Ki te Mārama i te Tangata
Me Mārama Hoki i Tōna Ao

Are cultural competencies critical for Māori mental health practitioners?

A thesis presented in partial fulfilment of the requirements for the degree of Master of Philosophy (Māori Studies)
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Abstract

“Ki te mārama i te tangata me mārama hoki i tōna ao” (if you wish to understand a man, know the world in which he lives) is a contribution to the field of cultural and clinical practice. It offers insight into the connections between cultural and clinical modes of service delivery and the inevitable interface between the two. In a broader sense, it also speaks to the application of traditional concepts to modern times – synergies and parallels, but also conflicts and contradictions.

Key words: *culture, competencies, Māori mental health, and practitioner*.

The research is an illustration of how it might be possible to walk in two worlds, and how this might be within health service settings. The methodology uses literature and formal interviews to formulate the research findings and to support the development of a Mātauranga Māori model of practice and service management – The Raukura Framework. A single hypothesis is central to this work: “Are cultural competencies critical for Māori mental health practitioners?”

“Me he toroa ngunungunu” (like an albatross with its head nestled under its wing) is the whakatauākī that has guided this work. Known for its majestic and inspiring presence, the toroa or (albatross) has often guided Māori. In traditional times the bird was seen as a chiefly figure, a symbol of high rank, and a metaphor for greatness and nobility. In this thesis, these types of metaphors are interwoven in its design; they have shaped and guided the research, and like the toroa they will hopefully reach beyond the pages of study to explore new horizons and new levels of insight. Moreover, to provide a catalyst through which sustained and positive health outcome for Māori might be achieved.

Acknowledgements

This thesis is about sharing a journey of whānau development. From the outset it has been about learning and understanding, but this must be shared with others.

I would like to offer my thanks to some key people who have supported and contributed to this process:

To my immediate whānau who have been on this journey alongside me for the past eight years. The whānau of Waiwhetu and Whakarongotai Marae, for your contributions to this work and for inspiring the health and well-being of our people.

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The Henry Rongomau Bennett programme for supporting and encouraging me to develop as a leader.

Finally, to the whānau of Ōtākou Marae, who have gifted this thesis with six feathers from the toroa (Albatross). The feathers are symbolic in providing the philosophical base for this thesis and laying the foundations on which, the Raukura Framework now sits.

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Karakia

Tēnei au Tēnei au Ko te hōkai nei o taku tapuwae, Ko te hōkai nuku, Ko te hōkai rangi, Ko te hōkai a tō tupuna a Tāne-nui-a-rangi I pikitia ai ki te Rangi-tū-hāhā Ki te tihi o Manono, I rokohina atu rā Ko Io matua kore anake I riro iho ai ngā kete o te wānanga Ko te kete Tuauri, Ko te kete Tuatea, Ko te kete Aronui. Ka tiritiria ka poupoua ki a Papatūānuku Ka puta te ira tangata ki te whai ao ki te ao mārama	*Here am I, here am I quickly moving by,* *The power of my karakia for swift movement,* *Swiftly moving over the earth, swiftly moving through the heavens, the swift movement of your ancestor Tanenuiarangi who climbed up to the isolated heavens,* *The summit of Manono, and there found Io-the-parentless alone.* *He brought back down the baskets of knowledge,* *The basket named Tuauri,* *The basket named Tuatea,* *The basket named Aronui.* *Portioned out and planted in Mother Earth,* *The life principle of human beings comes forth into the dawn,* *Into the world of light.'*

1.0: Introduction

In 2006 the first mental health and addiction prevalence study in New Zealand, Te Rau Hinengaro, confirmed the link between Alcohol and other drugs, and mental health, and identified it as an issue for Māori.

There has since been a debate about best practice standards for treatment of this dual diagnosis. This research will add to the current knowledge and literature about dual diagnosis, its treatment and dual competencies of practitioners. It also aims to uncover new insights to improve addiction treatment and mental health of Māori. Included is my own personal journey of receiving treatment and providing treatment. These personal reflections have inevitably informed the thesis and will provide a level of insight and intimacy that is so often missing from investigations of this type.

The karakia used to initiate this chapter is one that talks about the birth of our people, and the history of our tipuna, and is often used today to remind us of this. I have started and finished each chapter with a karakia, waiata or whakatauāki as it contextualises the discussion in a Māori mental health discourse. It also provides spiritual guidance for each section.

1.1: Research Question

The research question has emerged from a background of informed practice of over 30 years in the alcohol and drug sector, and also from my personal journey of recovery through these times. After reaching a certain point in my journey I found myself often asking the question "*Are cultural competencies critical for Māori mental health practitioners*?" To conduct the research was the obvious next step. This research will provide a complementary dimension to our clinical knowledge base; offering, it is hoped, a pathway forward for both practitioners and services for the years to come.

Definition of Cultural Competences

Cultural Competence is a term that has yet to find and absolute definition, however, and despite the fact that a number of positions and perspectives have been proposed, the exemplar offered by Martin and Vaughn (2007) resonates best with the objectives of this thesis:

> Cultural competence refers to an ability to interact effectively with people of different cultures. Cultural competence comprises four components: (a) Awareness of one's own cultural worldview, (b) Attitude towards cultural differences, (c) Knowledge of different cultural practices and worldviews, and (d) cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures. (Martin and Vaughn, 2007)

While other definitions might also have informed the design and development of this thesis, the definition above provides the scope and breath through which are broad range of issues might be considered. Importantly, it offers a position that is able to sufficiently accommodate Māori perspectives and world-views as well contemporary issues attached to Māori mental health service delivery.

1.2: The Discourse

Durie (1994) has studied and reviewed the topic of cultural competency at great length.

In his seminal précis on Māori development *Ngā kāhui pou: launching Māori futures (2003)* - he notes that the gap between competence and expectation is large furthermore, that greater emphasis needs to placed on narrowing this gap and on improve health outcomes.

In this book, *Te Mana, Te Kāwanatanga, "The Politics of Māori Self-Determination"* (2002), he also touches on the need to consider the socio-political context within which cultural competency has emerged and the fact that it has been shaped by both political enthusiasm and clinical need.

In a related frame, Keri Lawson-Te Aho, likewise highlights the tensions between the perspectives of indigenous and western world views (1994). Moreover, how these tensions tend to undermine the value of cultural factors and its role in promoting positive health outcomes for Māori, she writes:

> The relationship between Māori people and Pakehā [white] psychologists has been one of inequality in which, Māori, often positioned as client or student, have been abnormalised through the wholesale application of foreign psychological models and theories, Pakehā

> psychology may be understood as part of the mechanics of colonisation and neo colonialism. (Lawson-Te Aho, 1994)

The Takarangi framework (2010) was developed to provide a competence framework. It is characterised by three key areas:

- Clinical Knowledge
- Clinical competence
- Clinical practice

This framework supports Māori development in the above three areas of work.

These three elements highlight the need to apply a balanced approach to service delivery and that while cultural components are necessary to improve health outcomes for Māori, there likewise exists a need to also provide balance and reflect on clinical acumen.

The available discourse provides at least some indication of the range of issues experience by Māori practitioners and which are linked to cultural competence. It is clear that there remains some tension between Māori approaches and conventional practice but that both are needed to improve health outcomes. Moreover, and that while the efficacy of and integrated approach may eventually promote integration, certainly political and higher level factors may be just as relevant.

1.3: Historical Patterns and Concerns with Substance use in New Zealand

Alcohol use in Aotearoa/New Zealand has a long and varied history. Settlers used it for trading lands and goods and this practice was common with other indigenous populations (Diamond 1999). Prior to the arrival of Europeans, substance abuse, amongst Māori was unknown. On the arrival of Captain James Cook in 1769, Joseph Banks wrote, “Nor did I see any signs of any liquor being at all known to them, or any

method of intoxication, if they really have not; happy they must be allowed to be above all other nations" (Wright-St Clare, 1969, p. 327–331). This quote further illustrates the attitude towards alcohol and the knowledge of its overall detrimental effect on users. Even once alcohol was introduced to Māori, their reaction was of disgust. Moveover, the nutritional value of alcohol unlike other naturally occurring foods and liquids in their environment, was not obvious. Nevertheless, along with the other aspects of settler life that Māori grew accustomed to such as wearing European clothes, they too developed a taste for alcohol. Early reports and anecdotes provide some indication of the use of alcohol by Māori. As noted by Carkeek (2004), the grog shops conducted a roaring trade in the 1840s on the stretch of main highway between Wellington and the northern settlements. The public house on the Kapiti Coast was still in operation in 1849 when William Swainson visited Te Uruhi and stopped to sketch it (Carkeek, 2004) (Figure 2).

Signs were starting to be recorded that alcohol was making an impact across New Zealand. Government reports from the late 1860s show that by this time all generations were consuming alcohol and getting intoxicated which had begun to affect their behaviour and overall demeanour:

> The physical and moral condition of the native race in this district has, I believe, considerably deteriorated during the past 10 years. Venereal diseases and others connected with them are very common. The energies of the people are ill directed. Young of the race are growing up entirely uneducated, while the vice of drunkenness is unfortunately prevalent among the old and young.
>
> Their social habits are, in my opinion, of a lower character than when in a more savage state; they have lost a great deal of the energy they formerly displayed, and have acquired little else than the vices of civilization. (Thornton, 2004, pg 15-16).

Alcohol abuse had begun to negatively affect Māori society and was seen as a drawback of colonisation. By the 1870s others were to report similar trends in Māori drinking patterns. Major William Mair, Native Officer at Alexandra (Pirongia) wrote:

> The thirst for strong drink is growing upon the Waikato natives … while the craving for spirits manifested by Kingites is something very serious; where they are placed in position to obtain it in quantities, I believe that they would indulge to an alarming extent (Hutt, 1999, p. 91).

It became obvious that Māori were becoming alcohol abusers and if given the means would become addicts. However, funds, availability and access were still a barrier, but for how long until Pākehā broke down these barriers?

Te Whiti Orongomai (who's philosophy contributes hugely to this thesis) articulately summarised the attitude of some Māori at the time that used their money to purchase alcohol to get intoxicated while the land of their forefathers was lost:

> If you have taken silver, then you will be lost. What good you have got when you stretched forth your hand for it? Did it not turn to poisonous drink, which maddened? Then where was the land of your fathers (Scott, 2004, pg, 43).

While the impact of the introduction of alcohol was being felt in New Zealand in the early 1800s, it had also been used in the same way in other countries (Hutt, 1999). In 1886 James Anthony Froude said:

> The [Māori], like every other aboriginal people with whom we have come into contact, learn our vices faster than our virtues. They have been ruined physically, they have been demoralised in character, and by drink they love their poison. (Hutt, 1999, p.46)

Considerable synergies exist between Māori and other indigenous populations and in particular with respect to their alcohol consumption. In Australia, for example, the Aborigines used plants to ferment an alcohol type drink. It was used under control of the people, and primarily for medicinal purposes (Creative Spirits, 2009). Aboriginal alcohol use changed significantly after the arrival of Pākehā. Within weeks of the arrival of the first fleet, the first pubs opened which shaped the way Australian society developed over the next few decades and ultimately the Aboriginal relationship with alcohol (Creative Spirits, 2009).

Figure 1 Aboriginal life in the 1830s Natives of New South Wales as seen in the streets of Sydney – A Earle. Printed by C Hullmandel [1830].[1] (Photo: Alexander Turnbull Library)

Over the time period since 1800 until today there is very clear evidence that proves alcohol and its use has increased to the point of where it has become a normalised part of our lives and the damage associated with it.

1.4: My Journey

My personal interest in this subject is both personal and academic. I am a descendant of William Jenkins who was born in 1813 on the Isle of Sheppey, Kent, England. He went to sea at the age of 9 and arrived in New Zealand, on Kapiti Island, on the *Caroline* in 1836. He became a whaler and married Paeroke, daughter of Rawiri Nukuaiahu and Pakewa, who arrived in the Kapiti region around 1822 with the migration of Te Rauparaha of Ngāti Toa and Ngāti Raukawa. Jenkins built a lucrative business venture between the 1840s and 1850s at Te Uruhi (Raumati South) in the form of an accommodation house (see figure 2) that had a bush licence to operate the sale of goods and accommodation, including the sale of alcohol (Browne, 1978).

[1] Note the hotel in the background with its all-white occupants.

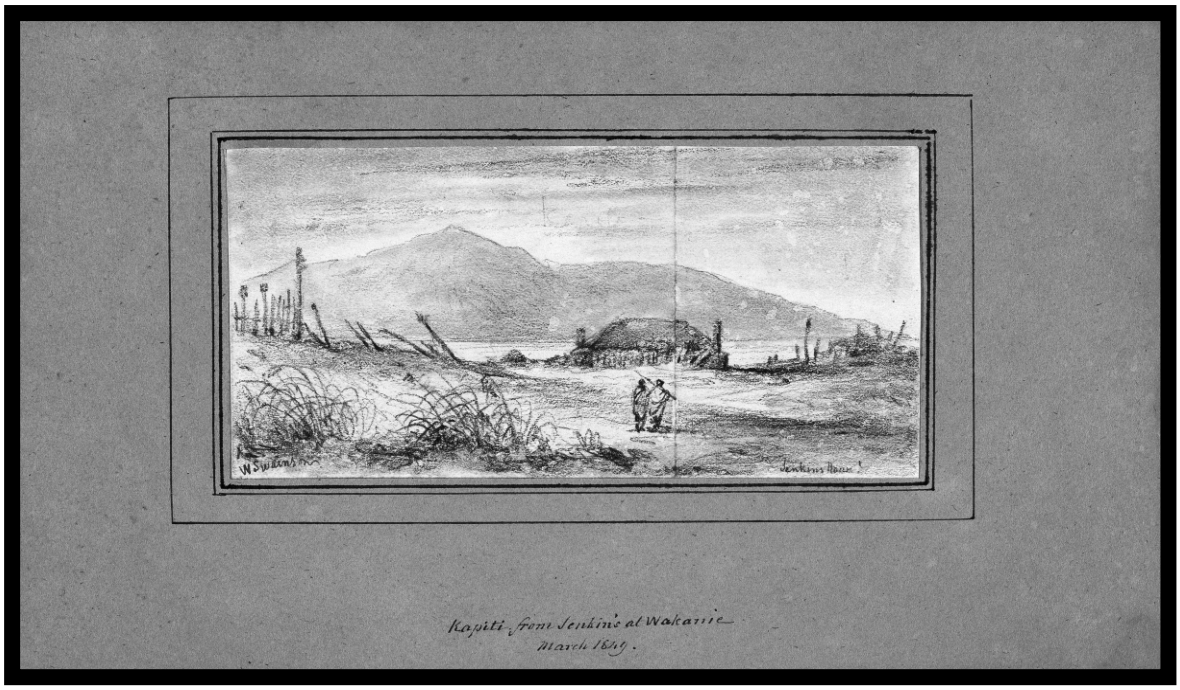

Figure 2 Jenkins accommodation house sketch by William Swainson in 1849. Source: Alexander Turnbull Library, Wellington, New Zealand

The traffic that passed his door and the ideal position of the house on the south side of the Waikanae River, on the beach that is now known as State Highway One, meant he was never short of customers and users of his services and provisions, including alcohol and tobacco (Carkeek, 2004).

Alcohol became a major part of my whakapapa when I myself was young and became addicted. As a 19 year old in the late 1970s, like many young men, coping with life was hard enough, on top of never really knowing who you were. My own mental health had been deteriorating since the age of 7, due to many other things that had happened in my life. My behaviour was seen as being a ‘naughty lad’. Today we treat an over active-child with medication in my day the treatment was not much different. I remember being seen by a psychiatrist at an early age and he told my mother I would either be an alcoholic or in jail by the age of 20. No one ever understood or asked what was happening in my world. His diagnosis was correct on one count as I did turn to alcohol.

At the age of 19, in 1979, I was admitted for treatment to the Queen Mary Hospital at Hanmer Springs in North Canterbury (see figure 3). At the time, it was unusual to have someone so young in treatment. I was with a group of 15 other patients over the 8-week

period of the course. We all shared our experiences and worked together to get our lives back, including a week with our family / whānau, which for me was the main impact of the treatment programme. All through the course of treatment, the question of identity was raised – “Who are you?” or Ko wai au for those who don’t know who they are makes accepting they have an addiction problem even harder as many use alcohol to avoid this question. Having to accept yourself and an addiction is not an easy process, and some never complete it, those that do often have a very good outcome in response to treatment and recovery. These two issues are critical to anyone’s treatment.

Figure 3 Chisholm Ward, Queen Mary Hospital, Hanmer Springs (personal photograph, 12 August 2008).

The Ministry of Defence built the hospital in 1916 initially for the treatment of tuberculosis (see figure 4). In 1921, Queen Mary Hospital was handed over to the Health Department. Chisholm Ward, named after the medical superintendent of 23 years, opened in 1926 and then Rutherford Ward in 1942. The hospital treated patients with hypertension and anxiety as well as some joint disabilities. It also became involved in treating alcoholics (Historic Places Trust, 2009).

Figure 4 The foundation stone from the opening of the first section built before Chisholm ward (personal photograph, 12 August 2008).

The Rutherford Ward (see figure 5) was built for the treatment of war veterans. However, it was found that alcohol was a major contributor to the condition of these men and their lifestyles after returning to society, and in the late 1960s the hospital focused on the treatment of addiction, led by Dr Robert Crawford. In 1990 it had the first Māori treatment programme to be run in New Zealand for Māori by Māori, which ran alongside the current programme at Queen Mary. The thermal springs and clear mountain air are said to have added healing powers, and it is here as a patient in 1979 that the journey really started for me. I also worked in this ward as a staff member from 1989 to 1992. The hospital was sadly closed in 2002.

Dr Robert Crawford, former Medical Superintendent of Queen Mary Hospital and Psychiatrist confirm's this caring approach in his book, *Too Good to Last: The death of a caring culture* (2009).

Figure 5 Rutherford Ward (personal photograph, 12 August 2008

In the 1970s Treatment models that were used to treat people with addiction related problems with Alcohol in New Zealand, was based on the Minnesota Model from United States. The Minnesota Model, also known as the abstinence model, of addiction treatment was created in a state mental hospital in the 1950s by two young men, one who was to become a psychologist, the other who was to become a psychiatrist, neither of whom had prior experience treating addicts or alcoholics.

The model spread first to a small not-for-profit organisation called the Hazelden Foundation and then throughout the country. The key element of this novel approach to addiction treatment was the blending of professional and trained non-professional (recovering) staff around the principles of Alcoholics Anonymous (AA). There was an individualised treatment plan with active family involvement in a 28-day inpatient setting and participation in Alcoholics Anonymous both during and after treatment. The education of patients and family about the disease of addiction made this a busy program from morning to night, seven days a week (Anderson, McGovern & Dupont, 1999).
This model was up until the late 1980's the only treatment model used in practice in New Zealand, and then we had the introduction of the Harm Reduction Model which supported a change in treatment options for clients became the model of policy and practice here in New Zealand.[2]

For the purpose of this thesis harm reduction is defined as: any programme or policy designed to reduce drug-related harm without requiring the cessation of drug use. Interventions may be targeted at the individual, the family, community or society (CMAJ January 23, 2001 164:173-174).

Not all interventions intended to minimise the adverse consequences of substance use are harm reduction. Harm reduction programmes and policies must demonstrate that they have the desired impact without producing unacceptable unintended consequences.

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[2] Harm reduction: Reducing the risks of addictive behaviors. Addictive behaviors across the life span: Prevention, treatment, and policy issues. Marlatt, G. Alan; Tapert, Susan F. Baer, John Samuel (Ed); Marlatt, G. Alan (Ed); McMahon, Robert Joseph (Ed), (1993). Addictive behaviors across the life span: Prevention, treatment, and policy issues, (pp. 243-273). Thousand Oaks, CA, US: Sage Publications, Inc, ix, 358 pp.

If its evaluation reveals no support for the reduction of specified adverse consequences, or shows the unintended consequences are too serious, the programme should not be considered part of a harm reduction approach and other alternatives should be developed.

The primary focus of harm reduction is on people who are already experiencing some harm due to their substance use. Interventions are geared to movement from more to less harm. Examples of proven harm reduction programmes are: server intervention programs which decrease public drunkenness; needle and syringe exchange programs which prevent the transmission of HIV among injection drug users; and, environmental controls on tobacco smoking which limit the exposure to second hand smoke (Centre for Addiction and Mental Health Collaborating Centre, 2009).

With the introduction of HIV/Aids into New Zealand in the mid 1980s and the introduction of methadone for treatment of opioid dependence the model of harm reduction became more user friendly in it approaches to addiction treatment, later the introduction of another theory and model was called Harm minimisation was promoted in about the mid 90s which aims was to reduce harm from drug use but they both have similar outcomes a philosophies. Even with these models abstinence can be a goal to reach with the client but the difference is the process may take longer.These new approaches in there time were a move away from the early days of addiction treatment that was totally based on an abstinence model of treatment that were run in programmes like Queen Mary Hospital. There is debate today around the definition of recovery. Professor Dr Tom McCelland, the director of the, Penn Center for Substance Abuse Solutions questions whether the term recovery can be used to refer to a person working within the harm reduction model.

The Queen Mary Hospital was seen as a garden city-style psychiatric hospital with its beautiful gardens set far away from urban society. The thermal pools were used as a part of the treatment. These mineral pools and the fresh high country air combined with the natural beauty of the region were paradise for many who visited and were patients within these grounds. I can remember many nights spent talking with patients in the hot pools about the events of the treatment groups. The day before we completed our programme on 20 December 1979 and graduated from the treatment centre (it was the first course I

had ever completed), we were in our final group therapy session and were lined up. We were told that the people at one end of the line were seen as being able to maintain their recovery and had everything going for them. My end of the line was the complete opposite and I was seen as one who would not make it.

Today, sadly, I know of only three of us left alive, but we do not have contact anymore. With over 30 years of recovery, I have continued to maintain a life of abstinence from alcohol and drugs from that time. The treatment programme, which was an abstinence-based approach to addiction, was accepted practice in the late 1970s and early ’80s.

Through the support of a 12-step programme based on the Alcoholic Anonymous approach, which I have used for over 30 years, I have maintained my recovery. Without this programme and the support of a wife and family I would not have made any recovery. While not including my Māori side of my life at this time, the treatment at Queen Mary gave me the tools to be able to survive until the year 2000 when I was able fully and finally to complete the puzzle of who I really was.

The turning point came when I finally embraced my cultural identity and understood my own culture. Although I grew up next to my own marae, I was 40 years old before I stood on it as a whānau member of the hapū of Puketapu. Today, there are still many similar lost people in our community due to the loss of cultural identity. For me, the picture is complete with a stable and positive cultural identity and I now see the results within my own whānau.

While these issues may be perceived as superfluous to this thesis (at least from an academic perspective) they inevitably inform and shape the context and background to this research. Indeed it has been these issues which have garnered my interest and which has allowed me to see what broader opportunities for Māori health development might exist. In this regard, and from a Māori perspective, it seems more natural that these issues (the past, present, and future) should be intertwined and used to plot a more positive way forward.

1.5: Māori Treatment Models

When we review modern-day treatment approaches, family/whānau are now seen as the key to recovery and the current practice model still seen as the best practice of working is client-centred practice in addiction (Rogers,1980). A Māori treatment model, *Mauri Ora Framework* (2004)*,* initially developed to address whānau violence also has currency for the mental health sector. The framework identifies key cultural practice imperatives that Māori practitioners must possess and demonstrate in order to be culturally aware and culturally safe practitioners.

If we look at Mauri ora as a model of practice and a Māori conceptual framework it has the goal of wellbeing of whānau with seven strains. These are:

1. Wairua (spiritual)
2. Hinengaro (mental)
3. Ngākau (Heart)
4. Tinana (Physical)
5. Ihi (refers to power, authority, essential force or personal magnetism)
6. Wehi (Fear a reaction to or response to Ihi)
7. Wana (Awe) (refers to expressed emotion)

This framework in practice measures and protects both the practitioner's and the client to achieve the goal of well-being. While it is a Māori based framework it can work with non-Māori in any setting that the practitioner's skills allow it to be infused.

Another more general Māori model of wellbeing *Te Wheke* (Pere, 1997) included teachings of the creator's own Iwi of Tuhoe. This model was the first Iwi based or tribal framework to be used in mental health and later in addiction practice. The model looks at eight fundamental elements using the octopus and its legs to support the framework.

Durie (1994) also promoted another broad framework *Te Whare Tapa Wha* that was seen as a guide to practice within mental health. The four cornerstones that are in the framework are Tinana (Physical), Wairua (Spiritual), Hinengaro (mental health) and Whānau (Family) that became the model that practitioners in any discipline could use that deals with the wellbeing of a Māori client. Durie also promotes the powhiri model as

a method of engagement with clients. This model identifies three key phases within a therapeutic relationship:

- Whakapiri (engagement)
- Whakamarama (enlightenment)
- Whakamana (empowerment)

(Durie, pers. communication, Ngātakuwaru Marae 7/08/2010).

The powhiri model is based on a cultural encounter process that Māori often use on marae when meeting and welcoming visitors. In relation to the therapeutic relationship the powhiri model guides the encounter process between the clinician, client and clients' whānau and sets the scene for moving the therapeutic relationship forward.

The New Zealand Alcohol and Drug (AOD) sector has developed the view that clinicians working in the addiction treatment sector need to practice cultural safety and cultural competence (that is awareness of what the clients themselves bring to the therapeutic relationship):

> The addiction treatment field has had an awareness of a range of 'cultural' perspectives since any of us can remember and in many ways has been in the vanguard of the development of appropriate responses to these in the health sector overall. Twenty years ago the terminology used was 'special needs groups' but this somewhat paternalistic way of describing cultural perspectives has not been the main way of referring to this area for many years. Some of the old 'special needs groups', such as patients with co-existing disorders and youth, with their own cultural issues and challenges for addiction treatment workers, have now become so mainstream and central to the addiction treatment field that they probably no longer need to be given a special status in order for them to be included in routine discussions about the sector. However, there is always a risk of marginalization of sub-groups in the overall sector, particularly when clinicians do not feel confident about working with certain groups, so continuing consideration of the wide variety of potential groups is necessary. (National Addiction Centre & Matua Raki National Addiction Treatment Workforce Development Programme, 2008, p. 7)

The National Addiction Centre, University of Otago, Christchurch, and the Matua Raki National Addiction Treatment Workforce Development Programme produced a manual to support any clinical worker's orientation into the addiction sector (2008).

For Māori, however, the collective approach of whānau is the key to recovery because as a people Māori do not look at the treatment of one area as the answer to a problem. The concept of whānau, hapū and iwi in the modern era is the basis Māori people understand and best respond to in any practice setting (Durie, 1994).

The Takarangi Framework developed in 2009, original concept by Matua Tukaki Waititi (Ngati Hine/Te Whanau-a-Apanui), provides a yardstick against which practitioners in the alcohol and other drug, problem gambling and mental health sectors, can measure their professional capacity, capability and personal competency to work with Māori.

The framework also provides a basis for creating workforce and service development pathways for individuals and organisations. The Takarangi Framework is an important tool to assist in the development of competent practitioners working towards whānau ora.

However, it is not a tribal based approach and it can been seen as not fitting for many Māori and non Māori due to each having their own tikanga that they know inherently which may sit outside of this framework and its measurements of practice.

The Takarangi is the intersecting spiral pattern used in whakairo on waka and whare (Carving). The Takarangi spiral links man with the wairua through the never-ending spiral. What is hard to discern is where it starts and where it finishes, if it actually ever does. The solid parts are the structured parts of practice.

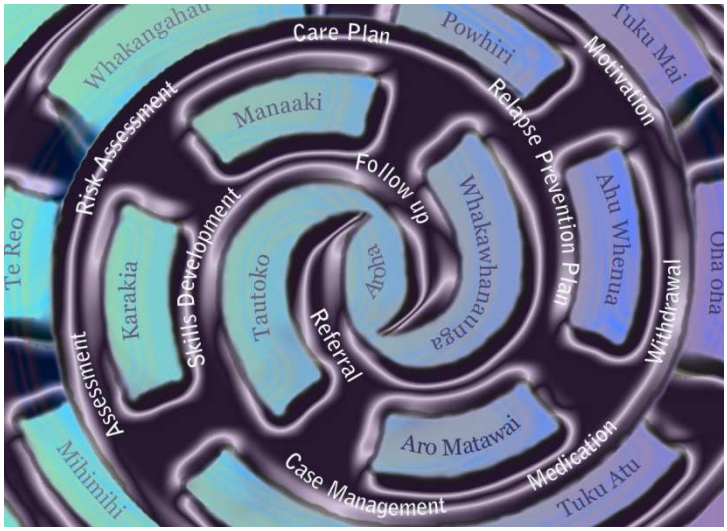

Figure 6 Te Takarangi Framework. This figure was Adapted courtesy of "*Clinical is Inherently Cultural*" from Competence for Māori Practitioners working in Addictions. Used with permission. Original concept by Matua Tukaki Waititi (Ngati Hine/Te Whānau-a-Apanui).

The Takarangi is characterised by bold intersecting spiral patterns, which are joined by frequent short links between the independent spirals. However, the spaces, which separate the spirals and the interconnecting links, are equally as important to the pattern as the solid spirals themselves. As the cultural and the clinical practice are co-dependent and cannot exist on their own without each other, so are the spaces between the solid spirals inherently part of the Takarangi. Without the spaces (western models of treatment), the Takarangi (Maori model approach to treatment) could not exist or be seen. It would have no form. Therefore, dual competency is about the integration/synthesis of the highest standards of both western clinical practice and cultural values, which includes identity as its core foundation.

If the person working with Māori has little understanding or awareness of Maori culture we can see that this model would be limited in its use. However, if the opposite were true this could create a stronger therapeutic relationship for both the clinician and there tangata whaiora.[3]

[3] Tangata whaiora refers to a client within a mental health and addiction service.

Huriwai (2006) argued that cultural competence is about the development of access, retention and outcomes and the balance between them. The integration of both clinical and cultural knowledge, competence and practice is the joining of the two worlds. It is not enough, however, simply to provide increased access, retention and outcomes for Māori practitioners. It is also fitting to consider how they incorporate Māori congruent values, beliefs and practices in their work, "*Cultural competence focuses on the integration of 'cultural and clinical' elements within practise that achieve whānau ora"* (Huriwai, personal communication, Christchurch, Sept 2006).

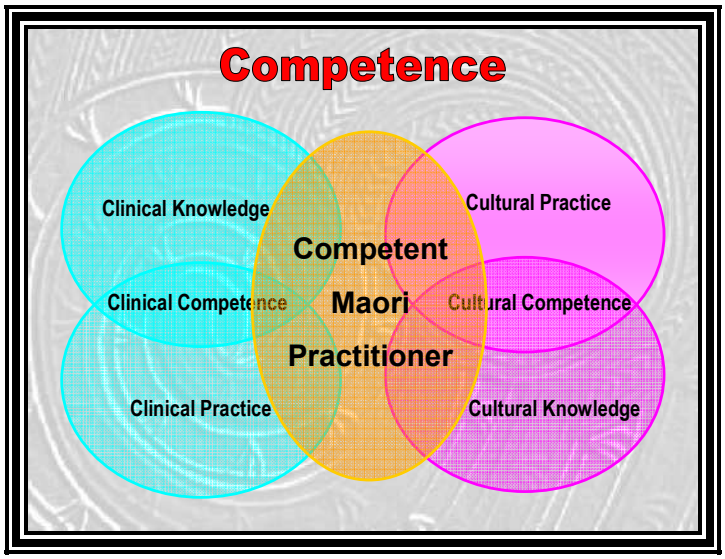

Figure 7 Cultural competence model (Huriwai, 2006)

1.6: Chapter 1: Conclusion

This chapter has provided the necessary foundation to this thesis. It has described the broad hypothesis, key concepts, major issues and concerns, current approaches, as well as my own personal journey. These issues have been used to demonstrate the potential contribution of the thesis to matauranga Māori, academic discourse, and ultimately improved standards of treatment and care for Māori.

The next chapter builds this one by detailing the various methods used to conduct the research and ultimately answer the research question.

This karakia is the final korowai that concludes this chapter. Its supports the belief in a greater power will provide the wisdom and guidance to support the work this chapter has provided.

Karakia Whakamutunga

I opened the chapter with the karakia of the birth of our people. The closing karakia is based on biblical teachings that thanks our Atua for daily life and the guidance in setting the foundation for this thesis

Te Inoi a Te Atua	Translation
E tōu mātou Matua i te rangi	The Lord's Prayer
Kia tapu tōu Ingoa	Our Father who art in heaven,
Kia tae mai tōu rangatiratanga	Hallow be thy Name
Kia meatia tōu e pai ai ki runga ki te whenua	Thy kingdom come. Thy will be done, on earth as it is Heaven.
Kia rite anō	
Ki tō te rangi	Give us this day our daily bread.
Hōmai kia mātou āianei	And forgive us our trespasses,
He taro mō mātou mō tēnei rā	
Murua ō mātou hara	
Me mātou hoki e muru nei	As we forgive those who trespass against us.
I ō te hunga e hara ana	
Ki a mātou	And lead us not into temptation, But deliver us from evil.
Aua hoki mātou e kawea	
Kia whakawaea	
Engari whakaorangia mātou i te kino	For thine is the kingdom, and the power, and the glory, for ever and ever.
Nōu hoki te rangatiratanga	
Te kaha me te kororia	
Ake ake	
Amine	Amen.(Paipera Tapu Māori Bible, 1952)

Chapter Two: Methodology

He Waiata

This Waiata is about the importance of getting the basics right. To fly well and reach its goal attention needs to be given to setting the direction of the flight. This is the methodology chapter and sets out the direction of this research.

Mā te kahukura ka rere te manu (ngā huruhuru e)	The rainbow signals the flight of the bird
Ka rere koe (rere runga rawa rā e)	As you take flight (flying to ultimate heights)
Ka tae atu koe ki te taumata	Reaching the highest of peaks
Whakatau mai rā e	Coming to rest there
Mau ana i taku aroha	My affection
Whai ake i ngā whetu	Pursuant, like the constellation of the stars
Rere tōtika, rere pai	Fly direct, Fly well
Rere runga rawa rā e	Fly to the ultimate heights.
Rere tōtika, rere pai	
Rere runga rawa rā e	

2.0: Methodology Introduction

This chapter describes the methodology used in this research investigation. The thesis used standard qualitative research approaches to gather data on cultural competency experiences of Māori practitioners involved in delivering mental health and addiction services.

2.1: Aims and Objectives

The overall aim of this research is to explore the relevance of cultural competence of Māori Mental Health Practitioners, particularly those involved in addictions treatment and client care. Therefore a key focus of this research is the link between cultural competencies of practitioners and improved health outcomes for Māori.

2.2: Kaupapa Māori Research

The methods used to inform this thesis have been developed on conventional lines and have incorporated methods and approaches that are not unfamiliar to most qualitative researchers. However, where appropriate, the researcher has also embraced cultural approaches and practices that are designed to ensure the overall integrity of the study has been maintained according to Māori culture and understandings of knowledge creation. While this approach has largely been intuitive, readings on kaupapa Māori theory and discourse have inevitably informed my ideas and the manner in which the research has developed (Smith, L, 1999). Kaupapa Māori theory, for example, is based on a number of key principles. Graham Hingangaroa Smith (1990) initially identified six principles or elements of Kaupapa Māori within the context of educational intervention (Kura Kaupapa Māori) and research. The key principles are:

Principals	Definition
Tino Rangatiratanga – The Principle of Self-determination	Is the principle that relates to self determination and independence and supports the goal of kaupapa Māori initiatives and a true destiny that allows for culture and aspirations to be expressed.
Taonga Tuku Iho – The Principle of Cultural Aspiration	It also allows spiritual and cultural awareness and other considerations to be taken into account within the research.
Ako Māori – The Principle of Culturally Preferred Pedagogy	This principle acknowledges teaching and learning practices that are inherent and unique to Māori, as well as practices that may not be traditionally derived but are preferred by Māori.
Kia piki ake i ngā raruraru o te kainga – The Principle of Socio-Economic Mediation	This principle asserts the need to mediate and assist in the alleviation of negative pressures and disadvantages experienced by Māori communities. This principle asserts a need for Kaupapa Māori research to be of positive benefit to Māori communities. It also acknowledges the relevance and success that Māori derived initiatives have as intervention systems for addressing socio-economic issues that currently exist.
Whānau – The Principle of Extended Family Structure	The principle of Whānau sits at the core of Kaupapa Māori. It acknowledges the relationships that Māori have to one another and to the world around them. Whānau, and the process of whakawhanaungatanga are key elements of Māori society and culture. This principle acknowledges the responsibility and obligations of the researcher to nurture and care for these relationships and also the intrinsic connection between the researcher, the researched and the research.
Kaupapa - The Principle of Collective Philosophy	The 'Kaupapa' refers to the collective vision, aspiration and purpose of Māori communities. Larger than the topic

	of the research alone, the kaupapa refers to the aspirations of the community. The research topic or intervention systems therefore are considered to be an incremental and vital contribution to the overall 'kaupapa. These principles have since been expanded by other kaupapa Māori theorists such as Linda Smith (1997), Leonie Pihama (2001) and Tania Pohatu (2005) to include:
Te Tiriti o Waitangi – The Principle of the Treaty of Waitangi	Pihama (2001) identified another principle to be taken into account within Kaupapa Māori theory: Te Tiriti o Waitangi (1840) is a crucial document which defines the relationship between Māori and the Crown in New Zealand. It affirms both the tangata whenua status of whānau, hapū and iwi in New Zealand, and their rights of citizenship. The Tiriti therefore provides a basis through which Māori may critically analyse relationships, challenge the status-quo, and affirm the Māori rights.
Ata - The Principle of Growing Respectful Relationships Source: Smith, 1990	The principle of āta, was developed by Pohatu (2005) primarily as a transformative approach within the area of social services. The principle of āta relates specifically to the building and nurturing of relationships. It acts as a guide to the understanding of relationships and wellbeing when engaging with Māori.

Other theorists have also contributed to the development and growth of kaupapa Māori methodology. Jill Bevan-Brown for example identified ten ingredients that are deemed highly desirable for Māori research in terms of developing distinctly Māori methodologies. Each of these is deliberately generic and allows the model to be applied to a wide range of research initiatives:

1. Māori research must be conducted within a Māori cultural framework and therefore should incorporate Māori concepts of knowledge, skills, experiences, attitudes, processes, practices, customs, reo, values, and beliefs.
2. People who have the necessary cultural, language, and research expertise must conduct Māori research. They must also possess a commitment to things Māori, the trust of the Māori community being researched, and an understanding of, and commitment, to the obligations, liabilities and responsibilities that are an integral part of Māori research.
3. Māori research should be focused on areas of importance and concern to Māori. It should arise from self-identified needs and aspirations
4. Māori research should result in some positive outcomes for Māori. These may manifest in many different ways, e.g., improved services, increased knowledge, health gains, or more effective uses of resources

5. As much as possible Māori research should involve the people being researched as active participants at all stages of the research process Māori research should empower those being researched. This empowerment should stem from both the research process and the product
6. Māori research should be controlled by Māori, particularly in relationship to ethical requirements, assessment, funding, intellectual property rights, and the ownership and dissemination of knowledge.
7. People involved in conducting Māori research should be accountable to the research participants and to the Māori community in general Māori research should be of high quality. It should be assessed by culturally appropriate methods and measured against Māori-relevant standards
8. The methods, measures and procedures used in Māori research must take cognisance of Māori culture and preferences. They must take into account the previous nine requirements. (Bevan-Brown, 1998)

The principles and strategies for best practice identified above are useful guidelines for the development of appropriate methodologies for Māori research based on distinctly Māori paradigms. This research has attempted to observe these principles and to incorporate them into the more pragmatic aspects of the investigation. With each interviewee the same process was used in all five interviews as to offer consistency across the investigation. Each person had the choice of venue where and when the interview would be done. We also had a sharing of food all throughout the process this is normal practice when working with māori. The use of karakia at the start and ending of our session was practiced often taken by the interviewee as to acknowledge there rangatira role within this work. A koha was given to all at the end of our process as to thank them but also to bring us back to state of noa as during the interviews some of them share parts of their past that they said were tapu for them. The guidelines developed by Smith and Bevan-Brown supported the researcher to conduct research interviews, from a Māori approach, which protected the participants. Information shared was sent back to interviewees post interview for comment and returned. It was determined that a more fluid approach to the application of these principles and models would best resonate with the objectives of the research and ensure that the overall approach taken was consistent with the objective of the study.

2.3: Analysis of Key Reports, Policy Statements and Literature

In the first three chapters of this thesis references are made to key documents outlining the rationale for the health reforms, including Government objectives for health, mental health and addiction, as well as Government objectives for Māori health, Māori mental health and addiction, priorities for Māori development and purchasing policies. The review of the written material is a major part of this study and findings are recorded throughout this report – a list of all published references is contained in the bibliography. The reason for this was to analyse the impact of policy, and its role within services.

While searching the many documents I came across information from what I call the formation days of our sector. These included the time span of the devolution of old hospitals into what we know today as Community Mental Health (CMH). This information was used to inform the development and findings of this research and to substantiate many of the issues subsequently identified. Moreover, it provided the required context for the investigation, a rationale, a platform, and a fundamental substrate upon which the research could be based.

2.4: Māori Health Research Frameworks

Given the focus of the research and its alignment with Māori health, consideration was also given to relevant theories and conventions with Māori health research. A Māori health research framework of particular interest to this investigation called Māori centred research was developed by Durie (1996b). The Māori-centred approach to health research shares several commonalities with a kaupapa Māori paradigm. Both approaches to research emphasise the importance of Māori cultural values, integration and interconnectedness, active Māori involvement in the research process, and building interest through the focus on research issues of importance to Māori.

The Māori centred approach to research places Māori people, culture and knowledge at the centre of the research activity (Durie, 1996b) by applying strategies based the principles of whakapiki tangata (enablement), Whakaurunga (integration) and Mana Māori (Māori control). Explain what these principles mean then explain what the table means.

Principles		Whakapiki Tangata Enable	Whakaurunga Integrate	Mana Māori Māori Control
Purpose of Research	1. Health gains for Māori 2. To strengthen Māori culture 3. To advance positive Māori development and acquisition of new knowledge			
Practice of Research	1. Active Māori participation 2. Multiple methodologies 3. Measurements relevant to Māori			
The Practitioners of Research	1. Māori researchers 2. Interim solutions 3. competencies • Māori knowledge • Health research • Māori society			
The Politics of Research	1. Treaty of Waitangi 2. Māori and Iwi 3. Funding			

Table 1 Māori centred framework. Source: Durie, (1996b, p. 13)

Māori centred research advocates for research that:

1. is for Māori.
2. is inclusive of Māori expectations of research.
3. considers the implication of the Treaty of Waitangi and self-determination, as well as access to funding for research.
4. Faciliatates rangatiratanga and meaning for Māori and non-Māori.

These principles were applied in an intuitive rather than rigid manner and in order to concord with the unique objectives of the research. It should further be noted that I did not perceive any conflict or compromise by adapting existing frameworks

Structured interviews

To complement the review of literature, a questionnaire was specifically developed to ascertain views and attitudes about cultural practice and activities within mental health services. A structured, open-ended questionnaire (Appendix 1) was used and with the consultation of my supervisor designed to fit the purpose of this investigation. The project was identified as low-risk and registered with the Massey University ethics committee (Appendix 2), which meant we could proceed with the interviews. One of the ethical

issues was management of information, which was addressed by securing the tapes after the interviews, which are kept with the researcher. The interview transcript was returned to each interviewee post interview for comment all were returned with no changes. These were the main ethical issues covered in this investigation. As this investigation focused only on the individual's journey no cases of clients were shared with the interviewer. To ensure their confidentiality I used codes to record their interviews and have reported them by number not by name as to protect this.

The sample was selected using the following criteria:

1. They were all Māori
2. Time in the AOD -Mental health sector, which ranged from 6 years to 35 years and gave a robust view of experience and competence levels.
3. Consumers of AOD services, but were now practicing within mental health and Addiction services or working at the level of management within services.
4. There was a balance of male and female
5. Kaumātua and Kuia needed to be included.

Five participants were recruited including 3 Alcohol and other Drug (AOD) practitioners, 1 Kaumātua and 1 Kuia, both of who are also in practice within services. All participants were involved in different aspects of practice; all had a range of experience from 6 to 35 years and worked throughout the country.

I believed that would answer the questions of this project as most had talked with me about common thoughts we had within our sector. Having worked in the sector at many levels and knowing all of the interviewees it was the practice of whakawhanaungatanga (relationship) that was the main link in this process of selection as I had trust and respect for these people and them for me.

Each interview took the same format, being undertaken at the participant's place of choice. The sharing of karakia was done at the beginning of each interview and the closing. The sharing of kai (food) took place as this is common tikanga whenever meeting with people.

The questionnaire was structured around eight areas:

1. Length of time in the sector
2. Their understanding of cultural competence
3. The role of their own identity with their practice
4. The role of kaumātua and kuia in their practice
5. Did they feel comfortable working in Māori models of practice
6. What models did they prefer to practice
7. Does their current work environment support this practice
8. Did they have anything further to add?

Once all the interviews were completed they were transcribed. For this purpose I did my own transcribing in order to hear again the essence of their kōrero, and to put this into the relevant chapter of the thesis. I have been back to the entire sample group with this chapter and all have agreed that it was an accurate reflection of their kōrero. When we review the process that was used, this is supported within both methodologies of kaupapa Māori and Western paradigms of research.

I have also consulted with iwi about this project and the findings, which they have supported. It is here where I came to understand that many of our Māori people are sick of being researched, as the research has not been undertaken to meet the needs of the people being researched (Personal Communication, Kaumatua T Thomas, Whakarongotai Marae, October, 2009).

Hui attendance, seminars and conference participation

To hear firsthand the collective views of Māori health experts, I attended many hui and seminars over the last two years to support my Masters research. This has included university lectures, workshops, and seminars, but also international forums, held in Canada, Melbourne, Darwin and Hawaii on mental health and addiction, alongside the national addiction conferences in New Zealand in 2007, 2008, 2009, and in September 2011.

2.5: Chapter Two Conclusion

Kaupapa Māori theory and Māori health research frameworks have provided the methodological platform for this investigation and have inevitably shaped my overall approach to this investigation. These approaches have been applied in an intuitive and deliberate manner and in a way that has matched my own expectations, the needs of the respondents, and the desire to produce outcomes that are both valid and useful. Linking these ideas to the more pragmatic aspects of the research has not, therefore, been difficult and has evolved in a manner designed to achieve best possible outcomes and to maintain the confidence of the respondents.

The next chapter is a review of psychiatric treatment within New Zealand. This informs readers about our past so that we can move forward in service delivery and clinical care. It also looks at Māori illness through these times. It examines how our leaders responded to the issues of the earlier days and how without our young Māori party leaders as they were known we could have been in a very different place. Without these leaders who set the platform for Māori health, and its development, would we be asking today where the next leaders are to come from?

Karakia Whakamutunga

This karakia talks about the winds from all four corners of our land like the knowledge that is carried within this chapter

Whakataka te hau ki te uru	Cease now the wind from the west
Whakataka te hau ki te tonga	Cease also the wind from the south
Kia mākinakina ki uta	Let the calm breeze sigh over the land
Kia mātaratara ki tai	Let the stormy seas subside
Kia hi ake ana	Let the red tip dawn come with a sharpened air
He ata-kura	A touch of frost
He tio, he huka, he hau-hunga	And a promise of a glorious day

Chapter Three: History of Māori Mental Health In Aotearoa New Zealand

He Wātea Kōrero

This korero was gifted to our Marae by Sir Apirana Ngata ("The Story of Arohanui ki te Tangata", 1960). This chapter explores the contributions of Māori leaders in Māori health development and Sir Apirana Ngata is one of the leaders featured.

E tipu e rea, mō ngā rā o tāu ao, *ko tō ringa nei ngā rākau a te Pākehā hei* *ara mō te tinana, ko tō ngākau ki ngā taonga a o* *tupuna Māori hei tikitiki mō tō māhunga, ā ko tō wairua ki tō Atua,* *nānā nei ngā mea katoa.* *(Sir Apirana Ngata 10.11.1949)*	*Grow up o Tender plant* *To fulfil the needs of your generation;* *Your hand clasping the weapons of the Pākehā* *As means for physical progress,* *Your heart centred on the treasures* *Of your Māori ancestors* *As the plume upon your head,* *Your soul given to God* *The author of all things.*

3.0: **Introduction**

As early as 1844 the first dedicated psychiatric facility known was in Wellington. Within ten years another, known as Sunnyside, was established in Christchurch, followed by another in Dunedin (Shearer, 1974). Prior to 1854 the care of mentally ill people was done through the prison system:

> Those who were seen to be socially undesirable were sent to jails for safekeeping. These included deserters, convicts, delinquents, waifs and strays, prostitutes, debtors, drunkards and vagabonds as well as lunatics. Lunatics were sent to jail because they upset the peace. Mentally ill behaviour was seen as a law and order problem and was dealt with accordingly (Williams, 1987, p. 3).

Williams (1987) reports the first separate accommodation for the 'insane' was built next to the then Wellington prison; however this separate accommodation remained part of the Wellington prison system. The first independent provincial lunatic asylum was built in Karori in 1854, then moved to the Town Belt and named the Mount View Lunatic Asylum. This was finally relocated to its present location at Porirua in 1887. As with most asylums around that time, Porirua Hospital was situated outside a large city (Wellington) and away from the general population (Haggerty, 2000).

Brunton (1986) describes how these institutions were primarily built on the outskirts of towns, based on the rationale that such siting would enhance mental tranquillity, not as a form of social segregation (as cited in Brookbanks, 1996). These asylums were often small to encourage family values and disguise the fact they were institutions (Brunton, 1986). Socially respected citizens such as lawyers, clergyman and doctors often provided funding for the institutions privately, as government funding was not established until the 1950s (Dew & Kirkman, 2002).

Class regularly separated residents, and placement within the wards was classified based on social status, usually based on monetary values (Dew & Kirkman, 2002). Many felt this was a direct representation of asylum management through patient classification (Brunton, 1986). In 1903 government recommended the villa system where villas were built to house 35–50 patients separated by plantations. The first planned villas were to be based in Tokonui where the establishment was nicknamed the 'garden city' (Brunton, 1986).

Durie (2004a) suggests that institutional care was quickly the accepted practice within mental health at these times, based on a very English approach towards treatment of psychiatric disorders. Rates of admission, however, were higher in New Zealand compared with England in these times (Durie, 2004a). It has been suggested that this was directly correlated to the high consumption of alcohol within the colony. Inspector Skae, the Inspector General of Lunatic Asylums, made this suggestion, believing it could be directly linked to the increased levels of insanity. This was dismissed and he was later relieved of his position, reportedly not for his views but due to alleged brutality within an institution (Durie, 2004b).

Public perceptions of those with mental illness were often skewed, with many believing that those with mental illness were a danger to others in the wider communities (Dew & Kirkman, 2004). This further added to the alienation of mental health sufferers.

In 1911 The Mental Defectives Act replaced the name of ‘asylum’ with ‘mental hospital’, and the definition ‘lunatics’ was replaced with ‘inmates’, implying that those hospitalised were criminals, and further adding to the social stigma associated with mental illness (Dew & Kirkman, 2002). The admission criteria also became unclear, with poor and indigent people often being committed to these hospitals. Those admitted to the hospitals were subject to a 6-month curability test, where those who had not recovered in their 6 month stay would become ‘lifers’; by the early 1900s over 90% of inmates were considered incurable and resided in the mental hospitals for the rest of their lives (Dew & Kirkman, 2002).

As the numbers of those committed to asylums grew, there was incredible pressure on bed availability and documented workforce shortages. Many mental hospitals became overcrowded and were operated by unqualified personnel where the treatment given was often thought of as barbaric in its approach and in some cases led to loss of lives (Dew & Kirkman, 2002). Due to these increasing numbers, the ideal of the homely asylum was discarded for large institutions (Dew & Kirkman, 2002).

In 1944 the rates of institutionalisation peaked when nearly 5 in 1000 New Zealanders were classed as psychiatric hospital inpatients (Hall, 1988). These numbers, however, did not reflect the number of Māori admissions during this time. The prevalence of Māori mental illness was not a documented phenomenon, and before the 1950’s mental hospitals were rarely used by Māori (Dew & Kirkman, 2002). From the late-1970s however the picture began to change and more and more Māori were becoming more visible within psychiatric institutions. Into the 1980 the rates of some conditions (suicide for example) increased by more than 200% while Alcohol and Drug induced psychosis became the leading cause of first admissions for Māori males (Durie, 1997). By the mid-1990s more major concerns were being raised:

> If infectious disease were the main cause of Mäori ill-health one hundred years ago and degenerative disease fifty years ago, then mental health disorders have now assumed first place as the major health risk. (Mason Durie, 1997)

3.1: Leadership that Developed Change in New Zealand

This section reviews four key leaders in Māoridom who were heavily involved in health policy during the times when Māori health was being most affected and changing dramatically. It is used to profile Māori development and how positive change has occurred on multiple fronts but also frequently linked to Māori leadership and the work of key individuals.

Sir Peter Buck (Te Rangihiroa)

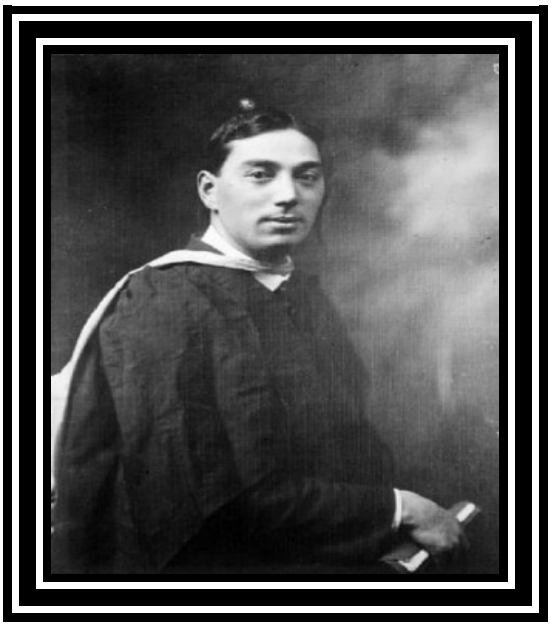

Figure 8 Sir Peter Buck (Britanica.com, 2010)

Sir Peter Buck was the first Māori doctor to graduate from a New Zealand University and was to further develop an interest in other fields including anthropology politics and the military - he was knighted in 1946. His career was divided into three phases. The first phase of his life was largely devoted to public health work among his own Māori people and, perhaps as a tangent to this interest to Māori welfare, with a rather brief political career in the New Zealand House of Representatives (Directory of New Zealand, 2009, para 6). During those years Buck appeared to be living in two worlds. It is said he

inherited his charm from his mother's culture and had the humour, patience and dignity of the Polynesian. It has been viewed that from his father and with his education came the ethic of hard work. Buck was however practicing as a medical doctor in a time when his own people held a different belief system in correlation with sickness. Sir Peter Buck describes sickness in the general Polynesian term, *maki.* In New Zealand the term *maki* has evidently become archaic. The Reed Dictionary of Modern Māori compiled by Ryan (1995) records *maki* as meaning "an invalid or sick person" (p. 141).

The root of this definition supports the Māori worldview that sickness was viewed from a holistic viewpoint and not a singular clinical viewpoint (Buck, 1962). Many Māori academics have theorised that sickness and disease were the result of the machinations of "Maikinui – a supernatural 'something' that existed somewhere in the void" (Buck, 1962:404). It was Maikinui and his family of Maki who unsuccessfully opposed the assent of Tāne to the upper realms in search of knowledge (Buck, 1962). In practice any departure from normal health was ascribed to attacks by malignant spirits (Buck, 1962). Based on this understanding Buck asserted that the role of the tohunga in Māori health was pivotal to Māori communities across Aotearoa (Te Ara, 2009). However, in 1907 an the Tohunga Suppression Act was introduced by the New Zealand parliament that caused anxiety and confusion. This Act will be discussed in more detail later in this chapter.

In his younger days Buck was a key member of the young Māori party where he formed a relationship with Sir Apirana Ngata, a friendship that endured for many years. Sir Māui Pomare was also part of this group, as was Sir James Carroll. In the six years between 1904 and 1909 they supported and saw to it that 1,256 unsatisfactory Māori dwellings were demolished and that 2,103 new homes and 1,000 privies were built (Kingi, 2005:.8).

After serving as a major and second in command in World War One, he returned to Aotearoa where he resumed his work as a medical officer of health and was appointed Director of Māori Hygiene within the Department of Health (Directory of New Zealand, 2009: para 10).

When he moved to Hawaii in his later years, he began to produce research that would have an impact across the entire Pacific, and he spent 25 years studying and noting the

indigenous cultures of Polynesian Pacific. He also produced scientific articles and monographs on the gold standard. He was seen both as an inspiring leader and also a teacher and administrator of immense skill and understanding (Directory New Zealand 2009, para 14).

The following quotation from Sir Peter Buck links him with this thesis:

> E whā ngā kokonga o tāku whāre. Ko te taha wairua, te taha hinengaro, te taha tinana me te taha whānau. Ka hinga tētahi, ka ngaro tāku whāre. There are four walls to my house – the spiritual side, the mental side, the physical side and family side. If one wall falls, so does the house ("The Story of Arohanui ki te Tangata", 1960, p13).

Figure 9 Inspecting the state housing scheme at Waiwhetu, 1949.

Left to right: the Prime Minister, the RT Hon. Peter Fraser, Mr Ihaia Puketapu, Colonel Charles Bennett, Te Rangihiroa (Sir Peter Buck), Mr Ralph Love, Sir Eruera Tirikatene and Mr M. Rotohiko Jones (Photo News, Lower Hutt Ltd).

The photo above, taken in 1949, was of Sir Peter's last visit to New Zealand. He visited Waiwhetu Marae as part of this tour to inspect the state housing development in the area led by our leader of Taranaki people in Te Awakairangi (Hutt Valley).

Sir Māui Pomare

Figure 10 Sir Maui Pomare (NZ History, 2009)

Another key person who stood alongside Sir Peter Buck was Sir Māui Pomare who was descended from Hoturoa, captain of the *Tainui* canoe (Cowen, 1905: 96). His grandmother was Te Rua-o-te-Rangi, one of the few women to sign the *Treaty of Waitangi*. Māui Pomare, was born on 13 January 1876 at Pahou Pā, 20 miles north of New Plymouth.

In 1887 Pomare attended Christchurch Boys' High School and later, Te Aute College, where he transferred after his mother's death in 1889. There he joined the Te Aute Students' Association where he and others were stimulated by a study of J.H. Pope's *Te Ora-o-te Māori*. He and his student friends often spent their vacations travelling and speaking at pā's on religion, education, and health. They felt that Māori could best rehabilitate himself through hard work on the land by living away from their unhealthy kāinga (villages) (Puke Ariki, 2009: para 15).

Influenced by a sailor-cook at Te Aute, Pomare joined the Seventh-day Adventist Church and left to attend their College (Battle Creek) in Michigan, where he graduated M.D. in 1899. He returned to New Zealand intending to establish a college on the American pattern but instead accepted appointment as Health Officer for one of the 19 districts created by the Māori Councils Act (1900) (Puke Ariki, 2009, para 21).

In 1904 Pomare wrote in his annual report: "*I cannot be emphatic to these Tohunga for I have seen the results of their work. 17 children of what he considered the hope and pride with this tribe were cruelly murdered by Tohunga as they only had measles"* (Puke Ariki 2009 para 50). This statement provides some context as to why Pomare sponsored the *Tohunga Suppression Act* which was passed in 1907. As a result of this Act Māori Councils were formed and sanitation inspectors were appointed to Māori villages. Enthusiastic, and tireless in his mission among the Māori people Pomare advocated and, in large measure, achieved the registration of all Māori births and deaths, and also encouraged sanitation in native settlements.

Through his efforts he brought new hope and life to many and lived to see the Māori people increase in numbers and in social status. In Parliament he was noted for his powers of concentration, for his ready wit, and for his forthright oratory, while his work for the lepers and the inmates of mental hospitals showed the breadth of his humanitarianism (Te Ara, 2008).

Sir Apirana Ngata

Figure 11 Sir Apirana Ngata (Answers.com, 2009)

As one of the young Māori Party leaders who served his people well in New Zealand, Sir Apirana Ngata could have easily practiced law and made a legal name for himself, but after a short period he found his passion was for his people – a position he regarded as the highest honour of all. In the last decade of the nineteenth century the Māori

population had dropped from to 150,000 in 1840, down to 40,000 in 1896 and were labeled a dying race.

A new breed of leadership developed from the Te Aute College Association, and a Young Māori Party was formed (Encyclopaedia of World Biography, 2009: para 3). Their aim was to use tribal organisations to promote development in health, which they believed would gain the best results.

Their programme was to influence Parliament to obtain legislation directly beneficial to Māori. Ngata entered Parliament in 1905 as an elected member, where he remained until 1943. He represented the native race in Sir Joseph Ward's Ministry (1909–12), and was Minister of Native Affairs and Cook Islands in Ward's second Ministry (1928–30) and under Forbes (1930–34) (Encyclopaedia of World Biography ,2009: para 3).

Ngata also promoted and encouraged the revival of the language, traditions and history both of Māori and Polynesians. He was president of the Polynesian Society for nine years and also on the board of the Dominion Museum. He was involved with the war efforts and played a major role with the 28th Māori Battalion.

One of the key points of all three of these men was that they all were past students of Te Aute College, which supports the role of education in advancement and achievement combined with cultural leadership. Two other reasons for the inclusion of the profiles of these men in this chapter are that they constituted the first real Māori political leadership heavily influencing policy and legislation regarding Māori health at the time and they also set the foundations for Māori development. When we look at public health and the impact of the acts these men supported we still see the results today, the Tohunga suppression act although it came out of a need to encourage Māori to access mainstream health services, it also led to the loss and suppression of mātauranga Māori.

A 1996 address by Mason Durie called *Identity, Conflict and the Search for Nationhood* supports the assertions that these three Māori leaders led the way for Māori health**.**

> The call for acceptance of a predominantly Western world was first made by a small group of Māori students from Te Aute College a little over a hundred years ago. During the summer vacation they began travelling to rural and often remote

communities bringing new messages – education, ventilated housing, agriculture, economic development and, important to this meeting, health and hygiene. Two of the Te Aute group, Māui Pomare and Peter Buck, were to become medical graduates before they entered politics. Both were subsequently knighted. A third, Apirana Ngata, also became a knight and achieved distinction in law, politics, literature and land reform (Durie, (1996)

Te Whiti o Rongomai

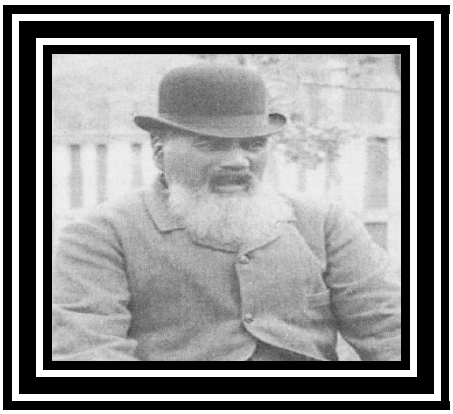

Figure 12 Te Whiti o Rongomai (NZ Edge.com, 2009)

Te Whiti led the world in the development of passive resistance. His contribution to Māori health development is sometimes overshadowed by his political endeavours. However, his role in providing a catalyst from Māori development and by association Māori health has not received the attention it perhaps deserves. For this reason he is included here and as an historical figure in Māori health development.

Collective Contribution to Māori Health Development

These men have all made a considerable impact on Māori society and in a variety of fields. However, and in one way or another they have also made a measureable contribution to Māori health development. Their approaches were as diverse as their skills yet they collectively maintained a focus on Māori development through community involvement, cultural enhancement, and a more fundamental belief in the ability to Māori to develop solutions which were in sync with contemporary Māori realities.

Tohunga Suppression Act 1907

Despite the efforts of the leaders Buck, Pomare and Ngata initial moves to better recognised the role of culture in promoting Māori health and Māori development one issue in particular almost single-handedly served to undermine this work. In 1907 the Tohunga Suppression Act was introduced and was to have a significant impact on the practice of tohunga in Māori communities. At the time, tohunga were ill equipped to deal with the illnesses brought by the settlers that were devastating Maori. The Tohunga Suppression Act although it came out of a need to encourage Māori to access mainstream health services, it also led to the loss and suppression of mātauranga Māori. Miria Pomare, said of her husband, “Sir Maui Pomare detested the practice of charlatan tohungaism and believed it was responsible for the continued deaths of Māori people and had to be stamped out" (Puke Ariki, 2008, para 38). The tohunga took no responsibility for the consequences. When a sick person died, the Tohunga would blame it on the patient, saying they had breached tapu or had committed a spiritual transgression (Puke Ariki, 2008: para 40). The Act impacted on Māori traditional health practice as it created a sense of fear and there was unease about the Legislature (23 August 1907,140 NZPD 403).

Writers such as Judith Binney (1940), Peter Webster (2001), Rayburn Lange (2001), and Malcolm Voyce (2001) have viewed the Act as a measure initially prompted by Māori and Pākehā concerns over the appalling state of Māori health in the turn of the century. In 1906 the Māori population was around 47,732; in 1907 many Māori were still not able to access consumption sanatoriums or hospitals. The number of doctors subsidised to treat Māori patients in rural areas were pitiful (Ward, 1995). The Act was passed to calm Pākehā fears about Māori attempts to claw back some of the political power and representation that had been lost over previous decades of colonisation.

Lange, as an Auckland undergraduate was the first historian to discuss the 1907 Act in any detail. His 1968 essay on tohunga and government in the twentieth century described the parliamentary debate that preceded the Act, before concluding that the legislation was enacted in response to the political activities of the Māori prophet and tohunga Rua Kenana Hepetipa (Lange, 1968: 12).The latter part of this claim was a

misreading of Lange's 1972 MA thesis, which did not link the Act with government health measures (Lange, 1968).

Voyce (1989) contradicted the statement that the Act was health when he argued that the legislation was not part of the Liberal Party impulse for social welfare. Rather, he claimed, it was just one of a series of coercive measures implemented by the liberals: these included the *Habitual Drunkards Act (1906)*, the *Habitual Criminals and Offenders act (1906)* and the proposed *Juvenile Depravity Suppression Bill*. However, he did not mention the *Quackery Prevention Act (1908),* which offers a direct parallel with the *Tohunga Suppression Act 1907* (Voyce, 1994).

The publication of Voyce's article occurred at a time when Māori were increasingly questioning and reviewing their health status. In 1988 Sam Rolleston, then known as a cross-cultural understanding consultant, was commissioned by the New Zealand Department of Health to compile a Māori health knowledge base that would view Māori health from a Māori perspective.

Rolleston identified a number of historical Māori health issues. These included the *Treaty of Waitangi*, early twentieth century epidemics, the *Tohunga Suppression Act* and its reappeal, the work of Māui Pomare and Peter Buck, religious leaders (such as Te Whiti o Rongomai and Tohu Kakahi), and the establishment of the Waitangi Tribunal in 1975. His recommendations incorporated a plea for research to provide a more balanced view of events leading to the *Tohunga Suppression Act* (Rolleston, 1989). At the end of the 19th Century defined plans for Māori health were not progressing well.

This was in part due to the drop in population and it was believed that Māori people, as a race, would be all but extinct and would be reflected only in historical contexts and anthropological text.

3.2: Conclusion

This chapter has profiled both historical and contemporary concerns in Māori health and especially as they relate to mental health. It has further examined the Māori response to these issues and with a particular emphasis on Māori leadership, Māori culture, Māori

community participation and a comprehensive approach to Māori health development. Moreover, and while leadership is a necessary requirement, the support of the Māori community is also paramount. Further is the need to consider the impact of cultural factors and how they might form part of any health strategy or initiative. It is in this regard that the implications of the issues resonate with the present study and further highlight the imperative to consider the role, function, and application of cultural practice to Māori health development.

Karakia

The Karakia below is one that is use on our Marae a lot given that three men in chapter Buck, Pomare and Te Whiti are all connected to our Marae and Iwi it is only fitting to conclude this chapter with this Karakia.

He kororia ki te Atua i runga rawa	All honour and glory to our maker
He maungarongo ki runga i te whenua	let there be peace and tranquillity on Earth
Whakaaro pai ki ngā tāngata katoa	Goodwill to Mankind

Chapter Four: Cultural Conflicts And Health

He Waiata: Whakatūpato

This waiata talks about being careful and taking heed of past lessons learned it also uses the concept of rangimarie which, will become clear to us all in a later chapter (Te Rau Matatini, 2008)

Ka hoki ana ki ngā kōrero mihi whakatūpato	Let us take heed of our past through the
Ā kui mā ā koro mā	lessons by our kui and koro.
Kaua e tuku whakahihi atu ki te tangata	Refrain from arrogance or inflicting harm,
Kei ngā ua e te kino	be gentle, maintain peace as the
Kia tau te rangimārie	world changes.
Ki runga i te ao huri noa (noa)	Tread carefully
Tūpato	Tread carefully
Tūpato	as darkness descends.
Kei pōngia	

4.0: Introduction

This chapter reviews the workforce in mental health and addiction. The view that these are quite different workforces is still being vigorously debated in the very sector that is charged with the care and treatment of all people, including Māori. The debate has been by mental health nurses and other professionals who don't agree, that addiction services is a part of their work however it can be seen by the evidence that it is very much a part of mental health and that clients often present with both issues rather than just one. Often clients have been told that "sorry you have an alcohol and drug problem and not a mental health problem" (Mental Health Commission, 1998, p7)when the client clearly expresses feeling in low mood but has been intoxicated at the time. If we are talking about inclusive practice we all need to be able to work with what presents and not establish blocks that prevent our people getting the best service possible.

There are three sections to this chapter. The first section of this chapter looks at our current workforce. One must note that this sector has undergone many changes in the last twenty years – from the 1980s, where we had large hospitals or "big bins" as they were known in the community, to the current era where we now have more services in the community to keep people out of the high-cost hospital units. However, with all this change the questions need to be asked, has the practice with clients changed and is it effective? This chapter will discuss this and other issues.

The second section discusses the role of education in the workforce. The recent change of Government has seen yet another set of changes likely to impact on health care delivery. This is an issue that recurs when we have a change in political power – it can build on development or set it back for years.

The third section looks into the current view of our workforce and suggests a change in workforce roles. The use of peers in services has been debated, but the concept has support when we look at the current needs that are not being addressed. The investment in treatment is very expensive; however, to have more services that meet the needs of clients is a must. Although treatment is also costly, if we are asking the country to address its use of alcohol, we as treatment service providers must take this line in offering supportive treatment that meets the needs of all people, whatever the cost.

4.1: Māori mental health and addictions related Policy

To review the current workforce in our sector, we first need to review the policy that currently drives mental health services. We have seen many changes in the direction of policy relating to mental health and addiction that have resulted in a change in service delivery and also in the skills of our workforce.

Looking back to chapter three on treatment in the 1800s and 1900s, we can see that things are very different today. However, the same issues, such as access, and workforce shortage within our current services, are still relevant.

In 1970 it was clear that the health sector needed a fundamental overhaul. A number of reviews had confirmed large inefficiencies within the system, poor accountability, and

inadequate measurements through which rising costs could be managed (Kingi, 2005). 1983 was the turning point; it was the year in which the first of what we know today as District Health Boards were created, together with the foundation of the Kōhanga Reo, which strengthened our cultural identity base, and the establishment of the Waitangi Tribunal (Durie, 2008).

It was not, however, until 1989 that any major restructuring occurred, when, through the *Area Health Boards Act 1983*, 14 area health boards were created, allowing for the integration of both population and hospital health services. In 1990 the National Government took the reforms to a new level, using a business model and deregulating the whole industry (Hornblow, 1997; 1892).

In the late 1980s the devolvement of the large psychiatric hospitals towards community-based care was the first major change that was to impact on our workforce (Durie, 2001). Having just entered the workforce in 1985 as an Alcohol and other Drug (AOD) worker, I can testify to the rapid change in service delivery. It was not until 1989 that I was requested to undertake any form of study to show competence in my work as a practitioner.

In 1993 the Government introduced health reforms for the purchasing of services and in 1994 the Government also outlined a strategy for the provision of mental health in New Zealand; it was called *Looking Forward*. This was followed in 1997 by a further report, *Moving Forward* that defined more clearly the direction and goals for the next 10 years (Mental Health Commission, 1998).

In this *Moving Forward* report Māori mental health was described as the number one health concern for Māori. As a result, the Commission visited seven providers throughout the country. They also canvassed input to the blueprint and a further nine hui were held nationwide. The key issues that were revealed in the hui, supported by written reports from such people as Professor Mason Durie, were the problems being experienced by Māori with mental illness: access to mainstream services, the lack of an adequate Māori workforce and he extreme difficulty Māori experience in developing and funding Kaupapa Māori services (reference the hui documents/blueprint or Masons reports).

At this time New Zealand was under the direction of the Health Funding Authority. The Commission's role was to specify clearly and define the performance criteria in the blueprint (Mental Health Commission, 1998). The Rt Hon Jenny Shipley, Minister of Health 1994–1996, set up the Mason inquiry after 'media frenzy' about 'mental health'. The Mason Report was commissioned by the Corrections Department to review the prevalence of mental illness amongst prison inmates and came at a time when the closing down of the older style institutions had been almost completely achieved Te Haerenga mō te Whakaoranga, (1996).

Those larger institutions, at their peak, held 10,000 inpatients at any one time. However, the new era of services delivered in the community was well under way. The earlier process of deinstitutionalisation was not well planned and the transition was not adequately funded (Te Haerenga mō te Whakaoranga, 1996–2006).

In 2000, the *New Zealand Public Health and Disability Act* started a policy change in direction to 3 key areas: requiring DHBs to have a population health focus, outlining how legislation will be used to recognise and respect Treaty of Waitangi principles and mechanisms for Māori to contribute to decision making (DHBs)(Ministry of Health*,* 2002*).*

This Māori focus was continued with the first Māori health strategy – He Korowai Oranga. The publication of *He Korowai Oranga* in November 2002 completed an extensive consultation process and aligns Māori aspirations and Crown aspirations for Māori health (Ministry of Health, 2002). The overall aim is whānau ora – Māori families supported to achieve their maximum health and well-being. The Treaty of Waitangi principles of *partnership, participation and protection* remain as the foundation to achieving the strategy with a key drive to improve Māori health and reduce inequalities. In setting out to achieve whānau ora, *He Korowai Oranga* has two broad directions that acknowledge the partnership between Māori and the Crown. Within the context of these directions, three key themes are woven throughout the strategy. Finally, four pathways set out how whānau ora would be achieved.

The Ministry also published *Whakatātaka – Māori Health Action Plan 2002–2005*. Detailed in *Whākatataka* are roles, expectations, responsibilities, performance expectations, measures, and initiatives for achieving *He Korowai Oranga*. Other key

policies that have supported the changing world of mental health and addiction workforces are Te Puāwaitanga, Te Tāhuhu, and Te Kōkiri and in 2008, Te Puāwaiwhero (The Second Māori Mental Health and Addiction National Strategic Framework 2008–2015) (Ministry of Health, 2008).

To explain these documents I have provided a brief description of them in chronological order.

Te Puāwaitanga (TPW) Maori Mental Health National Strategic Framework (2002)

- 5 year strategic framework
- Aimed at assisting DHBs plan services for Maori
- The Maori mental health environment has changed

Te Tāhuhu (2005) was a review of the Mental Health Commission's Blueprint for Mental Health Services *Looking Forward* (1994) and *Moving Forward* (1997). Te Tāhuhu set the direction for mental health 2005-2015.

Te Kōkiri (2006) reviewed *Looking Forward* and *Moving Forward a*nd provided an up-date of TPW included:

- *review of evidence*
- *building on the gains:*
- *strengths, weaknesses,*
- *limitations = lessons!*

In 2008 an update of the mental health and addiction sector workforce needs and a framework for service provision was provided in Te Puāwauwhero (Ministry of Health, 2008). The underlying push of this framework was so that whānau ora as a concept was becoming more widely understood as it was not being implemented in real practice settings or reflected in outcomes.

Te Puāwaiwhero has three key principles:

1. Prioritise Māori: Act on the evidence of health inequality in Māori mental health and addiction needs to ensure new and existing initiatives are responsive and effective for Māori.

2. Build on the gains: Current initiatives to improve Māori mental health and addiction are sustainable and have a development path for the future. 3. Responsiveness to Māori: Build on the link between health and culture to ensure initiatives are responsive to the unique needs of Māori (Ministry of Health, 2008)
Maori Mental Health Needs Profile was a piece of work that (Baxter) did that sat alongside the Ministry of health document Te Puāwaiwhero it provided: • launched alongside Te Puāwaiwhero • detailed analysis of research undertaken over more than 10 years. • an evidence base for the strategic framework (Ministry of Health, 2008)

In the first section were the foundation of clinical directions in mental health practice and finally addiction has now joined this group with the promotion of Te Ariari Oranga (Todd, 2010), promotes the role dual competencies across our sector in a practice and brings addiction practice and mental health practice closer together.

4.2: Client base

Te Rau Hinengaro (2006) was the first prevalence study done in New Zealand that clearly showed the gap for Māori in the current mental health and addiction services and informed policy. However, behind this is the even more concerning issue of the current workforce, which has now been shown to be inadequate to cope with the needs of tangata whaiora in a modern era.

However, one issue that has not been resolved is the provision of *mental health and addiction* services that has divided our workforces. The key debate is what, and who, can deliver these services to our people. My view is that a large percentage of those who are mentally unwell will often have had an issue with alcohol and drugs. Te Rau Hinengaro supports this in its findings (Oakley Browne et al, 2006).

We have in New Zealand a number of initiatives that have been instigated to increase the capacity of the Māori health workforce and to reduce barriers to treatment (Oakley

Browne, 2006). To support the need, Te Rau Hinengaro shows that Māori are a high priority group. Even after adjusting for sociodemographic correlations across the range of disorders, substance use disorders remain higher for Māori (6%) than others (non-Māori, non-Pacific) (3%), 2 times higher for substance disorders (Te Rau Hinengaro, 2006).

Furthermore, unmet needs including access to services were lacking. According to Te Rau Hinengaro (2006):

- Māori with substance use disorders were the disorder group least likely to have had service contact for their mental health needs (15.5% mental health specialist, 15.8% general medical care, 6.4% non-healthcare provider and 27.8% overall)
- 27.8% of Māori with substance disorders accessed any service in a twelve month period but this figure could be o lot larger than the study suggests
- Māori are less likely than others to make contact with services for mental health reasons (32.5% Māori, 41.1% others).

The extent of these disparities is little affected by adjustments for sociodemographic correlations, indicating that barriers to access for Māori are not explained by youthfulness for socioeconomic advantage (Oakley Browne et al., 2006).

Often by default many people don't gain access at a primary level and end up in an acute system that doesn't support them as well; access should be at all levels of service provision and any door is the right approach and is the way forward in practice. I also believe that Baxter offers a clear description that often Māori are coming from not just poor backgrounds but that this is a contributing factor. Baxter (2008) argues:

> The burden for substance use disorder is highest for Māori. The unadjusted findings provide the best indication of the actual level of Māori mental health population need compared to others. Adjusted findings show what the prevalence's would look like if Māori had the same age/sex distribution and socioeconomic profile as the other population ie: older and more socioeconomically advantaged (Te Rau Matatini, 2008: 20).

We can see that Baxter is saying that we need to really understand this whole area better to gauge the real prevalence rates. An example is many people who have a gambling problem will have depression and are at risk of suicidal behaviour (Sullivan, 2007). However these people often don't present for treatment until they are forced to and have lost everything mainly money but have covered their addiction well by not being seen as having a problem.

With the rest of the health sector, the workforce is the main contributor to service quality and the driver of the cost of service delivery. Although numbers are not readily available, it is estimated that the sector employs in excess of 12,000 Full Time Employees (FTEs) and considerably more people in a variety of occupations, among which nurses and support workers predominate. In the DHB provider arms, workforce costs account for over two-thirds of total costs. A quality-driven and sustainable workforce is thus the key to efficient and effective services (Ministry of Health, 2008)

The quality of the service provision for Māori is also worse. Juliet Rumball-Smith, a researcher from the Department of Public Health and General Practice at the university's Christchurch campus, reviewed 11 studies of health care in New Zealand (2009). In particular, she found hospital obstetric treatment was poorer for Māori. A newspaper article called *The quality of the service provision for Māori* that reported the findings of her study highlighted that "Māori get poorer clinical health care in public hospitals than non-Māori, a University of Otago study suggests" (Rumball-Smith, 19 June 2009). If this is happening in the obstetric area it is questionable about what is happening in other areas of health. The same study stated that researchers looked at cases of cardiac intervention, end stage renal disease, and care of patients with mental illness (Rumball-Smith, 2009). Many of the same issues in the mental health workforce are common to those found in health generally. Lack of information about the workforce, competing international markets for labour, professional boundaries, doctor training, professional supervision in smaller areas, stressful workplaces, and retention difficulties are some examples (Rumball-Smith, 2009).

For mental health and addiction services there are a number of sector-specific issues. Issues particular to mental health include:

- rapid expansion of the workforce

- the low numbers of Māori and of Pacific peoples in the workforce
- an aging workforce
- the importance of understanding cultural difference in diagnosis and treatment
- multiple paradigms within treatment teams which cover a range of occupations and the need to realise potential of the consumer workforce (there is a growing awareness in the sector that people with experience of mental illness can play an important and critical role in the workforce)
- building the capacity and capability of Non-Government Organisations (NGOs). (National Committee for Addiction Treatment, May, 2006)

Robertson, Haitana, Pitama, and Huriwai (2006) in a review of literature clearly concluded that there is an urgent need for a coherent approach to indigenous workforce development, to enable an increase in access to indigenous workers/and or services (National Committee for Addiction Treatment, May, 2006).

Baxter (2008), in her extensive review of literature on mental health needs, identifies that barriers to primary health remain, and this impacts on care for Māori. The primary health sector is the most common area in which mental health and AOD problems will or could be seen and addressed at an early stage, rather than later when whānau are often in crisis and an acute service becomes involved. A focus on prevention and early intervention is needed to arrest the growth of long-term conditions (Ministry of Health, 2008).

One in three Māori is under 15 years of age and over half of the Māori population (53%) is under 25 years of age (Dyall, 2009). Māori will be a large part of the workforce of the future and it will be through their education, life and employment skills that we will shape the future of the mental health and addiction workforce and ultimately care and provision of our own.

To support local services and development we need a workforce that is equipped with the skills and knowledge as well as services that share information that is relevant and delivered in an appropriate and timely way. Local forums and hui to discuss local research and needs are a key part to achieving this outcome. Having formal agreements

between services and local iwi with the focus on Māori responsiveness in line with whānau ora, mental health and addiction guidelines can strengthen and close many gaps, *"*Effective and efficient health service provision for Māori requires cultural and clinical competency by all those providing primary health care" (Ihimaera & McClintock, 2007: 21).

Another key theme in the literature is the need to develop training and contexts that enable indigenous workers to operate within the parameters of clinically sound and culturally responsive best practice. When working with Māori, to gain the best results and health outcomes, practitioners need to understand that for Māori the involvement of whānau/family/significant others in the early recognition and effective intervention stage is critical, *"*Improving health outcomes and inequalities cannot be achieved by health services alone and the well-being of the collective whānau will ultimately improve Māori Health*"* (Ministry of Health, 2008; 14).

As the main source of strength, support and identity, whānau provide an essential role in assisting their whānau member to fully comprehend what is happening in their current situation (Ministry of Health, 2008). Another way of expressing this is through the concept of a whare tipuna (meeting house): there are pou that hold the walls of the house up. The whānau are that pou within a clinical setting context. Addiction is known as a whānau illness that attacks the whole family that is the pou, so often our people become very separated from the main support that will support healing of them all.

4.3: Educational Development

When I first joined the sector in 1985, I really was thrown in the 'deep end'. With no training apart from my own journey of recovery, which at that stage was about 6 years, I had to 'learn the ropes' while on the job with the National Society on Alcoholism and Drug Dependence (NSAD) who employed me.

During this time I relied on my own experiences; however, I was exposed to some changes in our sector and new models of practice that had moved from the abstinence-based model to the introduction of methadone, Opioid Substitution Treatment (OST), and the Harm minimisation approach. The introduction of Motivational Interviewing (MI) was

to change the way practice was done in our sector, and today it is still held up as the model when working with people and addiction problems. Motivational interviewing is a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence (Miller & Rollnick, 2002).

It was not until 1989 that I started my journey of professional development by attending the Central Institute of Technology (CIT) to complete a Certificate in Addiction Studies. Today the training is delivered through to Master's level at WelTec. Completing this was my first step in gaining a qualification and I thought the certificate was all I would need to do. In 1998, while working at Rhanna Clinic in Invercargill, the Ministry of Health promoted a course funded by Central Training Agency (CTA), that offered a Diploma in Oranga Hinengaro at Te Wānanga-o-Raukawa and I was encouraged by my Manager, Lesley Rewi, to undertake this. In February 2000, another member of staff from Invercargill and I travelled for two days to get to Ōtaki to start our course. Attending the Wānanga for the year not only gave me a qualification, but also the key to my professional and personal development – my whakapapa and identity.

Through the guidance of Professor Whatarangi Winiata and his vision of the Whakatupuranga 'Rua-Mano' generation 2000 (1978), I can say that today I know who I am; a direct result of the vision.

> For all Te Wānanga-o-Raukawa students, the completion of their tohu (qualification), ensures they know themselves better as Māori – Te kākano i ruia mai i Rangiātea, for I will never be lost because I am a seed of Rangiātea (Winiata, 2006, personal communication)

Today I not only have a degree but have continued on to study at postgraduate level.

At a recent workforce programme celebration held at Wainuiomata Marae on 16 April 2009, those who graduated acknowledged that the key to their success was: first they knew who they were, second whānau, and third was the support of a DHB, *"The support network through study and the support of a great mentor who was there when I needed help I know today who I am and stand as a qualified Nurse" (*Karman Watene-Bryan, pers. comm., Wainuiomata Marae, 16 April 2009).

This also can influence your own whānau, and in my case it has. Since my daughter attended my graduation in 2004, she has now gone on to complete her nursing degree. Her statement in 2004 was that if I could do it, anyone could. It is the best form of workforce development I know and it is about role modelling wellness and success as whānau, *"Study was hard, with work, and children. When we started our Nursing Course there was 8 in our 1st year and when we completed our course only 2 were left. The difference was we had whānau and our whole DHB behind us…. I also supported 17 students during the 3 years of my own study as a mentor"* (Rizpah Evans, pers. comm., Wainuiomata Marae 16 April 2009).

Te Rau Puawai is a programme run out of Massey University with funding from the Ministry of Health that supports Māori mental health and addiction workforce development. It has seen a major increase in Māori reaching their goals in academic studies and this has in turn built and contributed to our current workforce.

The National Addiction Centre (NAC) conducted a telephone survey in 2004 about paid AOD workers. Participants who self-identified as Māori in the survey were asked to take part in a follow-up Māori telephone survey. Most of the 57 Māori AOD treatment workers at the time were involved. Some of the findings and issues for the Māori kaimahi were:

- They are strongly committed to their work and want to develop their expertise further.
- The development (and integration) of both Māori and western knowledge and practice are considered important.
- There is therefore a need to develop specific training for kaimahi Māori that integrates both Māori and western knowledge and processes of learning.
- The average age of our workforce is 47.5 years in Addiction Services with an average of 7.5 years in the sector.
- 63% of the Māori workforce has a pre-tertiary qualification or none at all.
- 21% hold a certificate, about 2% hold a degree, and about 12% hold a post-graduate qualification; the gap is clearly between Certificate and Degree level (National Centre for Addiction Treatment, 2004).

A follow up survey was completed in 2008 and was reviewed to compare what changes had happened since the first survey by (NAC) this was reviewed and supported by Matua Raki:

- 54% of the workforce worked in the NGO sector.
- 9% worked with both AOD and gambling clients.
- 60% worked in cities.
- Average time in the sector 9.5 years for addiction
- Average age of the sector workforce 50 years.
- 60% work with Adult population.
- 14% work with Youth.
- 26% work with both groups.
- 30% of clients were not Māori
- 17% were working in a management role
- 43% are members of DAPAANZ. (Drug and Alcohol Practitioners Association Aotearoa New Zealand)
- 40% don't belong to any professional body
  (Matua Raki, 2009).

Therefore we need training and qualifications that will address the areas highlighted such as certificate and degree level options, support from the workplace etc. Another example is to support work with youth. A youth workforce in addiction study undertaken by Dr Ria Schroder (2009) at Otago, the first of its kind in New Zealand (Ministry of Health, 2009), found a lack of trained staff able to work with youth on complex issues particularly when many come not just with AOD issues but also with a history of multiple problems.

A definition of what is necessary in relation to workforce development in youth addiction service was provided by Matua Raki (2009): "*A Māori practitioner's ability to work with whānau who have addiction or mental health-related problems in ways that apply cultural expertise infused with clinical knowledge*" (National Addiction Centre Workforce Development Programme, 2008: 23).

4.4: Looking ahead

The mental health and addiction workforce is large and diverse. There are more than 12,000 FTEs in DHB's and NGO's, including administrative staff, addiction practitioners, clinical psychologists and counsellors, family/whānau advisors, funders and planners, managers, nurses, occupational therapists, psychiatrists, psychotherapists, service user advisors, social workers, and support workers. Workforce stocktake data illustrate the distribution of FTE by staff role and service setting, as shown in the table below.

This data should be interpreted with caution as the information is not robust or comprehensive.

	DHB		**NGO**		**Total**
Staffing Type/Service Setting	**FTEs in inpatient settings**	**FTEs in community settings**	**FTEs in residential bed settings**	**FTEs in community support settings**	
Nursing Personnel	2,046	1,748	1,717	590	6,101(49%)
Allied Health Personnel	340	2,451	504	1,447	4,742(38%)
Medical Personnel	190	583	29	111	913 (7%)
Support Personnel	90	216	120	250	676 (5%)
Total	2,666 (21%)	4,998(40%)	2,370(19%)	2,398(19%)	12,432

Table 2 Estimate of Mental Health and Addiction Workforce FTE by Organisation and Setting, 2007–2008. Source: Ministry of Health, June 2008, Mental Health and Addictions Workforce Stocktake, final draft, p. 28.

Note: These workforce estimates do not include management and administration FTEs as data on these were not available in the 2006/07 National Pricing Project. The Mental Health Commission Workforce Survey (2007) reported 752 management and administrative positions. Due to rounding, percentages may not add up to 100.

According to this data, key features of the workforce are estimated as follows:

- Nurses and allied health personnel make up 87% of the workforce
- About half of FTE are nurses (49%), of which one third work in inpatient settings
- 38% of employees are allied health personnel
- 61% of FTE positions are in DHBs, 39% in NGOs.

In 2006 the following statement was made about the future direction of the Māori mental health and addiction workforce:

> Mā te whakapakari i te hunga hapai, e piki ai te hauora hinengaro o te whānau (To strengthen the Māori workforce to maximise mental health gains for whānau) Over the next 10 years there will be a significant increase in the number of Māori working at all levels of mental health services. The Māori mental health workforce, located in both dedicated mental health services and wider health and social support services, will be internationally recognised for cultural and clinical expertise that leads to best health outcomes for Māori. This vision anticipates a substantial increase in the quality and quantity of the Māori mental health workforce and is aligned to key strategic policy documents and directions. (Te Rau Matatini, 2006: 11).

Vicary (2002) found 92% of indigenous people in his study would not see a non-indigenous practitioner unless another indigenous person (cultural consultant) had vouched them as appropriate. We now know that there is a real shift towards dual practice and Te Ariari Oranga (2010) supports this, and to support this development we need a framework that promotes this approach; the practitioner in New Zealand may be the cultural consultant that is validated by the by local indigenous people of the area.

Tauawhitia te Wero (2005) provides national direction on key issues for workforce planning in the mental health and addiction sector. It emphasises a systemic approach to mental health and addictions workforce development and contains goals and objectives across the following five strategic imperatives:

- Workforce development infrastructure
- Organisational development

- Recruitment and retention
- Training and development
- Research and evaluation (Ministry of Health, 2006).

There is a need to develop a workforce that has the skills to work in any setting. Whether it is in a Kaupapa Māori service, Non-Government Organisation (NGO), Primary Health Organisation (PHO) setting, or an alcohol and other drug mental health service within a District Health Board (DHB), the workforce must reflect consistent practice standards as many Māori may choose not to use a Māori service but should get the same treatment in a western-based practice service.

4.5: Conclusion

This chapter has described the current workforce and the roles and policy changes that have happened recently, specifically for the AOD sector. The developments over the past few decades, particularly in terms of Māori health service providers, have been spectacular. The number and range of services now available is something to celebrate. However, this growth has not been without cost. Provider development has for the most part outstripped workforce capacity and has led to a severe shortage of appropriately qualified Māori staff. Additionally, there is growing awareness of the need to provide care that is culturally aligned and clinically sound. Despite this, there remains some scepticism within the field, with conventional practices still holding much sway.

Cultural approaches are often merely viewed as cultural enhancement activities and their links to clinical outcomes are often disregarded. A fundamental shift is required so that cultural approaches are afforded the outcomes they deserve.

In the following chapters this research will identify themes that support the development of new practice. It will also challenge a review of the way we can offer change; not only in practice approaches, but also in the way we meet the needs of all peoples. All the changes in our sector over the last two decades have seen Māori exert an increasing influence over the shape of the health services they receive and also deliver.

The next chapter will present the findings of the participants' interviews.

The waiata below is the conclusion of this chapter. It speaks about knowing who you are, our past, and being proud of our ancestors and the role of our language carries this forward .

He Waiata Whākamutanga

He Kākano	
He kākano ahau	And I will never be lost
I ruia mai i Rangiātea	I am a seed born of greatness
He kākano ahau	Descended from a line of chiefs
Chorus	
Ia ra ahau e hitekiteki ana ka mau	My language is my strength
Tonu I ahau ōku Tikanga	An ornament of grace
Tōku reo tōku ohooho	
Tōku reo tōku māpihi maurea	
Taku whakakai mārihi	
Ka tu ana ahau, Ka uhia ahau e ōku Tipuna	My pride I will show that you may know , Who I am, I am a warrior, a survivor
He mōrehu ahau	(Source: *Nga Puna Ora*, Waiata 2008 , , p.13)

Chapter Five: Results

He Waiata

Ua Marama koe Ua Marama koe Ua Marama koe Ua Marama koe Ua Marama koe Kai hea tonu rā Ua Mārama Koe Nō hea tonu rā Whāka te maru nā kamo rā Ka puta te oranga mai rānō Ko te rapu nga Ko te kimihanga Ko wai Aha ko kohatu ra Ka eke ngia a tama a roto Me o nga hua Tukua ki a kimi noa (tukua ki a kimi noa) Ko te rapu nga Ko te kimihanga Ko wai	This waiata is about identity and knowing who you which is a key theme from the data that is presented in this chapter.

5.0: Introduction

This chapter presents the results of the interviews. The material is presented in a descriptive style with some analysis of information. This is deliberate and allows the material to be displayed in a raw form, for later analysis, and in a way that demonstrates a clear link between the research, the information gathered, and the conclusions which are eventually made.

5.1 Participants:

Five interviews were conducted with 3 Alcohol and other Drug (AOD) practitioners. This included one in recovery on Methadone Treatment, 1 Kaumātua and 1 Kuia. All participants were Māori, and all applied Māori models of practice within their work. All five consented to participate in the research; their identities are protected by the use of numbers in interview recordings, to ensure confidentiality. The criteria for participation were:

1. Being Māori
2. At least two years experience in the AOD and Mental health sector.

5.2: Profile and Length of Time in Sector

The length of time people had been in the sector ranged from 6 years to 35 years. The interviewees had worked in the church and workforce development services, AOD services including non-Māori services for addiction, with one now working in the Kōhanga Reo Trust. However, one interviewee admitted that they had been involved for a lifetime:

> *As a professional my time within the mental health and addiction sector has been short 5 or 6 years, but as a person who is working within a Māori community, it has been over 50 years and I was raised in this community, it's a life-time experience* (Interview 01).

The participants described how their knowledge was learnt (primarily through observation) and how it was applied suggesting a Māori approach to learning and practice. When these participants engaged in practice such as working in mental health and addiction they brought their life experience and knowledge with them as an active

Māori member and leader of their community. It is blended into their practice, which can sometimes be a conflict for them as it may not conform to the western treatment model or practice; however, they are very skilled at being able to negotiate the similarities and walk in two worlds.

In supporting this view, one of the participants commented on the similarities with her whānau gathering Titi (mutton bird). A task they did every year in the most harsh conditions at the base of New Zealand. It was this type of tenacity that she has brought through into her practice and informed the way in which she operated – the application of life-skills and the the ability to apply both Māori and western world views :

> *While we know as indigenous people who still practise natural food gathering processes gathering titi. We were proud of it and much of it was something done and kept private which, I realise now, that it is the people, who we are and has built on my knowledge base, which wasn't my focus during at sometimes in my life* (Interview 02).

The church is another community experience that we do not often acknowledge as contributing to practice experience; however, many of the practitioners and clients were involved with the church and mental health in many different ways:

> *I have been in the area of mental health for around 35 years now as a kaikarakia (Minister) from within the Anglican Church, and I did a lot of counselling with our people in the area of mental health. Now, mental health within the church has a very different view towards mental health than some of our own peoples' views* (Interview 05).

The church as an environment for addressing mental health was new to the researcher as many would say that it is not a clinical environment. Perhaps this is an area of research that needs to be further investigated.

This raised some key questions for the researcher about the standards practiced, the monitoring of these, the support, supervision provided and qualifications required and the cultural competence practiced by the church when addressing Māori mental health.

The role of consumers within the workforce is something we tended to move away from in the early ’80s. However, a number of participants also had a recovery background, having been consumers in services, and therefore had a passion to support and work with people they knew and understood:

> *I first started in 1987 – I crossed over from the world of a user and then into helping users by joining the Salvation Army bridge programme. I was employed to work with their Māori men and that’s why I was there* (Interview 03).

The model of practice in the ’80s was abstinence focused; however, other treatment options came into practice, which supported whānau with a harm reduction approach to recovery for people who were injecting substances such as heroin. The Methadone Maintenance Treatment (MMT) (Methadone Maintenance Protocol for Treatment, 2001). Some ex-users have become advisors or a consultant to such programmes that is why I have included this aspect in my sample group:

> *In addictions in a paid role going back to my early days in the needle exchange, which was funded through public health 2001, I started working there part time and then I went to ADANZ (Alcohol Drug Association of New Zealand), as a consumer advisor and then I went to the Bay of Plenty DHB, and then to this position here. As the consumer project leader, having been involved in consumer issues since 1994, through a retired psychiatrist, Dr John Dobson, and Maria Duff who was John’s right-hand man – sorry woman – and she came from down south and we used to talk about methadone for Māori. If I extend to working with co-existing and disability sectors – [I have been working] probably since 1989* (Interview 04).

Very few Māori appear to be working in this specialist area as a consumer advisor and there is a need to investigate why. Having been the coordinator of a Methadone Maintenance Treatment (MMT) programme, I know that about 25% of our total population on the programme were Māori; however, I suspected there were many more who did not access treatment and I would suggest this was for two main reasons and we did not have an advisor for this client group to work with us and our programme: first the service was based on a very medical model approach and was not supportive of Māori models of practice. Second privacy concerns in the whānau; not wanting others to know, which is a common barrier to treatment for Māori.

An example of a journey into our work force is given below:

> *I was a recreational user of drugs at this time, like most of New Zealanders, and didn't have a problem with it, but after my son died in 1990 I got into it in 1992 – hard-gear injecting – but I had smoked it before this but only during opium season and injecting was not my thing then but this is how I got into working with people* (Interview 04).

The participants were very open and honest about their drug use and how it began a life-long career in mental health and addictions. Undoubtedly this better enables them to relate to their clients with a shared common history/experience.

5.3: Understanding Cultural Competence

This section outlines the interviewee's understanding of cultural competence. The participants were asked to describe their views of cultural competence as helping practitioners to relate to people of other cultures:

> *What I like about cultural competence is we are able to adapt, we can bring it into focus so that our partners can understand where we are coming from, and I call that real competence* (Interview 05).

One of the research participants supported the similarities between some holistic approaches and Māori approaches:

> *In my training I use to kid around, and say that the theories [that] underline counselling in addiction had to be Māori, as the kind of things they were saying I know work and are still valued in our world* (Interview 01).

Being able to adapt to a working environment is important, with a collective approach incorporating traditional alongside western methods is dynamic:

> *Well, I think what you do, and how you live your life, I believe I live my culture, I can't be anything else but me, and I work from the heart. Being aware across the board is important as it affects every part of our work. I work from my heart really* (Interview 02).

The participant's felt that their approach of integrating Māori culture was inherent and genuine and the only way that they know how to practice. However, when we examine cultural competence, there have been many changes over time in the workforce that have meant that practitioners now need to be able to demonstrate what cultural competency means and how they practice it. Some practitioners have not been in the sector long enough to know the history and the development of cultural competencies. One of the descriptions I use to support this argument is taken from *He Tētē Kura* and a person who has travelled this journey.

> *I don't think just being Māori is good enough anymore. We can't just work from our hearts. It's a challenging time, and we need to be able to show the relevance and importance of both sets of competencies. A holistic approach means being able to appreciate, and do a number of things.* (Manuka-Sullivan in *He Tētē Kura*, 2008: 139).

Another participant gave a specific example of these cultural values and frameworks and how they are integrated with western models:

> *My values will be birthed out of cultural frameworks such as Manaaki, Aroha, Wairuatanga. Those are the internal frameworks, or the internal āhua, that is expressed in my practice, and in my practice is the clinical tools that I have been given through different institutions to learn how to practice. Like Pharmacological approaches, the understanding of the physical and medical practice, which are my clinical values. But my cultural competency is my values I have with the Po's or those spiritual concepts that then keeps that client safe* (Interview 03).

The common word that comes through is 'values' and its role within cultural competency. However, this word in effect represents the continuation or preservation of human knowledge, beliefs, values, arts, customs, behaviour patterns, institutions, and all other products of human work and thought typical of a population or community at a given time.

The word manaaki was raised often by in many ways wasnot fully understood by many. There is core fundamental views that manaaki is to support others before you. This can mean for example if people arrive at the marae you always feed your visitors first with the best food and the home people wait until last before serving themselves.

Often practice settings are not a welcoming place for people, let alone for those who are very whakamā (shy) about having to attend a clinic or a service within their community. One of the key issues in practice is about building a rapport with your client. I have always offered clients a cup of tea or coffee to bring into our session, but had not realised why I did this and was often told that I was not being professional. One of my research respondents had this kōrero to offer:

> *Basically I am a pa girl and the teachings I have learnt have been here and in other whārenui across New Zealand and the teachings I have learnt, the foundation of this whāre here is ngā manaaki o ngā manuhuri* (Interview 01).

These cultural values are often learnt whilst growing up some aspects of Māori society have changed, but values remain intact***, "****I could not be a practitioner with Māori people unless I had the teachings and base learning's from the marae"* (Interview 01).

5.4: The Role of Identity within Practice

This section explores the role of identity within practice.

> *Ko wai ahau – 25 years ago when I lived in a world of heahea I thought that Ko wai au was to be the drug dealer, to be the bully, to be the man and king because that's about me. 25 years down the track, today I am my mother, grandfather, grandmother and all the values that were in them are in me"* (Interview 03).

Before their recovery and shift to a practitioner their identity was derived from their peers, fellow drug users. As a culturally competent practitioner they have embraced an identity that is based on whānau and the different roles that we play within it. Before becoming a practitioner and moving from one world to another, there can be a large shift in cultural understanding. Some of them forget that many people in the field come with that background. They were Māori before they used services and will be Māori after they leave them.

Recovery and whānau ora are about being Māori, not about staying a service user or consumer – that's just a stage they go through (Miline, 2008). Linking recovery with

whānau ora and Māori identity meant a commitment to life-long collective change as opposed to being discharged at an end point. Understanding who you are is something that is not learned in a classroom. For Māori who have been brought up in the traditions of their old people this is with you forever, the transference in practice is a natural progression:

> *The values of being a mutton birder make me the person who I am. In a clinical sense, as you well know, I encourage people to be what they are and believe in themselves. Many of our clients have four-by-twos as eight-by-ones, using them on themselves day and night – hence it's part of the problem – and to try and get them to a place of them valuing themselves, and taking them back to where they came from – a people, a race of people who are unique on this earth and there is no one on this earth like you* (Interview 02).

The participants discussed the importance of locating themselves in order to better relate to the clients in a transference process that challenged their own identity as professionals:

> *The thing you need to know, Ko wai au – who are you, secondly, you need to have an understanding of the person you are working with, Ko au ko koe, ko koe ko au. If you can't establish that then you can't do much; so what is a central need for cultural competence is knowing who you are, having the support of whānau, knowing that the environment must be conducive to who your client is* (Interview 01).

Identity was identified as important for both Māori and non-Māori with in practice being grounded as a practitioner and is critical to any therapeutic relationship:

> *Identity is very important, whether you are Māori or Pākehā, it is really important with our people. I find this a lot with being on the Kaumātua council when our people call for a minister, they become separated when they see someone not of their own. Whether you can kōrero Māori or not, if you are not the same skin colour those fears are gone. I would go to a person who doesn't look Māori but they connect straight away, the connection is through wairua* (Interview 05).

This practice often led to conversations about general information that would include the question, where are you from – Nō hea koe? Being able to share whānaungatanga

connections through blood, waka or family histories with the client if they are Māori or even if they are not was useful and broke down huge resistance between both parties. This is also the process used in the pōwhiri when entering the marae.

One participant articulately sums up the role of identity in culturally and clinically competent practitioners:

> *Walking within the two world's clinical and cultural interface is the most valuable skill we have. What we need to do is be aware of who we are and where we are, what we touch and where we walk – we are always interfacing with different personalities and different beliefs and things around us. The principle of culture in terms of Māori and the tikanga and call down of atuatanga stabilises our ability to interface, so no matter what the beliefs are we maintain that. So that's having knowledge, but walking with integrity – they sustain our ability to function and operate and not react to everything in an inappropriate way* (Interview 03).

Understanding identity affects every part of our being not just as a practitioner and also impacts on generations to come:

> *I think understanding identity is a crucial part of competence because unless I know my identity and know it well then I can get up on the Marae and speak it. If I don't know my identity and I get up and speak off the top of my head it doesn't work. Our manuhuri, our children must know –and where we come from, our Whākapapa, so they apply the Kaupapa* (Interview 05).

5.5: Working in Māori Models of Practice

This section explores practitioners' strengths in working from and with Māori models of practice. It cannot be assumed that being Māori ensures practitioners are comfortable working in this paradigm. In the modern setting some Māori models of practice are not safe because they are based on a total western medical approach.

In the research I found that most practitioners preferred working with Māori models; each having their own model from which they worked, which had come from their own tikanga and values system, *"Models of practice in Māori is common sense and sometimes I get frustrated with our sector"* (Interview 04), and:

I only work in Māori models of practice. I tried to use western models when I first graduated, I said 'I will try and be a modern-day practitioner'. Well, it didn't work, but I do value ithe techniques that enhance, whatever – I can only operate by who I am, my first thing is I do care whether… I was at the hospital… home… wherever… you apply the principle of the marae (Interview 01).

The following statement seemed to me to capture the essence of being a Māori practitioner, the combination of Māori and being able to translate that into a position of compassion and strength:

My strength is in recognition, in tikanga, those Pārākau's they have within them tikanga, they have descriptions of person who should be truly expressed within the universe, and everything we are connected with is express through those. Then we look at the principal of manaakitanga, then my existing on this earth is not to just focus on myself, but to see that there [are] others you can empower to be better than yourself. These are principles of atua, so if one aligns themselves to those as a discipline and align themselves to it, then this leads to a spiritual principle. So, in other words, you are a vessel or conduit of principles that learnt and studied but they just express through you and manifest in others (Interview 03).

This particular practitioner utilised traditional creation stories to guide their practice and interaction with others.

Working in a mainstream service can control how you work by constraining cultural practice and is why many Māori chose to work closer with their own people and services:

As a person who comes from a mainstream system of working to a Māori organisation, as with many of my colleagues, I just feel like I have landed in banana land – we all have the same values and beliefs, which is a great thing to work with (Interview 02).

The increasing access, retention and outcomes for Māori mean that practitioners, Māori and non-Māori, must also consider how they can incorporate in their practice values, beliefs and practices that are culturally congruent for Māori (National Addiction Centre

and Matua Raki National Addiction Treatment Workforce Development Programme, 2009).

The participants argued that it was not just the model but also the environment that they worked in that needed to be culturally safe and comfortable, *"Safe environment to practice is critical. The moment someone older walks in it changes everything and they bring a balance to wairua, they, the older ones, generate that"* (Interview 01).

This response suggests that, after completing training, the practitioner needs to find a balance that suits them between both worlds. This is an area where mentoring with senior practitioners becomes critical in retention and development. Furthermore, the practice of Māori models was seen as a risk management tool within practice:

> *I think we tend to use it (Māori model) in the context of risk management, which in a contemporary context – that is how we are interpreting it, but in a traditional context, there are actions that follow, tapu, rāhui when we go to Marae or urupā (cemetery). Basically, the tapu we maintain within ourselves the integrity to transition ourselves into the next domain. Then at the urupā we recognise that we have a place in there with our ancestors and with people who have crossed over to the next world and what we have done is respect that and we enter that with dignity, respect and maintain creditability. So that is the type of tapu we need to conduct ourselves in* (Interview 03).

The overall results showed that all preferred to work in their own model of Māori practice while always being open to using some of the techniques of the western world to balance this with their clients' needs:

> *The addiction treatment field has had an awareness of a range of 'cultural' perspectives since any of us can remember and in many ways has been in the vanguard of the development of appropriate responses to these in the health sector overall. Twenty years ago the terminology used was 'special needs groups' but this somewhat paternalistic way of describing cultural perspectives has not been the main way of referring to this area for many years. Some of the old 'special needs groups', such as patients with co-existing disorders and youth, with their own cultural issues and challenges for addiction treatment workers, have*

now become so mainstream and central to the addiction treatment field that they probably no longer need to be given a special status in order for them to be included in routine discussions about the sector. However, there is always a risk of marginalisation of sub-groups in the overall sector, particularly when clinicians do not feel confident about working with certain groups, so continuing consideration of the wide variety of potential groups is necessary (National Addiction Centre and Matua Raki National Addiction Treatment Workforce Development Programme, 2009).

5.6: Supportive Work Environment

This is the relationship of the work environment to practice and how management can impact on this area for practitioners. In an ever-changing world the practitioner has to adapt to constantly changing demands within practice. This can create anxiety for the practitioner, and if they are not strong what can seem like an attack on their own foundations can affect their practice:

"Due to changes in management, Rhanna clinic became a shell of its former self. I had no allowance or decision-making power, but we did not want to change a service that the feedback from clients' was working and was wanted. We practised in a holistic way that was client driven, and was able to meet their needs. It reached a stage that when I was asked about 5 years ago to join the service I am now with I did" (Interview 02).

Working in Māori services that have mainstream quality assurance procedures can be increasingly seen in today's clinical world. If the service does show leadership it should be reflected across the whole service.

One participant gave an example of a way Māori can show how their own practice abilities meet the requirements of a modern world:

Our organisation is driven by five pou and these determine how we act. So the mentoring process, for instance, one of the clinical persons we have given the role of leadership and this not just as the clinical leader. While he will come out of WelTec with a clinical tohu, he is also now getting the manaakitanga from myself and the organisation. So I have to view him as having more potential than me.

When he is doing his job and even though he may stuff it up my role is to make sure and confirm in my mind that it is my responsibility to support him in his stuff up (Interview 03).

5.7: Conclusion

This chapter has presented the views and perspectives of those interviewed as well as shared their experiences of working in, or as part of, the mental health and addictions sector. It has demonstrated the breadth of knowledge that currently exists and how competence and expertise if often derived from personal experience as much as formal qualification.

The comments have also reinforced the view that culture has a significant role to play in the application of treatment and care. It also highlights the fact that while the application of cultural models of care might encourage participation and compliance, the personal journey of clinicians and practitioners will likewise create a useful point of focus – a means through which client/clinician empathy might be enhanced and positive outcomes achieved.

The research also reveals that culture is not an absolute or rigid construct. It tends to move and evolve, and in contemporary times especially, it may take various forms. The implications for this thesis are that cultural competence has a role to play in the delivery of services and furthermore the outcomes achieved. However, the application of cultural competence, what this means and how it might be applied will inevitably vary – according to the values and experiences of the practitioner and what personal resources they are able to draw upon.

This whakatauāki is the conclusion of this chapter talks about the strength of many that support directions that have been laid by ancestors in this case the kōrero has come from people that should never be lost as it adds to the strength and the development of practice for the future of all peoples. .

Whakatauāki

Ehara taku toa I te toa takitahi Engari he toa … Toa takimano Aku tapu aku ihi I heke mai ki ahau nō Aku tipuna hi Aue hi aue hi aue ha hi Aue hi aue hi aue ha hi	My Strength is not mine alone But it is a strength of thousands All of my ability, authority power confidence, Respect esteem, sacredness, vigour Has come from my ancestors. Source: The late Canon Wi Te Tau Huata

Chapter Six: Analysis and Conclusion

He Waiata: E ngā iwi

This waiata belongs to our people of Taranaki but is sung across our boundaries today to remind us of who we are and significance of the Raukura that we wear as symbol of who we are as a people.

E nga iwi o te motu nei	Kua tū kua tū a Te Whiti
He raukura rā tēnei	Nō runga i āna mahi pai
E titia nei e Te Ati Awa	Nō runga i āna mahi tika
I te iti i te rahi te katoa (x2)	I tōna ngākau pai[4]
E ngā iwi o te motu nei	E nga iwi o te motu nei
Nohoia rā te whenua nei	He raukura rā tēnei
Manaakitia ngā iwi	E titia nei e Te Ati Awa
I te iti i te rahi te katoa	I te iti i te rahi te katoa

6.0: Introduction

This thesis set out to answer the question: *"Are cultural competencies critical for Māori mental health practitioners?"* This research clearly indicates that Māori culture, knowledge and personal life experiences are an integral and critical element of participants' current practice in delivery of mental health and addiction services. It is argued that cultural competencies are essential for establishing effective clinician-client relationships and achieving positive health outcomes for Māori. The participants strongly advocated that the basic values associated with cultural competencies could be

transposed into any clinical setting and applied by Māori and those not familiar with Māori culture and knowledge.

This chapter links the data to a framework that provides a possible pathway for best practice in delivery of mental health and addiction services. The Raukura framework is based on the teachings of Te Whiti Rongomai and Tohu Kakahi of Parihaka that emphasises the importance of relationships and exhibited good will to all people.

The Raukura Framework is a useful tool for conceptualising the main themes that have emerged from this research related to participants' understandings and aspirations of cultural competencies and best practice in mental health and addiction settings. The framework offers a guide to Māori and non-Māori clinicians to provide a greater understanding of the importance of cultural competencies in mental health and addiction services.

6.1: Key Themes

The framework uses the metaphor of the Raukura (the three feathers of the albatross) as its foundation. The Raukura has multiple interpretations but is part of the legacy left by the prophets Te Whiti Rongomai and Tohu Kakahi of Parihaka to their people. Its principles are conveyed in the following message:

> *He kororia ki te Atua i runga rawa (Glory to God on high)*
> *He Maungarongo ki runga i te whenua (Peace on earth)*
> *Whakaaro pai ki ngā tāngata katoa (Goodwill to all mankind).*
> *(*Atiawa, 2009 Raukura Feathers, p1)

The Raukura Framework has seven principles that begin with each letter in the word Raukura: Rangimarie; ake ake; ukaipō; ko wai au; uenuku; rangahau, and; arahi. The following section describes each principle and discusses how this principle has been emphasised by participants.

Rangimārie – Peace and Goodwill to All Men

Rangimārie is the first component of the framework and simply translates into peace or harmony. Its inspiration is drawn from the various Māori practitioners spoken to as part of

this thesis as well as the teachings from the tribal leaders Tohu and Te Whiti, and others such as Ngata, Pomare and Buck. Within the context of this thesis, rangimārie can be demonstrated in a number of ways. When viewed as part of service delivery it emphasizes the value of supportive attitudes and working with others. It further emphasises, that good practice, for Māori at least, need not be confined to formal regimes or assessment criteria but includes a capacity to work alongside others and to respect alternative perspectives – to create an environment which is nurturing and facilitates positive outcomes. Interviews with research participants reinforced these types of issues and were frequently raised and placed alongside cultural values, beliefs, and associations with cultural competence.

In this research participants acknowledged the principle of Rangimarie through these examples:

- All five interviewees practiced goodwill within their practice often beyond what was expected of them with in their practice setting.
- They all expressed the passion to prevent people from harm associated with alcohol and drug misuse.
- All had a very strong values based process within their practice.
- All five brought their knowledge at different levels of Te Ao Māori from the Kaumātua to one participant who was searching for their whakapapa but still held the value of Rangimarie as a core component to their clinical practice.
- Even though one of the participants had been in the sector for 6 years, they still identified the value of Rangimarie as intrinsic to their practice similarly to those who had been in the sector for 35 years.
- All were dealing with conflicts in the practice setting by those who did not understand them.
- Relationships with others were a common theme.

AkiAki te Tangata – Credibility and Role Modelling/Mentoring

This concept has been a central finding of the research. The participants emphasised the need to have support from kaumātua and kuia to guide them and teach them in their cultural practice. They also highlighted the need to have professional development in terms of furthering education and qualifications. Lastly, they stressed the importance of leading by example by committing to a life of recovery abstaining from previous

addictions. Role modelling and mentoring is something, which is not unknown to Māori and has informed our approach to development and capacity building for centuries. Durie (2005) stated at Hui Tuakana Futures planning, Māori endurance can be largely attributed to successive waves of inspirational leadership. Role-modelling wellness and well-being is a critical part of this framework, which is at the foundation of any service and person working within it.

The examples below from the research findings confirmed role modelling as a core element of their practice:

- Practitioner's personal experiences with recovery provided a positive role model for clients.
- Practitioners emphasised the importance of positive cultural role models for informing their practice to mentor.

Ūkāipō – Nurturing

The research provided a key finding of the value of being nurtured. This principle is similar to the one above but places greater emphasis on nurturing of the client and treatment outcomes and objectives. While formal intervention regimes are often characterised by process and activity there is an implied need to consider more philosophical and fundamental requirements. That is, the creation of a therapeutic environment which is indigenous, positive, and sincere. Furthermore, an environment, which caters for the spiritual, cultural, social, emotional and mental aspects of wellbeing, fits with Durie te whare tapa wha model that was talked about in chapter one of this thesis. The examples below from the research findings emphasise the importance of nurturing:

- All participants identified that taking care of self both physically and mentally enabled them as clinicians to provide better clinical care to clients; Being able to nurture one self is a key to nurturing others.
- Being able to understand the role of nurturing for others and its importance within clinical care was essential to best practice.

Ko Wai Au – Who I am

Knowing who you are has been reflected very strongly in this investigation. The knowledge of ***who I am*** links not only to a person knowing himself or herself but also to hapū (family) knowing who they are. It links an individual with a community/collective that has origins from the beginnings of this world and our atua through to our future progeny. It also enables connections to others through similar genealogy or life experiences. In chapter one it was described in the personal journey section as one of hardest things any person faces in treatment. Facing addiction issues is hard enough but with this principle alongside the treatment approach this would support clients reaching their goals. As a principle, it provides a foundation for progress and development – a substrate that is both a platform and objective. In practical terms, knowledge of one-self (including cultural knowledge) permits the relevance of culture to health and wellbeing to be considered. Moreover, there is potential alignment between culture, therapy, and outcomes. The examples below from the research findings emphasise the importance of personal identity:

- All participants identified their personal cultural identity was important for establishing credibility, connecting and building trust with the client to facilitate positive health outcomes.
- An awareness of Māori culture and knowledge was highlighted as a critical part of cultural competence.

Uenuku – the rainbow

Another broad theme that has emerged in discussions within the research participants has been the concept of Uenuku. Its colours and nebulous design have often inspired human thought and as such it serves as a reminder of our collective capacity to grow and evolve – a desire to move forward and reach our potential. An awareness of the unique individuality of each person raises their potential ability to feel they are contributing to our world. Providing an environment for this process should be at the forefront of every health plan. That is, and while treatment outcomes are most often focused on a single objective or to alleviate the consequences of addiction, broader outcomes are also possible which resonate with an individuals desire to embrace their community, to contribute to society, and to be valued as a member of their whānau.

All five participants indicated that their own substance abuse histories were an advantage in delivery of services to clients. Every participant identified that in some point of their career, pivotal figures identified their own potential. Support and encouragement from others was critical in providing a chance to develop their own potential as practitioners. As a result the practitioners' life experiences and potential could be transposed into clinical practice.

Rangahau – Research (Direction)

This is an area that can be used to measure and ensure good outcomes for Māori. The investigation showed this as a weakness within the addiction sector. Research must focus on trends and measurements that support development. Moreover research could support Māori models of service delivery and practice. The current dearth of information has in many ways stymied the advancement of Māori focused interventions as they struggle for recognition. Moreover, it has been difficult to assess current issues and trends, what they are, how they have evolved, what progress has been made, and what solutions are possible.

In order to effectively plan, quality research is needed which will ultimately support positive health outcomes for Māori. The data emphasised that:

- There is a lack of evidence base to supports development of cultural competency tools and practice standards
- research is necessary to set directions for best outcomes in all practice and services.
- Knowledge is power so evidence is critical to reach the highest levels as the Albatross reaches the levels in its flights to reach its goals.
- An interesting point made by one participant was the role of the church in delivery of mental health and addiction services. This is an area not considered a clinical setting by practitioners and is an area that needs further investigation.

Ārahi – Active Leadership

Leaders are not often born but are created through development however some would debate that whakapapa is a right to leadership. This research has found that leadership is a key component in the development of the future sector and workforce. In chapter four of this thesis we looked at key polices and strategies, we have to develop leaders who can carry this vision forward into reality for all our peoples and their well-being. Then taken into practice, establishing leadership has to be maintained and evidenced to support positive growth and development within the sector. The participants strongly advocated that active leadership was critical for attaining positive health outcomes for Māori:

- As practitioners we are all leaders and have to provide the leadership for our peoples across New Zealand.
- We have to develop leaders who can carry this vision forward into reality for all our peoples and their well-being.
- Leadership within clinical practice has to be maintained and evidenced to support positive growth and development within the sector.

6.2: Raukura Framework

The following table summarises the application of the framework in mental health and addition settings. In a broader sense the table is also a synthesis of this thesis, the views of those interviewed, and the multiples insights, which have been shared. Like many frameworks, it is designed as a tool and as a guide for dual diagnosis practitioners and which might in some way contribute to gains in Māori health.

The Raukura Framework
He aha te mea nui o te ao? He tangata, he tangata, he tangata

What is the greatest thing in the world? It is people, it is people, it is people

	Focus	*Issue*	*Opportunity*	*Threats*
R	**Rangimārie** The elements of a supportive attutide	Peace to all men and values based approach	Everyone has the same opportunity to contribute to all men.	Doubts are cast by those who do not understand.
A	**Ake ake te tangata** Credibility and role modelling	Mentoring	Māori autonomy in health offers much potential, and the use of whanaungatanga in practice	• Shortage of mentors • Resources to support mentoring
U	**Ūkāipō** Nurturing	Connection to the land and a place to be nurtured	Māori health gains must be seen within the overall context of Māori development	Environment and political impacts on practice
K	**Ko Wai Au** Empathy	Identity, a place to stand	Māori have the capacity to contribute to innovations in health – nationally and internationally	• Balancing between two worlds • Limited understanding in the non-Māori world
U	**Uenuku** The rainbow	Allowing for potential	Māori custom and protocol can be used as a base for positive health gains	Challenges to current systems and processes
R	**Rangahau** Direction	Research	Best practice needs to be evidence-based	• Not seen as a part of practice • No funding to allow this in practice
A	**Ārahi** Active Leadership	Leadership	Māori leaders in health are required and may emerge from a variety of settings	• Workforce is getting older • Stretched resources

Table 3 The Raukura Framework

6.3: Conclusion

This thesis is unlikely to reduce the burden that Māori currently experience in mental health and addictions. Nor has it identified the seminal characteristics of Māori health development or the pathways to achieve this. Its objectives have in fact been far more

modest. To this end, it simply seeks to make its own contribution to Māori health development, to walk towards greater enlightenment, and to create new knowledge and insight. It has provided a rare glimpse at a journey of someone who has been through treatment and is now providing a view that is often not heard by many while our services are meant to be providing the best care for our people.

This thesis has sought to answer the fundamental question of whether or not cultural competencies are critical to the development of Māori mental health practitioners. This question has been explored through a structured research process and especially informed by the views of practitioners and experts in the field. To this end, there is clear evidence that cultural competence has a role to play and that in many ways it is the platform upon which effective care – for Māori at least, can be sustained. It provides the mechanism through which clinicians are able to better engage with Māori clients, to aid compliance, to encourage participation, and to ultimately promote sustained an optimal outcomes.

The various chapters of this thesis have led to this point and final conclusion. In chapter one a background and context was provided alongside a description of why this research was needed. Chapter two built on this and described the focus of the investigation, reiterated the key questions and outlined the methods through which a conclusion could be reached. Chapter three offered a historical view of Māori mental health in Aotearoa and sought to place alcohol and drug issues with a broader context of mental health. Chapter four explored the relationship between culture and health and provided additional critique and support to the research questions. The results of the various interviews were described in chapter five and provided a more contemporary and pragmatic perspective of the relationship between culture and health – the role of practitioners, the challenges faced, as well as the more seminal issue of cultural competence. One of the key findings of this research seen in chapter five has been around the role of relationships, not only to practice, but everything associated with practice, and the person delivering the practice, the Raukura framework provides a guidance tool for all things to be considered with in a therapeutic relationship but

supports cultural values that can lead to good outcomes for all. The next step is to put this to the true test within a practice and service setting.

When we look at the seven areas within the framework they all relate to each other, the research showed that these areas of the framework offer a paradigm that practitioners can offer a quality service, that is research based that support quality service development .

Another key area which has come through is about mentoring our services and people who work within them, this includes the need for workforce development through education, but allowing for a consumer of the service to also be developed to reach .a role they may be able to support or one day run a service.

This chapter (chapter six) draws together the various threads of the research and presents the Raukura Framework.

The framework is the synthesis of this work and demonstrates how cultural competence, cultural values, and cultural perspectives, can be used to enhance health outcomes for Māori. However, the utility of the framework resides in its application, in the extent to which the health community embraces it, and its capacity to bring about positive change. These questions are of course beyond the scope of this thesis, but have nevertheless guided its development. Whether the framework might reach a broader audience or resonate with others is uncertain. Nevertheless, the potential for change, for growth, for development, and for improved health outcomes is apparent. In this regard, it is the potential of the framework, which is the ultimate outcome and likewise the enduring challenge.

Mauri ora.

Paimarie

Glossary Of Terms

ahuri	potential
ake ake	creditable
aki aki	leadership
au	self or I
hapū	extend family
Hawaii	a Pacific Island
iwi	tribe
kai	food
kaupapa	vision of the task
kaumātua	elder male
ko wai au?	who am I?
koha	offering
konohi kitea	face-to-face meeting
kuia	elder female
marae	home of the Māori
rangahau	research
rangimārie	the elements of supportive attuide
te tangata	the person
tohunga	skilled in tikanga practice
whānau	family
whānau ora	well-being
Waiwhetu	a Marae in Lower Hutt
whakatauāki	family genealogy
whakapapa	proverb
whanaunga	relation
whanaungatanga	practice whānau relationships within hapū
whakawhanaungatanga	practice whānau relationships within iwi
ūkaipō	nurturing

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Appendices

Rawiri Evans Student ID: 01198053 Research 2009

Questionnaire

1. How long have you been working in this particular area of Mental Health?

2. Can you describe your understanding of Cultural Competence and how it impacts on your practice?

3. Can you describe your understanding of identity and how it impacts on your practice?

4. Can you describe your views on the role of Kaumauta and Kuia within your practice?

5. How comfortable are you working within Māori Models of practice?

6. Can you describe what models of practice that you prefer to work within?

7. Does your working environment support this practice?

8. Do you have any further comments you wish to add

Massey University

Te Kunenga ki Pürehuroa

NOTIFICATION OF LOW RISK RESEARCH/EVALUATION INVOLVING HUMAN PARTICIPANTS

(All notifications are to be typed)

SECTION A:

1. • **Project Title** • ***Ki te marama i te tangata***

• ***me marama hoki i tona ao***

• *"If you wish to understand a man, know the world in which he*

• *lives"*

• **Projected start date for data collection**	• Feb 2009	• **Projected end date**	• December 31st 2009

2. • **Applicant Details** *(Select the appropriate box and complete details)*

• **ACADEMIC STAFF NOTIFICATION**

• **Full Name of Staff Applicant/s**	•
• **School/Department/Institute**	•

- **Region** *(mark one only)*
  - **Albany** ☐
  - **Palmerston North** ☐
  - **Wellington** ☐
- **Telephone**
- **Email Address**

STUDENT NOTIFICATION

Full Name of Student Applicant	Rawiri Evans		
Postal Address	17 Berkeley Road Wainuiomata Lower Hutt		
Telephone	04 9768547 or 0277380999	**Email Address**	Rawiri_evans@moh.govt.nz
Employer (if applicable)	Ministry of Health		
Full Name of Supervisor(s)	Te Kani Kingi		
School/Department/Institute	Māori Studies		
Region *(mark one only)*	**Albany** ☐	**Palmerston North** √	**Wellington** ☐
Telephone	021 223 6008	**Email Address**	t.r.kingi@massey.ac.nz

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GENERAL STAFF NOTIFICATION

Full Name of Applicant

Section					
Region *(mark one only)*	**Albany** ☐	*Palmerston North*	☐	**Wellington**	☐
Telephone	**Email Address**				

Full Name of Line Manager .....

Section .....

Telephone ..... **Email Address** .....

3. Type of Project *(mark one only)*

Staff Research/Evaluation:		**Student Research:**		**If other, please specify:**	
Academic Staff		**Qualification**	√		
General Staff		**Credits Value of Research**			

4. Describe the peer review process used in assessing the ethical issues present in this project.

Discussed with supervisor issues of ethics and concluded after filling out the screening questioner that this research is a low risk research project.

A range of experts are going to be consulted for their opinion on health perspectives for this research.

.....

5. Summary of Project

Please outline the following (in no more than 200 words):

1. **What you intend to do, and**

My intention is to identify the role of cultural competence within a Māori mental health practitioner, and to compare these alongside an international indigenous context and consider what impact these some of these cultural perspectives may have on current practice and therapy practiced here in New Zealand.

2. **The methods you will use.**

To accomplish this I plan on interviewing experts consisting of 5 from Alcohol and other drug sector & Māori mental health therapists, 1Kaumatua and 1Kuia , this will be presented to the national professional conference and a collective of Māori workers in order to receive feed back on the research to support my conclusions.

(Note: all the information provided in the notification is potentially available if a request is made under the Official Information Act. In the event that a request is made, the University, in the first instance, would endeavour to satisfy that request by providing this summary. Please ensure that the language used is comprehensible to all)

Massey University

OFFICE OF THE ASSISTANT
TO THE VICE-CHANCELLOR
(Research Ethics)
Private Bag 11 222
Palmerston North 4442
New Zealand
T 64 6 350 5573/350 5575
F 64 6 350 5622
humanethics@massey.ac.nz
animalethics@massey.ac.nz
gtc@massey.ac.nz
www.massey.ac.nz

28 January 2008

Rawiri Evans
17 Berkeley Road
Wainuiomata
LOWER HUTT

Dear Rawiri

Re: Ki te marama i te tangata me marama hoki i tona ao
"If you wish to understand a man, know the world in which he lives"

Thank you for your Low Risk Notification which was received on 26 January 2008.

Your project has been recorded on the Low Risk Database which is reported in the Annual Report of the Massey University Human Ethics Committees.

The low risk notification for this project is valid for a maximum of three years.

Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis that it is safe to proceed without approval by one of the University's Human Ethics Committees.

Please note that travel undertaken by students must be approved by the supervisor and the relevant Pro Vice-Chancellor and be in accordance with the Policy and Procedures for Course-Related Student Travel Overseas. In addition, the supervisor must advise the University's Insurance Officer.

A reminder to include the following statement on all public documents:

> *"This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher(s) named above are responsible for the ethical conduct of this research.*
>
> *If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher(s), please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz".*

Please note that if a sponsoring organisation, funding authority or a journal in which you wish to publish requires evidence of committee approval (with an approval number), you will have to provide a full application to one of the University's Human Ethics Committees. You should also note that such an approval can only be provided prior to the commencement of the research.

Yours sincerely

Sylvia Rumball

Sylvia V Rumball (Professor)
Chair, Human Ethics Chairs' Committee and
Assistant to the Vice-Chancellor (Research Ethics)

cc Dr Te Kani Kingi
Research Centre for Māori Health and Development
Wellington

Prof Chris Cunningham, Director
Research Centre for Māori Health and Development
Wellington

Ki te marama i te tangata me marama hoki i tona ao"

Te Mata o Te Tau
Office of the Deputy Vice-Chancellor (Māori)
04 3800621
c/o Research Centre for Māori Health and Development
Massey University
Private Box 756
Wellington
New Zealand
temata.massey.ac.nz

PARTICIPANT CONSENT FORM

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree/do not agree to the interview being audio taped.

I agree/do not agree to photos being taken.

I wish/do not wish to have all my audio recording returned to me or deleted after …… (date).

I wish/do not wish to have data placed in an official archive.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: ..... **Date:** .....

Rawiri Evans wants to thank you for participating in this research

Ki te marama i te tangata me marama hoki i tona ao"

Te Mata o Te Tau
Office of the Deputy Vice-Chancellor (Health Research Council of New Zealand & Health)
04 3800621
c/o Research Centre for Māori Health and Development
Massey University
Private Box 756
Wellington
New Zealand
temata.massey.ac.nz

INFORMATION SHEET

Researcher Introduction

David (Rawiri) Evans is the researcher with Dr Te Kani Kingi who is the researchers Supervisor

Rawiri Evans Dr Te Kani Kingi

027738099 0212236008
048162667

Project Procedures

- The data will contribute to a Masters thesis. .
- The data will be transcribed by an employee of the researcher who has signed a confidential agreement.
- data will be stored in a locked cupboard and destroyed after seven years.
- a summary of the project findings will be offered to all interviewees prior to submission of thesis.

Participant involvement

Interviews are expected to take one and half hours and will be face to face or over the phone if desired. Notes will then be taken of the interview with main points fed back to interviewees for checking at the time of the interview and post interview. The interviews will be sound recorded only.

Participant's Rights

The following Statement of Rights must be included:

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study a month out from interview;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.
- I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.
- Confidentiality of all participants will be maintained.

Committee Approval Statement

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the Massey University's Human Ethics Committees. The researcher named above is responsible for the ethical conduct of this research. If you have any concerns about the conduct of this research that you wish to raise with someone other than the researcher, please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Research Ethics), telephone 06 350 5249, e-mail humanethics@massey.ac.nz .

Rawiri Evans wants to thank you for participating in this research.

Department of Conservation
Te Papa Atawhai

AUTHORITY TO HOLD
Absolutely Protected Wildlife

File Reference: PAM-13-01-01 OTCO-01
Permission Number: OT-25804-DOA

DEPARTMENT OF CONSERVATION
PERMIT GRANTING AUTHORITY TO HOLD ABSOLUTELY PROTECTED WILDLIFE

Pursuant to Section 53 of the Wildlife Act 1953:

Dave Evans (Te Atiawa)
17 Berkeley Road
Wainuiomata
Lower Hutt

is hereby authorised to hold 6 toroa flight feathers from a royal albatross (*Diomedea epomophora*) at,

17 Berkeley Road
Wainuiomata
Lower Hutt

or,

Waiwhetu marae,
Petone,
Lower Hutt

as a gift from Te Runanga Otakou, Tamatea Road, Otakou, R D 2, Dunedin.

subject to the following conditions:

1. The feathers are obtained from Te Runanga Otakou.
2. This permit does not authorize any act to be done in contravention of the Wildlife Act 1953 and the Conservation Act 1987 or any regulation or proclamation or notification under those Acts.
3. Unless sooner revoked or varied this authority is valid from date of issue.

Issued this 13th day of July 2009 at Dunedin.

SIGNED for and on behalf of the
DIRECTOR-GENERAL OF CONSERVATION
by Robin John Shaw Thomas an officer of the Department of Conservation pursuant to a designation given to him by the Director-General of Conservation and dated the 24th day of November1997.

Doedm-454138