

At the frontline: An evidence snapshot of pandemic risks in South Auckland that need to be addressed

A rapid (frontline) evidence brief for the government prepared by Professor Ian Lambie (DSA Justice Sector) as a voice for local staff.

Introduction

Vulnerable communities are identified worldwide as facing disproportionate harm from the health, economic and social effects of the COVID-19 pandemic.¹ They have higher rates of the respiratory and cardiovascular diseases² that are associated with poverty, overcrowded and poor housing, and social deprivation.³ ⁴They are also overrepresented in family violence statistics.⁵ Access to primary care is negatively affected by lack of resources such as money and transport or phone/internet for virtual consults, and by individualistic care approaches⁶ and variable commitments to equity- and Treaty-based practice.⁷ Lack of access to digital devices and data compromise health literacy, employment and educational prospects.⁸ ⁹ The effectiveness of communication on pandemic health risks depend on how the life circumstances, cultural values and perspectives on risk influence people's behaviour.¹⁰ The pandemic may be global but the evidence suggests it is the local health inequities that will be significantly exacerbated, with lack of community capacity and mobilisation in deprived areas a block to providing timely testing and assistance to patients and families affected.¹¹ Furthermore, there is evidence that local solutions, that are culturally led (for example, 'by Māori, for Māori', by Pacific, for Pacific), are vital in producing creative, sustainable health and social actions.¹² ¹³ ¹⁴

The following is a snapshot of information from people working in South Auckland. Services and speakers have not been identified, as there are issues about the confidentiality of those they work with, plus constraints on who is permitted to speak on behalf of whom. In my role as a clinical psychologist and justice science advisor (and formerly a registered comprehensive nurse), I have networks in both senior nursing and allied health that I reached out to, as I was not sure we were hearing sufficiently from those most at risk.

Let's start with this call to action from a reputable service-provider:

*The key premise underlying our **face-to-face approach** in the community is the commitment to continue to walk alongside our whānau during their hardest times, and to continue our commitment that we will always be there for our people when they need us.*

We understand that poverty and the pressure of the pandemic/lockdown has led to a significant increase in the way people struggle to manage stress, including a large increase in family violence, substance use, mental health and anxiety across the South Auckland population and community where they live.

We can take preventative action.

Specific challenges to families are first outlined in *Ten challenges*. Then, some points of success are described, followed by ideas on preventative service delivery – that is, preventative of disproportionate harm from COVID-19 to those we work with, compared to others who have access to more resources. *The word on the street* summarises some concerns from services, like food banks, GPs, the OT call centre, who are based in these communities and cannot function as they would normally. A short list of *Principles* concludes this brief report; these could be elaborated in decisions made to address the 10 challenges.

1. Ten challenges

Usual processes and access to resources have been very difficult. That means there is a risk of undetected COVID-19 cases, as well as other undetected harm. These 10 challenges are not supposed to be all-encompassing but capture key issues that staff were concerned about.

1. **Testing.** Whānau do not know where to access help to be tested for COVID-19, when they should go, how and where they should go, and struggle to access their GP/Healthline to discuss this. They are left feeling scared and frustrated. In addition, a phone call to the GP costs money on their mobile phone, and they do not have credit to phone them. This means many children and whānau are sitting at home significantly unwell, for issues that **do** require medical attention. Whānau consistently say that they cannot get through on the Healthline phone number - waiting 2 hours *without answer* remains common. People have been told they need a test by Healthline, but they have no transport to get there. It is not appropriate for the staff members/support workers who might normally provide transport to do so, due to the individual being unwell.
 - a. **Outreach testing.** There needs to be outreach testing – organisations would be happy to do so but need to be resourced. *People are turning up to ED as the only port of call; they're given some sort of card to access a 24-hour medical emergency centre, but the nearest place might be miles away in Botany. Also, if the family has been dropped off at ED by a support worker, they therefore have no transport to get somewhere like Botany; or they have to stay at ED until the next day when they can catch a train home.*
 - b. **Need to conduct mobile testing with our vulnerable communities.** *Have a testing clinic at the local church or on the street, close to their homes. Work with churches and faith groups to increase accessibility; have community people who can help mobilise and reassure families to get tested. Work with Police to target those at-risk in at-risk communities.*
2. **Medical care.** Families have been told that they do not meet the criteria for a face-to-face visit to the GP when that seems inaccurate (for example, a child who had a significant cough and respiratory concerns). *Alternately, others are referred to ED, only for ED to be wondering why it has come to them when it is a matter that can be managed by GPs.*
3. **Usual agencies not available.** The fact that support agencies are mostly not doing face-to-face visiting has been very problematic. Through plans set up at family group conferences (FGCs), mandated by Oranga Tamariki (OT) or directed by the Family Court from police/social work/OT referrals, families are often told to rely on Family Start, Barnardos, social workers in schools etc., but these agencies have not been visiting face-to-face and people do not have phones capable of calling all the time, nor privacy to do so. They have been abandoned.
 - a. **Support services need to be 'essential'.** *'Essential' services need to be re-defined to include social support services into people's homes, e.g. welfare support, pastoral support, mental health support, spiritual support, etc - all with well-equipped PPE etc.*
4. **Not enough food.** Food provision has been extremely challenging. Many whānau cannot afford food for their children when they are not at school being fed by school programmes, and the lack of access to cheap food such as Asian supermarkets and bakeries has been an issue. Many households do not know how to cook with raw ingredients and have been living on boxes of cereal and canned food.
 - a. **Financial support/MSD.** The waiting time on hold by phone for MSD to access financial support appears to be about 2 hours. This is extremely challenging for those caring for

young children while under stress, and managing social challenges (such as family violence, urgent social and health needs, crying hungry children, etc).

5. **Family violence.** People are reflecting shame and embarrassment about the jump in violence in their whānau.
 - a. **Connection.** Families report feeling very socially isolated, disconnected from their communities, their churches, and friends and family. At home visits, whānau tend to cling together and are not willing to chat as individuals. The nurse/social work/support work/iwi visit is seen as very important, so all want to be involved and participate. This restricts the individual from seeking help for family violence and managing private conflicts with one-on-one support and privacy.
 - b. **Infants lack follow-up.** Babies with significant growth and feeding issues are ending up at ED or being referred to DHB high needs services. Some are under Plunket but they are not doing face-to-face visits so they have had nowhere to go except the ED (or to DHB high needs Well child service to see if they are still visiting). Midwives are not seeing the babies physically after 2 weeks; this means that new mothers and babies (including those most vulnerable) are poorly supported and potentially at risk.
6. **WIFI / internet.** A lot of people access 'free' wifi, such as outside libraries etc. In lockdown they are unable to do this, and do not have the finances to purchase data. The 'school' based provision of resource by the government does not cover teen mothers out of school, older adults, or pre-school aged children. This has left people feeling vulnerable, cut off, and not knowing what is happening or how to access communication around COVID-19, how to get help, and without a method to contact their usual support network of friends and family.
7. **School/educational resources are extremely limited.** *Families are not getting data and device resources. Further, parents are likely to have their own difficulty in understanding the curriculum for their children, and are therefore limited in their ability to act as 'teachers', particularly if English is not their first language.*
 - a. **Lack of support for high-needs children.** Having children at home who have significant behaviour issues such as autism spectrum disorders, attention-deficit hyperactivity disorder (ADHD), and conduct disorders has been overwhelming. Normally these children are managed in ECE or schools and, in the holidays, they are shared out across other family members. If there is another Level 4, there may need to be provision of in-home support agencies.
8. **Self-medicating.** They are telling us that using drugs (mainly marijuana) is the best idea they have to manage the stress of what is happening around them and to them; and the older adults in the whānau are supporting the use of marijuana as a way to cope and stay calm, reducing the violence. This is being seen across many households.
9. **Not going for walks.** Many households with adults over 40 years are very afraid of becoming sick. They are not going out for walks and are *not permitting* the young adults to leave for walks and relaxation out of the home.
10. **Health literacy/information.** This has been very hard as often access to information is from social media or word of mouth only, this has meant many whānau are very afraid and only have access to misinformation and myths.
 - a. **Adequate, multilingual and multi-media information.** *While information has been translated, it is limited to only the risks of COVID-19 and the safety practices. However,*

to find out more means accessing MSD or COVID-19 website which is in English and requires an ability to navigate online. Assumption 1: You have data and device access. Assumption 2: IT and health literacy is appropriate.

In summary, pre-existing disparities are magnified by COVID-19. Information about COVID-19 is online, therefore automatically excluding a significant portion of families in low-income communities. Furthermore, these are the families who needed support prior to COVID-19, with social, health and economic disparities increasing exponentially with the impacts of COVID-19.

*Those spoken to know that **long-term effects on South Auckland will be significant.** There is a need to identify now the long-term risks, e.g. unemployment, substance abuse, family violence, and to address these within cultural frameworks appropriate to the demographics of South Auckland.*

2. Feedback from our people: Successes

There are examples of successful input, that further highlight the need to fill the gaps just listed. Workers outlined the following examples.

- Families have been described as being thrilled, relieved and excited when “their people” come to visit. They all consistently talk about how “You guys are always there for us”, “I knew you could help me”, and talk about their key people who help them manage their family violence, financial crisis, stress, etc.
- Support people continue to reach out to support those with violence in their homes in face-to-face work alongside them. There is currently a huge barrier for women having no safe space to talk freely without their partner or family members hearing but they are finding methods to “pocket call” staff or use a code word to ask for help where they can.
- “You had my back when no-one else in the family did.” This was a situation where a young mother was assaulted by her father at home in front of her child and the rest of the family. She messaged the team – they went out and provided daily support until resolved.
- “When Oranga Tamariki rung me I just told them that K.... has his own social worker, I told them to talk to you.” (Family violence incident – pocket-called us to get help; staff then ensured that police reviewed the case and completed “report of concern” – they had not done so before our follow-up.)
- There is an appreciation of education around COVID-19 that our staff have completed at every home. This is a full discussion, face-to-face, to ensure understanding, and how this applies to them as individuals and as a family.

3. Overview of preventative service delivery

Here are some preventative ideas from frontline people. They could be scaled up but also rely on good relationships that have been built, not ‘one-size-fits-all’.

1. We have developed a **family violence** code word across all whānau, so they can ask for help and we will come despite the lockdown (while still following our family violence policy to ensure staff safety). We are actively contacting and working alongside police, to ensure the best possible police response, and access to resources. We have built health literacy around the ‘breaking of bubbles’ to keep people safe.
2. We understand that **poverty and financial stress** carry a burden of shame at times. We have developed a system of providing ‘food parcels’ as a matter of routine for all. For example, pre-Easter we partnered with two local community providers (marae and Pacific) and delivered huge fruit and food boxes to every home. Recipients were thrilled and thankful, allowing them to receive as a gift for all without stigma, without needing to ask for help. We regularly

continue to provide food boxes across the service intensively. We perceive that this reduces stress, children are not hungry, adults are not pushed to their limits. (At first contact, people were going hungry and not eating – no money, too afraid to go out, etc.)

3. A face-to-face approach has brought to light the **high health needs** of many. Barriers around health literacy and a lack of their usual communication channels and supports would have otherwise kept these hidden. We manage these in the home, enabling virtual care with GPs when needed. We organise prescriptions and the receiving of medications, and monitor any ongoing challenges, such as infants failing to thrive.
4. With the increase in **substance use and violence** in the home, we are sitting down with whānau and forming sound, practical plans to ensure that the children and infants in the home are protected. We have observed that whānau are sticking to these in relation to their substance use, maintaining one sober caregiver for the child. Our people know that they can be honest with us around their challenges and their own solutions, and we will walk alongside to uphold them without judgment. This allows true effectiveness, working with what we know to be true, not what they think we need to hear.
5. **Creativity** means completing the contact with our people how we need to when we need to. The sense is that where services are known and trusted, we can uphold families to find solutions in creative ways that work for them and that we can help facilitate.

4. Feedback from services: The word on the street

As one provider put it, 'Life out of the normal has many challenges, and those working with vulnerable people are truly afraid of what is happening behind closed doors with all safe eyes now removed.' It is as much about what is NOT evident (i.e., lack of calls to services) than about what is.

1. It has been reported that the **OT call centre** usually gets 300 calls per day; currently they are getting about 50.
2. **'Well child' services** are functioning only as a virtual service. There is no planning or risk management for the vulnerable. There is no consideration for those living with family violence, or any of the huge social or health concerns (mental health, child protection, etc). This absolutely is leaving children and vulnerable alone without access to help, or eyes on to be their voice.
3. Many of the **community mental health** services and NGOs are now virtual, with staff reporting that 'management' will not let them visit; despite their preferences or that they would choose to be face-to-face to be more effective. Understanding mental health within indigenous worldviews is now even more important. For example, dealing with practical needs for many Pasifika families will mitigate the stressors that lead to poor mental health and violence. That is, the principle that, "If my family is well looked after, then the individual will survive."
4. **GPs providing virtual care** prevents a large proportion of the community from accessing or receiving care. This only works for those with money on their phones, or with the ability to somehow contact their doctor. Staff have found the evidence of this widespread, where they are able to visit the homes. Families are opting not to bother GP services and will wait until the problem is acute before going to ED, running the risk of further exacerbating health issues.
5. **The food banks** tell us that they are desperate and overwhelmed. A local food bank reported: "We have had people crying, desperate for help, we have never seen anything like this before." And, "We have seen a 250% increase of genuine families in need seeking food parcel assistance."

6. **Health services** who are working at the frontline are struggling with a scared – and scarce – health workforce. There are daily challenges of staff crying at work, refusing to go out, and feeling unsupported and unsafe. The constant barrage of conflicting information across social media is very challenging for the managers of staff (across DHBs); and many managers and staff are expected to work significantly over and above their hours without recognition.

5. Principles for change

There are many opportunities for change; here are some principles those at the frontline called for to guide change.

1. **Service provision needs to be led locally and culturally.** The work that is quietly going on is driven by those committed to the communities they serve, with links by culture or community vital to respond creatively and appropriately.
2. **Vulnerable, ‘high risk’ people should be planned for.** We need to uphold the duty of care for what we know people need – face-to-face, responsive services. Family violence and child abuse is likely to cause more harm with services out, than if services were safely “in” (and can be easily negated with solid, home-visiting COVID-19 processes). Would we be comfortable with 20 COVID-19 deaths but 1000 extra FV assaults? Or children hurt at home daily? This is a trade-off that must be reconsidered, when there are agencies who are providing appropriate preventative, responsive support, without compromising the safety of their workers.
3. **One rule does not fit all.** Flexibility is needed to prioritise vulnerable people and keep them safe when they cannot do so themselves, especially without the structures and relationships that were in place prior to COVID-19; and even more for those many who were already disadvantaged but largely unsupported.
4. There are many **communication basics** that could be addressed, such as free helplines with a *timely* response (and communication not just via social media), and a solid communication picture of how to access help, such as food, police, medical etc; alongside encouragement of when it is OK to leave the home – e.g. for help seeking, medical care, etc. This could be via a leaflet drop one-pager into every home.
5. **Face-to-face visits** to our vulnerable households to understand their needs and what is supporting them currently. This has to be maintained even post-lockdown as that will be when some risks will increase even more (e.g. job loss, access to alcohol). We need to ask families directly.

In conclusion, the plan for lockdown changes should continue to be developed based on the needs and priorities of our most vulnerable communities, such as those portrayed in this snapshot of South Auckland.

We can – and must - provide the supports and services they will need to survive – and thrive – through the pandemic and beyond.

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