Neuro-Rehabilitation with Maori

Garry McFarlane-Nathan, September 2014

He Kai Ana Aku Ringa

‘Food comes from my hands’.

‘Our hands bring forth kai / resource’.

1. **The Ethics of working towards a successful intervention and useful outcomes with Maori versus the time, resource constraints, and sometimes unrealistic expectations imposed by ‘those who pay us’.**

Too many clients and not enough time to establish successful interventions.

Referral rates influenced by client turnover with little regard for client outcomes.

Poor outcomes with Maori are so prevalent that successful outcomes become exceptional. So its easy to be ambivalent as a clinician and as long as you get your paperwork in no one really notices.

Each of us as working clinicians need to consider these matters, where we stand with such tensions

and conflicts, and how this influences our practice. (This may be a private or public process).

Supporting successful outcomes with Maori takes time.

2. Growing compliance in Maori clients

Maori are more non-compliant than any other client population.

They may turn up, and then still be non-compliant by choosing not to (often not knowing how to) become an active partner in the neuro-rehabilitative process.

Many Maori just wont turn up at all. Some may do, but so intermittently that in concert with TBI-related new learning difficulties any significant intervention remains unlikely.

The logistics of getting to sessions:

Can’t manage bus, car, fuel costs.

Financial management, resourcing issues (perhaps poor previous to the TBI, and now even further compromised).

Often worse in rural areas.

Feeling too shy (unsafe) to come alone and korero at close quarters with a sttanger.

Often preferable to treat Maori clients at home as they are more likely to be present. Can be difficult with noise, children, music, ‘social’ gathering, psychologist’s sense of safety.

NeuroPsych interventions ultimately need to be experienced as ‘useful’ by clients and/or their partner/whanau. Empathy, sympathy, reinforcing strengths, support in re-establishing ‘what they feel they have lost, (what have they lost?), support in learning to work around cognitive deficits, support in minimising what they (or their partner/whanau) see as post-TBI risks.

Enabling a sense that ‘;this is what has happened to me, this is how it has affected me and those around me, this is what I can work towards to minimise these things, a pathway to ‘make things better (at least better than they are now!)

3. **Assessment and treatment planning. (Initial Assessment and the constant modification and refining of interventions as new material is discovered and as treatment progresses)**.

Initial assessments can gain lots of additional information from observation ‘in situ’, as in being at the Maori client’s home.

<u>Neuropsych Report (‘When done by others’.)</u>

- Critical Interpretation. Level of qualitative material presented? How did the assessor form their conclusions? How useful or not is it in informing us as clinicians in order that we can meet the neuropsych-related needs of the Maori client?
- The treatment phase of neuro-rehabilitation enables the building of a collaborative working relationship, and the space and time to gather lots of important material.

Partner/Significant others being present at least initially, and then periodically if possible: Need to establish their perspective of pre and post injury cognitive and behavioural ability. What do they see

as having been lost by their partner? What do they see as still being present in their partner? Pre and post emotional lability, anger/violence, depression, fatigue, motivation, substance use. We need their partner and whanau to invest in and support the neuro-rehab process.

Establishing behavioural and cognitive norms, historical versus immediately pre-injury.

What was their ‘cognitive-life’ like pre-TBI for the client? What were their ‘normal’ cognitive structures, cognitive abilities, and behaviours.

Whanau and community life: Historically and at the time of the index injury. They may have been ‘dragged up’, not ‘brought up’ and so to what degree has their cognitive resource and behavioural display retained those influences?

Their pre-injury cognitive ability may be indicated by their propensity to survive in hostile environments. Perhaps they were ‘trained’ to be reactive (and creative) as dictated by necessity, rather than consciously considering situations in advance and then making plans accordingly. So insight and forethought may be less conscious and more intuitive.

Formal education can enable the acquisition of extra-environmental cognitive skills (for Maori from so-called deprived backgrounds), such as a more complex ‘inner-vocabulary’, an increased awareness of ‘cause and effect’ relationships, an increased ability to consciously consider one’s own actions and behaviours, and how these effect oneself and others. So how much schooling did they get through and how useful has it been in giving them cognitive tools and strategies?

Pre-index injury work roles: Most recent, previous, historic, work history generally, degree of structure present in the workplace, did they need to pre-plan, did they have responsibilities. Challenging work experiences can often be as effective if not more so than formal education. For many Maori from harsh or abusive backgrounds (that is, for a significant proportion of Maori), work has often been a turning point in their lives, bringing a sense of achievement, of positive social cohesion, such as they had not experienced previously.

4. Treatment (Should be a dynamic process for both parties)

Growing a collaborative overview of what kind of pre-injury insight they operated with, how they learnt to deal with problem solving in their whanau, community, and work role contexts, the kind of ‘inner-vocabulary’ they used, how aware they were of ‘cause and effect’ relationships, and to what degree they consciously planned and carried out their days, weeks, months, lives. This process is a significant intervention and treatment.

Growing a collaborative measure (as noted by self and partner/whanau) of their post-injury degree of memory loss, insight, emotional dysregulation, impulsivity, and the impact it has had / is having upon their partner/whanau, work role. This process is a significant intervention and treatment.

Growing a neuropsychological analysis

- Providing plain language notes and reading material to client and partner/whanau around TBI-related memory loss, organisation and planning difficulties, reduced impulsivity, emotional lability, reduced insight.

- Reinforcing these when discussing both pre and post injury cognitive ability and behaviour.
- Supporting them in attending meetings of the Brain Injury Associated and/or similar gatherings of those who have sustained and live with a TBI.

A succinct, collaborative, written summary at the conclusion of each session. (Carbon paper's useful). Then starting with this summary at the beginning of the next session

Ascertaining the extent and quality of their working relationship with occupational therapists and supporting them in contextualising the functional training they are gaining. Particularly around fatigue management, organisation, and planning.

Calendars and white boards.

<u>Fatigue management and substance abuse</u>.

- Alcohol, Cannabis, often used to help go to sleep and/or to chill out.
- Methamphetamine abuse is prevalent in many Maori communities and whanau. May be used post-TBI to offset fatigue and reduced motivation, to 'help get things done'. Often becomes a prelude to anger and frustration,

then becoming increasingly abusive and violent.

Anger and Violence

Fatigue management invaluable.

Increasing a sense of being able to intervene into their TBI-related deficits, of knowing more about themselves than previously, of discriminating between the head-injury and ‘themselves’.

May have been violent and abusive previously, but now more so.

Psychologist may have to intervene for the sake of partner and whanau.

5. Consolidation and integration of compensatory strategies post-rehabilitation

- Partner and whanau will reinforce what seems most practicable.
- Fatigue management works! Its amazing, you just have to get them to do it! Whanau and partners really support fatigue management.
- Memory management, organisation and planning strategies. More likely to be operated

and retained by those whose partner and/or whanau themselves utilise structure and pre-planning.

- Clients who used cognitive strategies pre-injury will look to re-engage and retain these post-injury.
- Clients who have successfully learnt about cognitive tools and compensatory strategies during neuro-rehab will need whanau-support to reinforce and consolidate these post-neuro-rehab. If their partner and whanau do not consciously utilise structure and planning in their daily lives then reinforcement will not accrue and retention and integration into their lives becomes unlikely.