary, the obligation resting on the health entities means that they have to structure their affairs so as to give effect to the principles; this in turn means that the way they engage with others, for example, regarding contractual arrangements, should be done in a way that incorporates these principles. In short, from a legal perspective, it may be that the way the principles are enforced vis-à-vis an individual practitioner is through contract law, whereas the health entities’ obligations are ones that arise directly under the statute and so are enforced through public law processes (most obviously, judicial review).

An additional general point is the change to referencing Te Tiriti o Waitangi rather than the Treaty of Waitangi. It is increasingly evident that Te Tiriti and the Treaty use different language, which supports the proposition that they mean different things (see Museum of New Zealand | Te Papa Tongarewa, 2024). We also note that the legislature heads section 6 as "Te Tiriti o Waitangi (the Treaty of Waitangi)", and notes that its requirements are "In order to provide for the Crown's intention to give effect to the principles of te Tiriti o Waitangi (the Treaty of Waitangi)", which may suggest that the legislature considers that Te Tiriti and the Treaty are equivalent on the context of these principles. That also may be so, but it may be not! In short, this is an issue which requires ongoing discussion and further research.

Now we consider each of the principles with regard to psychotherapy in general.

Equity

According to the World Health Organization (WHO) (2019), health equity is achieved "when everyone can attain their full potential for health and well-being." This requires identifying and eliminating discriminatory practices which are often embedded in institutional and systemic processes. Chin et al. (2018) argue that health inequities involve more than inequality, regarding health determinants and access to the resources needed to improve and maintain health outcomes. Creating and maintaining equitable health outcomes also requires "the removal of obstacles to health such as poverty, discrimination, powerlessness, and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare" (p. 803).

With regard to health in Aotearoa New Zealand, the Waitangi Tribunal (2019) bases this on the Treaty principles of equity, active protection, and options, asserting that:

> These principles require the Crown not only to recognise and provide for Māori to act in partnership with the Crown in designing and providing health services for Māori but also to design and provide services that actively pursue equitable Māori health outcomes. (p. 66)

It continues, that:

> The broad intentions behind the reforms to primary health care were to target funding and support according to need. In the same way, when applying Treaty principles to the question of health inequities, the principles do not make individual Māori the priority but rather make the inequities suffered by Māori as a whole a priority area for action. (p. 67)

Notwithstanding this, there remains some misunderstanding at best, or anti-Māori sentiment at worst, which confuses equal treatment with equality of outcomes. In terms of outcomes, equality requires that the disparities between Māori and other New Zealanders are reduced and eliminated. If this requires that services and resources are allocated and delivered in a way which addresses these disparities, then so be it. Moreover, Māori communities have their own specific needs and challenges, which require their own specific solutions. Equitable health outcomes for any population does not come about by a one size fits all approach (Lyndon et al., 2024).

Respectful enagement

Respect is a fundamental human principle if not a direct human right, though one might argue it is a meta-principle as the Preamble to the United Nations' (1948) *Declaration of Human Rights* includes the wording "to promote respect for these [following] rights". More locally, the APANZ includes respect as part of its definition of the principle of autonomy (NZAP, 2018).

With regard to respectful engagement, the *HPCA Act* included the clause "to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession" (s118 (i)9), which the *HPCA Amendment Act 2019* clarified in relation to working with Māori. The function became: "to set standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct to be observed by health practitioners of the profession" (s118 (i).2). Like it or not, psychotherapists as health practitioners are obliged to do this. Unfortunately, three years after this amendment, only four of the 17 responsible authorities (which regulate health practitioners under the original *HPCA Act*) had referenced this amendment for their respective health practitioners, and only two (the Medical Council and the Physiotherapy Board) had linked this specific cultural competence to the requirements of the *HPCA Amendment Act* (Shaw & Tudor, 2023). Elsewhere, Tudor (2021) offers a response to such respectful engagement.

Māori autonomy

Fundamentally, Māori autonomy requires that services are "for Māori, by Māori", which, therefore, requires the resources, including governance, authority, and control, to do so. Ultimately, Māori self-governance in the health sector (or any other sector for that matter) is a prerequisite for any long-term and lasting transformations in Māori health outcomes. Unfortunately, Māori cannot rely on, i.e., be at the mercy of, the short-term cyclic changes of government and governmental policies. Māori must have the opportunity, as *Pae Ora* put it, to "exercise decision-making authority on matters of importance to Māori" (s7(c)). One expression of Māori autonomy in psychotherapy in the advent of Waka Oranga (since 2010), is its development of an indigenous pathway to APANZ membership, and its engagement with the PBANZ to have it accredited as a training provider (though it remains unclear how this accords with its principled stance against the state registration of psychotherapists).

Choice

We consider this in terms of the freedom of choice to work with a range of health services that meet Māori cultural preferences, through mainstream services, kaupapa Māori, or Māori-centered services. Such services must provide for the needs and aspirations of whānau, hapū, and iwi. Due to the centrality of whānau within Māori communities, services should be designed to support the health and wellbeing of the whānau as a whole, rather than on an individual level. The implications of this for psychotherapy are, simply, free choice — for clients and for psychotherapy students/trainees. In this sense, we propose that the profession is person- and whānau-centred, rather than theory-, modality-, or organisation-centred.

Cultural safety

Both as a concept and a practice, cultural safety has a long and honourable tradition in this country (Curtis et al., 2019). Culturally safe and relevant practice at the service level would result in the creation of a health system of which Māori could take ownership or, at least, in which Māori could have some faith. In short, this means Māori would see themselves as active agents in the development, delivery, and engagement with health services in which Māori can thrive (see also section on Māori-centredness). Neither the APANZ, the NZACAP, or the PBANZ refer to cultural safety, though the New Zealand Psychologists Board (2011) does:

> Cultural safety relates to the experience of the recipient of psychological services and extends beyond cultural awareness and cultural sensitivity. It provides consumers of psychological services with the power to comment on practices and contribute to the achievement of positive outcomes and experiences. It also enables them to participate in changing any negatively perceived or experienced service. (p. 2)

This raises the question "Is Western — and Northern — psychotherapy culturally safe for Māori?" Huata's (2010) paper 'Māori psychotherapy: A cultural oxymoron' remains an important critique — and a wero for all involved in psychotherapy in this country to pick up and to which to respond.

Representation

While we don't assume that Māori will necessarily want to seek psychotherapy for issues of mental ill-health or illness, personality, relationship problems, and/or personal development, it is, nonetheless, important to consider the principle of representation. We consider this in terms of the number of Māori people experiencing mental ill-health and illness, etc. in relation to the number of Māori psychotherapists, which is high, and low, respectively, and, therefore, disproportionate. One challenge for the discipline of psychotherapy is to recruit more Māori into the profession. This must include:

1. Making psychotherapy relevant to Māori — which involves decolonising education/training programmes and the institutes in which they take place. While this process has begun, especially in the tertiary education sector, it has to reach parts of the independent/private sector; and, in both sectors, there are still too many examples of entry requirements that make it more difficult for Māori to consider training as psychotherapists, coupled with Eurocentric curricula and colonial attitudes.
2. On the basis that this is undertaken, by actively encouraging Māori to enrol in psychotherapy education/training programmes — which also involves having appropriate structures and processes to support their successful completion of a given programme.

Māori-centredness

Māori-centredness refers to both methods and methodologies which prioritise and respectfully and deeply engage with Māori knowledge, practices, and worldviews. In application, Māori-centredness involves active Māori participation in every aspect of the process, from planning to implementation and evaluation. Importantly, Māori-centredness is not only inclusive of Māori perspectives, but is based on and led by Māori values and priorities throughout. A major framework that conceptualises this is *He Ara Tika* (Hudson et al., 2010) which positions practice with, about, and around Māori values and perspectives

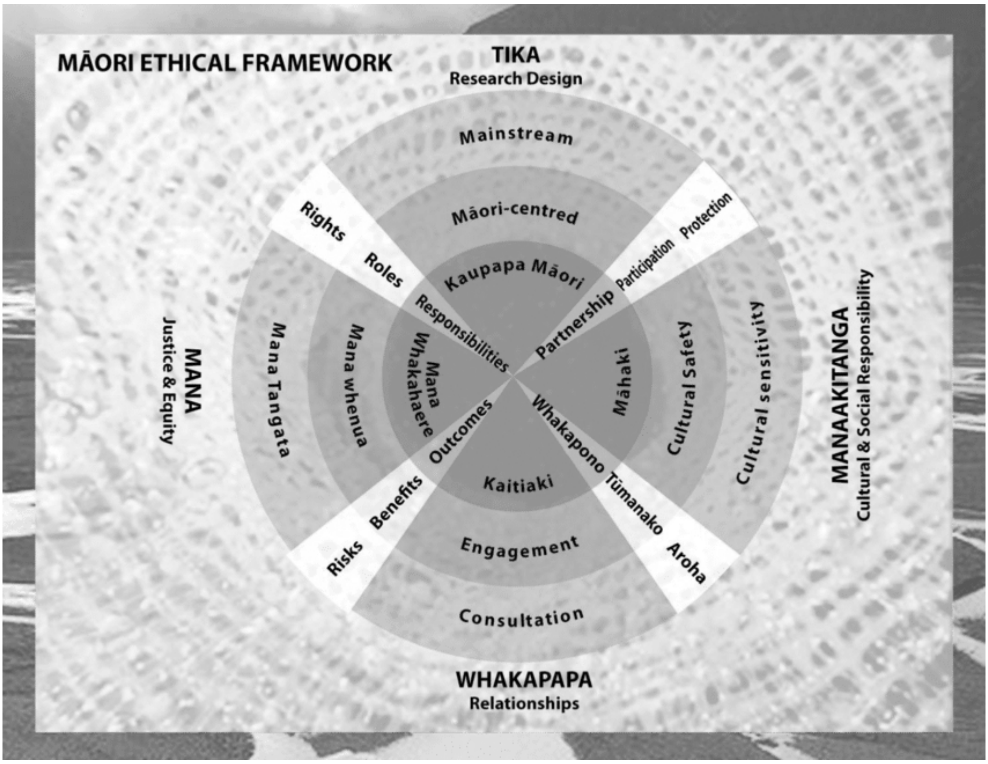

Figure 1. He Ara Tika (Hudson et al., 2010)

Notwithstanding that this framework is focused on research design, we consider that it can equally be applied to psychotherapy practice.

Protection

Health protection is one of the core fields of public health work. Ghebrehewet et al. (2016) define it as: “The protection of individuals, groups and populations through expert advice and effective collaboration to prevent and mitigate the impact of infectious disease, environmental, chemical and radiological threats” (p. 4). The inclusion of “environmental” in this definition of the taxonomy of threats is quite radical in that it encompasses threats from dominant systems. Given that the preamble of *Te Tiriti o Waitangi* envisaged relationships of care and protection (Berghan et al., 2017), we consider that, in our local (national) context, health protection requires community involvement, whereby Māori decide what health services are culturally relevant and effective. Thus, one important question psychotherapy and psychotherapists need to answer is: "Is psychotherapy protective of Māori?" As part of a wider response to this question, we consider that health policies governing and/or related to psychotherapy in this country must be aligned with Te Tiriti o Waitangi and to address specific Māori needs as decided upon by Māori. Furthermore, it is imperative that barriers such as cost, distance, language, and other cultural considerations are addressed and worked with mana-enhancing and nonjudgmental and empathic care.

Promotion

Health promotion is a distinct professional discipline and generally understood as a process of enabling people to take control over their health (WHO, 1986). As Berghan et al. (2017) observe,

> It can involve community work, policy development, advocacy, and empowerment as well as working in settings where people live, work and play. It is different from other public health approaches, such as immunisation or health literacy, as it is overtly driven by values, and is often political in its attempts to transfer power to communities and strengthen social justice. (p. 9)

Adopting this view means that psychotherapists need to promote psychotherapy as being of value to clients and, in this context, especially, Māori. In this context, one important question psychotherapy and psychotherapists need to answer is: "How effective is Western — and Northern — psychotherapy for Māori?"

Collaboration

Collaboration is ultimately about trust. In terms of Māori health, collaboration means trusting that Māori have ways of working and strategies, that can improve Māori health outcomes, with non-Māori agencies willing to listen and work with Māori to implement and support those strategies. However, research has found that both at the advisory and policy-making levels, collaboration more often looks like non-Māori agencies "consulting" with Māori health advisors but then devaluing their experience, knowledge, and interests (Came et al., 2019). Senior Māori leaders and health advisors in the study conducted by Came et al. reported that they "experienced racism and tokenistic engagement. Some indicated it took considerable effort to establish credibility, be heard, have impact, and navigate advisory meetings, but even then their inputs were marginalised" (p. 126). With regard to psychotherapy, such concerns need to be addressed or, preferably, avoided. Overall, with regard to the main Western — and Northern — approaches to psychotherapy which form the mainstream in this country (see Tudor et al., 2013), there needs to be more genuine recognition of and deeper engagement with Māori knowledge and worldviews. Collaboration requires non-Māori psychotherapists to support Māori to be Māori — whether as clients, practitioners, and, hopefully, the next generation of educators/trainers — and to engage with Māori in culturally appropriate ways.

Prevention

Adopting approaches that prevent, reduce, or delay the onset of health needs and improve Māori health and wellbeing is not only of benefit to Māori, but to all New Zealanders (Came, et al., 2019). As such, early intervention is critical to beneficial and positive long-term outcomes. Yet research consistently shows that Māori face more significant barriers to accessing healthcare than other New Zealanders (Manatū Hauora | Ministry of Health, 2023). These include: systemic racism (manifested in unwelcoming spaces and longer wait times); socioeconomic challenges (i.e., lower incomes affecting affordability, and lack of transportation); and geographical barriers (i.e., living in rural or remote areas, or in areas with no or few psychotherapists). Here, there is potential for psychotherapy as a practice, and psychotherapists as practitioners, to address these barriers and, more broadly, to look at ways to make itself/themselves more visible, relevant, and inviting to Māori.

Health principles in psychotherapy

In the context of psychotherapists being health practitioners, in this section, we turn our attention to reviewing certain principles within the field of psychotherapy as health principles in psychotherapy, before offering a comparison of them with those from the *Pae Ora Act 2002*.

The APANZ

The APANZ articulates five core principles and values of the Association which provide a guide for responsible practice and which "constitute the main domains of responsibility within which ethical issues are considered." (NZAP, 2018, p. 1) The principles are:

- Autonomy: respect for the client's and the therapist's right to be self-governing.
- Beneficence: a commitment to act in the best interests of the client.
- Non-maleficence: a commitment to avoid harm to clients.
- Justice: a commitment to the fair and equitable treatment of clients under Te Tiriti O Waitangi to Tangata Whenua, Pakeha, and Tauiwi, providing fair and equitable treatment for all people regardless of age, gender, sexual orientation, ethnicity, religion, disability, and socioeconomic status.
- Interdependence: a commitment to maintain relationships of reciprocity and respect with all living beings including, the natural environment. (p. 1)

It also names three additional values which it views as "Central to the ethics of psychotherapy in Aotearoa/New Zealand... [of] Integrity; Trust; [and] Respect." The APANZ also refers to upholding the principles of Te Tiriti o Waitangi. It refers to equity in a clause under the heading "3. Psychotherapists' responsibilities to the community", i.e., "3.4 Promote equity. Psychotherapists shall seek to improve social conditions through the fair and equitable distribution of community resources" (p. 4).

The NZACAP

The NZACAP (2018) states that its *Code of Ethics* serves a number of purposes:

> It provides a statement of what clients and the general public may expect from the Association and its Members. It helps define professional autonomy in relation to employing institutions. It indicates the standard on which the commitment to maintain and improve services to children and families is based. It reinforces the cohesion of the Association and offers Members a resource for understanding the nature of responsible practice. (Clause 37.1, p. 22)

It incorporates a social as well as an individual ethic "because of the influence of institutional policies and practices and broader social factors on the welfare of children and their families or caretakers" (Clause 37.1, p. 22). It refers to equity when it states that the Association and its members "have an obligation to advocate for adequate social provision and social equity for children and adolescents in the community at large" (Clause 37.1, p. 23). In terms of principles, it refers to those of respect and social justice.

It also refers to the intention that their members "shall seek to understand how the principles of Te Tiriti o Waitangi influence and guide the practice of their work" (Clause 37.1, p. 23).

The PBANZ

The PBANZ introduce its *Standards* (PBANZ, 2021) with a strong reference to Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand. It continues:

> In upholding the Standards of Ethical Conduct, psychotherapists should have regard to the principles derived from Te Tiriti, be knowledgeable about Te Ao Māori (the Māori world view) and be sensitive to the pillars / pou of Māori health and wellbeing. (p. 2)

It then states that:

The following principles / mātāpono underpin the Standards of Ethical Conduct.

- Autonomy / Mana Motuhake
- Respect / Whakahōnoretanga
- Care of others / Tiaki
- Integrity / Mana Tangata
- Justice / Mahi Pono
- Whanaungatanga / Community
- Ūkaipō / Nurturing
- Manaakitanga / Hospitality and kindness
- Wairuatanga / Spirituality
- Pūkenga / Expertise (PBANZ, 2021, p. 2).

We recognise that the APANZ's and the NZACAP's codes of ethics predate the *HPCA Amendment Act 2019*. The PBANZ's *Standards* state specifically that they "have been developed by the Psychotherapists Board of Aotearoa New Zealand under section 118(i) Health Practitioners Competence Assurance Act 2003" (p. 1), but, despite being revised in 2022, do not refer to the *HPCA Amendment Act 2019*. In any case, Table 1 summarises these three documents in the light of the principles of *Pae Ora* (which we have identified from Section 7 of the *Act*) in order to assess both the existing congruence between these documents and the *Act*, as well to highlight work to be done by these bodies and, more broadly, the field of psychotherapy in order to align with this *Act* and the political and social shift it signals and represents.

Table 1 Health principles and psychotherapy

Health principles as enshrined in Pae Ora (Heath Futures) Act 2022 (Section [s]7)	**Comments — include material from Waitangi Tribunal**	**Code of ethics (NZAP, 2018)**	**Code of ethics (NZACAP, 2018)**	**Standards of ethical conduct (PBANZ, 2022)**
Equity — with regard to access, levels, and outcomes (s7.(1)(a)) and improvement and treatment (s7.(1)(e)(iii))	Ōritetanga (equitable outcomes) (Te Tiriti o Waitangi, Article 3). Note the importance of outcomes, which may entail doing things differently. See also *Hauora* (Wai 2575) (s9.3.2, s9.5.2).	Equity related to justice in terms of the fair and equitable treatment of clients under Te Tiriti o Waitangi and for all "regardless of age, gender, sexual orientation, ethnicity, religion, disability, and socioeconomic status" (p. 1). "Psychotherapists shall seek to improve social conditions through the fair and equitable distribution of community resources." (clause [c]3.4)	The Association and its members "have an obligation to advocate for adequate social provision and social equity for children and adolescents in the community at large" (c37.1, p. 23).	No reference.
Respectful engagement – with Māori and others (s7.(1)(b))	With regard to cultural competence "(including competencies that will enable effective and respectful interaction with Māori)" (*HPCA Amendment Act 2019* (s37(2)). See also the reference to the principle of partnership in *Hauora* (Wai 2575) (s9.3.1).	(Respect)[1]	(Respect)[2]	Notes this requirement of the *HPCA Amendment Act 2019* but gives no guidance on it.[3]

Māori autonomy (decision-making authority) (s7.(1)(c))	Tino rangatiratanga (sovereignty) (Te Tiriti o Waitangi, Article 2). Kawanatanga (co-governance) (Te Tiriti o Waitangi, Article 1). For a reference to "The guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of primary health care", see *Hauora* (Wai 2575) (s9.3.1); for the recommendation for a Māori Health Authority (s9.4); and for the final recommendation for such an entity (s10.2).	(Respectful relationships)[4]	(Professional autonomy)[5]	(Autonomy as a principle)[6]
Choice – of quality service, including resourcing iwi, hāpu, and whānau (s7.(1)(d))	Tino rangatiratanga (sovereignty) (Treaty of Waitangi, Article 2). Kawanatanga (co-governance) (Treaty of Waitangi, Article 1). As to funding, see *Hauora* (Wai 2575) (s9.5.1).	"Psychotherapists shall foster client self-determination and choice, except where these may cause harm to self or others." (c1.9)	"Child and Adolescent Psychotherapists should seek to increase the range of choices and opportunities that meet the needs of children, adolescents and families." (c27.3.(iii), p. 24)	Refers to client choices (c1)5.), also with regard to the needs of children and adolescents (c2)4.), informed choices (c7)1.); also, when describing tiaki/to take care of, acknowledges the client's vulnerability to the choices practitioners make, and, when describing whakahōnoretanga/respect, acknowledges the right of others to make choices.
Cultural safety (s7.(1)(d)(ii))	Implicit in the material listed above, particularly in relation to respectful engagement but also equity and choice.	No reference.	No reference.	No reference, though, in its document on *Psychotherapist Cultural Competencies* (PBANZ, 2019), the Board does refer to the fact that "All psychotherapists will be knowledgable of culturally safe practices" (p. 3).
Representation (s7.(1)(d)(iii))	Implicit in the material listed above, particularly autonomy; see also *Hauora* (Wai 2575) (s9.5.3).	No reference.	No reference.	No reference.

Māori-centredness (i.e., reflecting matauranga Māori) (s7.(1)(d)(vi))	Implicit in the material listed above, including equity, respectful engagement, autonomy and choice.	No reference.	No reference.	No reference.
Protection (s7.(1)(e))	Implicit in the material mentioned above, particularly equity; see also *Hauora* (Wai 2575) (s9.5.3).	"Protect client well-being … Psychotherapists shall have regard for the needs of clients who are unable to exercise self-determination or to ensure their own personal safety and act to protect the clients' best interests, rights and well-being." (c1.10)	No reference.	Has one reference to child protection.
Promotion (i.e., health promotion) (s7.(1)(e))	Implicit in the material mentioned above, particularly equity; see also *Hauora* (Wai 2575) (s9.5.3).	No reference.	No reference.	No reference.
Collaboration (s7.(1)(e)(iv))	Implicit in the material mentioned above, particularly equity; see also *Hauora* (Wai 2575) (s9.5.3).	No reference.	No reference.	Notes this requirement of the *HPCA Amendment Act 2019* (with regard to the delivery of health services) but gives no guidance on it.
Prevention (s7.(1)(e)(v)	Implicit in the material mentioned above, particularly equity; see also *Hauora* (Wai 2575) (s9.5.3).	No reference.	No reference.	No reference.

Notes

1. Contains ten references to respect.
2. Identifies respect as a principle.
3. Refers to forming "respectful relationships with clients based on clear, open and honest communication" (c1)4.), and with colleagues (c9)1.).
4. Autonomy is defined in terms of "respect for the client's and the therapist's right to be self-governing" (p. 1).
5. Is framed as helping to define professional autonomy.
6. Has a principle of autonomy, which is translated as mana motuhake.

Conclusion

The *HPCA Amendment Act* and the *Pae Ora Act* have profound implications for all health practitioners in this country, including psychotherapists. The discipline and profession of psychotherapy may be a little behind in responding to the requirements of the *HPCA Amendment Act*, but, given that it has principles by which it operates, and given the APANZ's commitment to a Tiriti-based relationship with tangata whenua, and informed not least by the analysis this article offers, we would hope that it is in a good position to respond.

Appendix: Health sector principles (section 7 *Pae Ora (Healthy Futures) Act* 2022

(1) For the purpose of this Act, the health sector principles are as follows:
  (a) the health sector should be equitable, which includes ensuring Māori and other population groups—
    (i) have access to services in proportion to their health needs; and
    (ii) receive equitable levels of service; and
    (iii) achieve equitable health outcomes:
  (b) the health sector should engage with Māori, other population groups, and other people to develop and deliver services and programmes that reflect their needs and aspirations, for example, by engaging with Māori to develop, deliver, and monitor services and programmes designed to improve hauora Māori outcomes:
  (c) the health sector should provide opportunities for Māori to exercise decision-making authority on matters of importance to Māori and for that purpose, have regard to both—
    (i) the strength or nature of Māori interests in a matter; and
    (ii) the interests of other health consumers and the Crown in the matter:
  (d) the health sector should provide choice of quality services to Māori and other population groups, including by—
    (i) resourcing services to meet the needs and aspirations of iwi, hapū, and whānau, and Māori (for example, kaupapa Māori and whānau-centred services); and
    (ii) providing services that are culturally safe and culturally responsive to people's needs; and
    (iii) developing and maintaining a health workforce that is representative of the community it serves; and
    (iv) harnessing clinical leadership, innovation, technology, and lived experience to continuously improve services, access to services, and health outcomes; and
    (v) providing services that are tailored to a person's mental and physical needs and their circumstances and preferences; and
    (vi) providing services that reflect mātauranga Māori:
  (e) the health sector should protect and promote people's health and wellbeing,

including by—
  - (i) adopting population health approaches that prevent, reduce, or delay the onset of health needs; and
  - (ii) undertaking promotional and preventative measures to protect and improve Māori health and wellbeing; and
  - (iii) working to improve mental and physical health and diagnose and treat mental and physical health problems equitably; and
  - (iv) collaborating with agencies and organisations to address the wider determinants of health; and
  - (v) undertaking promotional and preventative measures to address the wider determinants of health, including climate change, that adversely affect people's health.

(2) When performing a function or exercising a power or duty under this Act, the Minister, the Ministry, and each health entity must be guided by the health sector principles—
  - (a) as far as reasonably practicable, having regard to all the circumstances, including any resource constraints; and
  - (b) to the extent applicable to them.

(3) In subsection (1)(d), **lived experience** means the direct experience of individuals.

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