Matua Raki
National Addiction Treatment Workforce Development

He Tētē Kura,
Māori Addiction Treatment: 1980 - 2008

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Mate atu he tētē kura, ara mai he tētē kura

The whakataukī 'Mate atu he tētē kura, ara mai he tētē kura' is often represented by the image of the koru. The koru represents birth, regrowth and regeneration and symbolises sustainability and the passing of knowledge and resources from one generation to the next. This monograph *He Tētē Kura*, reviews the growth of the Māori addiction treatment sector through its history, and examines some of the knowledge for transfer across a new generation of addiction treatment sector workers. It expresses the continuity of history, growth and regrowth.

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Mihi Maumaharatanga

History is interpreted and communicated through the eyes of the storyteller. The history in this monograph is shaped by the kōrero and whakaaro of a number of people (see Appendix 1), all of whom have been participants and observers of many of the events that have helped develop Māori alcohol and other drug (AOD) treatment services and associated workforce in Aotearoa New Zealand. In fact, many of them have also been involved in some of the developments of the wider mental health sector. The unpublished manuscript *Tungia te ururua kia tupu whakaritorito te tupu o te harakeke*[1] (Huriwai and Robertson, 2000) has also provided a whāriki on which to build the history.

Unfortunately, there are many who have provided input into the Māori AOD sector who have now passed on and many more who have moved to other endeavours. Their important contributions live on as we, the kaimahi of today, have become the repositories and kaitiaki of their wishes, hopes, dreams and aspirations. This work captures some of those contributions and also asks the reader to consider how far we have progressed in achieving those moemoea. Further, we hope this work will invite the reader to consider future aspirations for the Māori addiction treatment sector.

As a result of the scope of this monograph, and the fact we are basing this history on the recollections of a particular group of informants, some places, people and events may not be specifically mentioned. However, the authors in collating this history acknowledge the individual and collective commitment, passion and desire for excellence of all those who have been involved in the developmental path of the Māori addiction treatment sector.

[1] Literally, 'Clear away the undergrowth so the flax can grow'.

Introduction

According to Māori, creation usually begins with three states of existence known as Te Kore, Te Pō and Te Ao Mārama. Translated roughly as 'the nothingness', Te Kore was a great void of emptiness and space which evolved into Te Pō, which shrouded the world in complete darkness. The darkness of Te Pō prevented the production of knowledge. Weary of living in a world of darkness created by the embrace of their parents, the children of Ranginui and Papatūānuku conspired to separate their father and mother to bring light and warmth into the world. The eventual separation of Rangi and Papa brought into existence the third state, Te Ao Mārama, or the world of light.

The creation of the universe through the whakapapa of Te Kore, Te Pō and Te Ao Mārama has similarities with the development of the Māori AOD sector in Aotearoa New Zealand. The Māori AOD sector grew from nothing, into a few workers existing and 'struggling away' in darkness. Eventually the number grew, and through the strength of collective action and a strong belief in their rangatiratanga, created a space to stand and define kaupapa or taha Māori treatment. More recently, this story has been replayed in the development of a dedicated problem gambling sector.

In Part I of *He Tētē Kura* - Te Aka Roa mo te Oranga, explores developments within the Māori addiction treatment sector over the past 20-30 years. This is mainly done by drawing heavily on the experiences of a number of key informants who were interviewed during 2006 by Māori Assistant Research Fellow, Tami Cave. Unless otherwise noted, the quotes featured throughout the monograph are from these interviews. The concluding section of Te Aka Roa mo te Oranga is a broad look

at elements of workforce development that have impacted on the Māori addiction treatment sector.

Part II of *He Tētē Kura* - Mai Te Whakaatu, Ka Mōhio: Insights and Understanding, provides analysis of the interviews with the key informants. Emergent themes from the interviews - including passion and commitment, use of Māori values, beliefs and practises, and the impacts of changes in the sector - are expanded on.

Te Ao Hurihuri, or the 'modern' world, provides a backdrop for Part III of *He Tētē Kura* - Haere Tonu: Ways Forward, considers some of the challenges identified by the key informants, such as leadership, service development and responsivness. With those broad themes in mind, and consideration of the wider landscape in which addiction treatment currently operates, we identify future directions and potential foci for continuing to build Māori responsiveness in the addiction treatment sector.

About The Project

> *Those new ones that are coming up, they have to have creativity and innovation, but also the history. In Māoridom, it's history that helps us go forward.*
> ***Peter Waru***

Over the last two and a half decades, there has been considerable development in the provision of treatment services for those with alcohol and other drug-related problems in Aotearoa New Zealand. More recently, these developments have extended to include problem gambling[2]. A growing responsiveness to the needs of Māori, an increasingly visible Māori addiction treatment workforce, and the development of a range of dedicated Māori treatment services and interventions has also occurred.

Attendees at the pre-Cutting Edge[3] Māori hui, held in Palmerston North in September 2004, identified the need to record the history of Māori AOD treatment services and the developments in workforce in Aotearoa New Zealand. A number of significant social and political events, as well as the commitment and passion of many people, have shaped the development and growth of these services and the workforce. Recording the history was seen as a way to provide an insight to those new to the sector as to how Māori AOD treatment services and the workforce have developed.

Those at the hui also felt that people, services and organisations within the Māori addiction and mental health sector often seemed to be caught up in 'reinventing the wheel'. Additionally, problem gambling was an emerging sector that appeared to be

[2] The term addiction is used in this document to include both alcohol and other drug (AOD) and problem gambling.

[3] Cutting Edge is the annual addiction treatment conference in Aotearoa, New Zealand.

facing similar challenges as the Māori AOD sector once had. Thus, a second intention for writing this history was to identify and review themes and lessons that have occurred at individual, organisational and systems levels. Matua Raki[4], the National Addiction Treatment Workforce Development Programme, took up the challenge of securing funding to compile the history requested by the hui attendees, as well as gathering information and experiences that might be able to inform future service and workforce development.

As the project progressed, another reason for recording the history of the Māori addiction treatment sector emerged. Over the years people had left the sector or had passed on, and institutional knowledge of services, groups and events was being lost. Thus, recording some base data while knowledge was still available was imperative, as was the desire to acknowledge the footprints of those who have created the paths we now walk in.

He Tētē Kura describes and celebrates some of the events and people from our past, and identifies various strands of learning that might help shape the future viability and sustainability of not only the Māori alcohol and other drug treatment sector, but also the emerging problem gambling sector. This history is not intended as an in-depth account of social and political developments and their influences on service development. Rather, *He Tētē Kura* is an account of opportunities and events from a 'flax-roots up' perspective that offers possible explanations for the current shape of the sector.

While *He Tētē Kura* primarily tracks developments in Māori-focused services, it should be noted that a number of Māori have achieved their recovery in, or are working in, services that are not specifically Māori focused.

[4] As the original base for Matua Raki was in the South Island it has adopted the Kati Mamoe use of the letter 'k' as opposed to 'ng' in its name.

PART I – He Aka Roa mo te Oranga:

A History of the Māori Addiction Treatment Sector

The Socio-Political Context

The development of Māori alcohol and other drug treatment services and interventions over the last three decades needs to be viewed in the context of wider socio-political developments for Māori in Aotearoa New Zealand. In the early 1970s there was an emphasis on the goal of Māori self-determination, the capacity for Māori to define their own goals and to develop their own separate organisations and institutions. The late 1970s and early 1980s brought an era of resurgence during which Māori began to overtly challenge the status quo and more vociferously highlight past injustices. The 1975 Māori land march, 1977 Bastion Point occupation and the 1981 Raglan Golf Course protest are examples of significant events that mark the reassertion of Māori identity in Aotearoa New Zealand around this time.

The mid 1980s saw the establishment of the National Kohanga Reo Trust, toll operator Naida Glavish challenging the Post Office to say 'Kia Ora' and in 1987 the Maori Language Act validated Te Reo Māori as an official language of New Zealand. It was also a period of time that saw increasing recognition being given to the relevance of the Treaty of Waitangi in contemporary New Zealand society and the impacts of colonisation.

Government departments and crown agencies introduced a series of 'Cultural Perspective Statements', groups and initiatives. All identified the key role of the Treaty of Waitangi and emphasised the need for partnership and biculturalism. In the Department of Social Welfare, *Pūao Te Atatū* (Rangihau et al, 1988) provided momentum for a greater institutional response to the needs of Māori. Mātua Whāngai (a joint venture between the Departments of Social Welfare, Māori Affairs and Justice), is an example that not only emphasised departmental responses to Māori but also the need to work more closely and

in partnership with Māori organisations. *Te Urupare Rangapū* (Wetere, 1988), is another example of Government policy of the day designed to guide Māori towards greater self-sufficiency and reduce dependency on the state. It promoted the process of devolution of many functions of the state to Māori. Despite cynicism in some quarters about how effective these initiatives were, they helped create an environment that supported the growth of a number of Māori programmes within state agencies as well as in the community.

In terms of health, Māori began to challenge the organisation of health service provision in Aotearoa New Zealand and the perceived shortcomings of 'western-based' models of health and treatment. This mounting dissatisfaction with such treatment options occurred at about the same time that Māori ways of being and knowing were experiencing revitalisation across a range of issues, including Māori language and education.

> *Within a wider context the relatively recent development of Māori substance abuse centres can be viewed in light of the Māori renaissance and its thrust for self-determination.*[5]

The Hui Whakaoranga held at Hoani Waititi Marae in 1984 provided an opportunity for a review of Māori health philosophy, health care provision by Māori and advocacy for Māori health initiatives. Later that year the Hui Taumata, held at Parliament, launced the Decade of Māori Development. A key theme of the hui, and a hope for the upcoming decade, was greater Māori autonomy and greater Māori self-determination.

> *The early 1980s was a period during which many Māori gained increasing confidence and were encouraged to become more assertive and participative in their own healthcare.*[6]

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[5] Spooner and Manuka-Sullivan (1990)

[6] Tipene-Leach (1994).

There was, in the early 1980s, one bicultural service development that provided positive role model for others in mental health and to a lesser degree in AOD. This was the Whaiora Unit at Tokanui Hospital[7]. It, like Te Whare Paia Unit at Carrington Hospital, which had its beginnings at about the same time, had a distinctly Māori milieu, utilising Māori values and practices such as wairuatanga, manaaki and whanaungatanga. The Whaiora Unit, however, was operated by Māori nurses and had the benefit of positive and supportive senior clinicians (especially Dr. Henry Bennett, the superintendent of Tokanui,[8] and psychiatric registrar Dr. Jennifer Rankin) that a number of other units did not.[9] Systemically this level of support had distinct advantages.

Within a decade, Māori were playing a greater part in service delivery and had engaged with health, education, social welfare and labour sectors as providers of services. Many of these services had previously been provided by the state. Often, services became part of wider iwi services (such as Ora Toa, a health service managed by Ngāti Toa[10]), but many non-tribal organisations also assumed the roles of service providers. Some providers, such as John Te Au and Carol Marino who were the enduring driving forces behind the treatment centre Pūangi Hau in the lower North Island, established as stand-alone organisations (Durie, 2004).

Although the environmental influences described above were not strongly felt in the addiction treatment sector until the period from 1985 onwards, these 'fair winds' helped to shape climate that supported the development of the Māori AOD

[7] See Rankin (1986) and Elliot (1986).

[8] Dr. Henry Bennett was also the first Māori psychiatrist.

[9] See Durie (2001) for a fuller description of Māori health service realignments and developments in the area of cultural enhancement and affirmation.

[10] See Williams (2000) for a history of Ora Toa Health.

treatment sector and workforce. Within the broader context of an increasing understanding of the relevance of the Treaty of Waitangi, the 1980s saw Māori argue for the right to make decisions about their own health care, and to have equality of health status under Articles Two and Three of the Treaty. Early leaders within the Māori AOD sector and in fact across the range of health and social service settings, already recognised the significance of the Treaty and the ensuring opportunity for growth within their respective sectors.

> *The growth of these units* [Māori AOD units] *is viewed as a practical expression of that document* [the Treaty of Waitangi] *and a means for the Māori community to care for their own people and determine their own destiny.*[11]

The 1990s saw a number of health reforms which for many NGOs led to greater assurance of resourcing. In the AOD sector one of the impacts was the bringing of AOD more firmly under a health banner and 'closer' to mental health. Previously, funding for Non-Government Orgamisations (NGOs) came from a variety of sources, with services undergoing a long and arduous task filling out applications to a number of possible funders.

> *To get money, you were applying to every agency. There was an Inter-Department Committee for Substance Abuse*[12]*, there was COGS*[13]*, there was Social Welfare and Justice. We were all doing 10-15 copies per application – and there always seemed*

[11] Spooner and Manuka-Sullivan (1990).

[12] The Inter Departrment Committee for Substance Abuse (IDC) was a committee that sat under the auspices of the Department of Internal Affairs. It was made up of representatives from the Alcohol Liquor Advisory Council, the Departments of Justice, Health and Internal Affairs.

[13] Community Organisation Grants Scheme (COGS) is a community based grant-making scheme, providing grants to community organisations that provide social services to people from one or more of the COGS priority sectors. Before AOD became sorely dependent on Vote Health funding, many NGO AOD services applied for grants from COGs.

to be a number of those needing doing, to send to Wellington or wherever, to get maybe a third of what you actually needed.
Terry Huriwai

Funding became more clearly a responsibility of Vote Health. Despite a more assured funding source for AOD services in the 1990s, there was a much more competitive edge to relationships, increased expectations around contract compliance, and more emphasis on service delivery than service development.

This was the era of the Crown Health Enterprises, Regional Health Authorities and the Health Funding Authority. A guideline for purchasing Māori services was published (Durie et al, 1995) and in 1998, the Health Funding Authority (HFA) began the development of Māori service specifications for purchasing 'by Māori, for Māori' mental health services.

Increasingly, one of the organisational realities many NGOs needed to adjust to was the requirement for management that was more 'professional'. This also meant Boards, Trusts and Committees of concerned people having to learn the difference between governance and management. The funder-provider split also theoretically provided some NGOs with 'equal' opportunities for resourcing as hospital-based services (including competing for service contracts). The increased competitiveness, however, impacted on the way services worked together and in some areas strained already fragile relationships.

Bulk funding was coming out in a 'divide and rule' type thing, where you kept your stuff to yourself. It wasn't set up so that you could work co-operatively and get the most out of things.
Pam Armstrong

The 21st century has seen the development of District Health Boards (DHBs) and the responsibility for problem gambling services transfer to the Ministry of Health from the Problem Gambling Committee. The establishment of 21 DHBs saw the end of the provider-funder split and there is now an emphasis on local responses to local issues. Government goals, objectives, targets, and other expectations of DHBs in respect of Māori are clearly articulated through its *New Zealand Health Strategy* (Minister of Health, 2001) and *New Zealand Disability Strategy* (Minister for Disability Issues, 2000). DHBs must demonstrate their responsiveness to Māori through consultative and decision-making processes reflected in each DHB's strategic and annual plan, including through partnership relationships. Rather than an environment of competition, providers now find themselves encouraged towards collaboration and increasing regionalisation.

Another key development, not only for the wider AOD sector but also the Māori AOD sector, was the work undertaken by Phillipa Gaines and Terry Huriwai to produce a background document and subsequent strategic funding document for the Ministry of Health (2001). This plan signalled an intention by the Ministry of Health to play a key leadership role in the AOD sector by providing a framework within which the DHBs were to operate. As a result of this work, a new position was created in the Ministry of Health (mental health directorate) dedicated to the implementation of the plan and the AOD sector. Initially this position was held by Terry Huriwai.

The Treatment Context

Pre-1980, there was little in the way of a formalised Māori AOD sector in Aotearoa New Zealand. In fact, there was limited specialist AOD treatment for anyone. In 1970 Roy Johnston, the President of the National Society on Alcoholism and Drug

Dependence New Zealand (NSAD), told the audience at the Southland Hospital Post-Graduate Committee's Alcohol in our Society seminar that there was an estimated 30,000 alcoholics in New Zealand. At the same seminar, David Simpson, a Research Fellow in Medical Sociology based at the Medical Unit at Wellington Hospital, reported that Māori were admitted to mental hospitals for alcoholism disproportionately less than Europeans (three times less likely)[14]. The second report of the Committee on Drug Dependence and Drug Abuse indicated that during the years 1970-1972, Māori involvement in drug offences was much less than the proportion of Māori in the total population[15]. Given the lack of any other reliable data, involvement in drug-related offences was a proxy measure of drug use and therefore drug-related problems.

The main pathway to treatment for addiction-related problems (particularly alcohol-related) was admission to public and mental health hospitals. Some hospitals developed specialist units, for example Mahu Clinic[16] at Sunnyside, or wards such as Ward 1 at Cherry Farm Hospital. These units typically worked with alcohol-related problems rather than other drug misuse. There was increasing debate as to the appropriateness of placing the small number of drug users in mainstream psychiatric wards.

> *I feel that the present mental health/mental hospital setups are just not suitable for treatment of these people* [drug users], *especially the very young or the adolescents. These people fit in poorly into our present addiction programmes which are mainly concerned with alcoholism and with barbiturate*

[14] National Society on Alcoholism & Drug Dependence New Zealand Inc (1970).

[15] New Zealand Board of Health, Report Series 18, (1973).

[16] Alcohol education and awareness programmes run by probation officers in Christchurch in the mid to late 1970s utilised Mahu Clinic at Sunnyside Hospital as part of their course (see Cree et al., 1975). Likewise, probation officers in Hamilton included visits to Tokanui Hospital in their awareness courses of the late 1970s.

> *addiction in middle-aged women. I feel that treatment procedures in the past have been oriented too much to what we as administrators and doctors think is good for the addicts.* [17]

On the other hand, some of Dr. McDonald's colleagues would seem to have felt 'these people' could be accommodated both in terms of treatment and also support. The following quote articulates the importance that Alcoholics Anonymous (AA) had placed on it in terms of continuing care.

> *The method and style of treatment of drug users does not differ significantly from that provided in any modern treatment programme for patients with impairment of personality functioning who are not promptly relieved by specific medication or ECT. Alcoholics Anonymous provides a useful and fully established model; thus some patients will require life-long support in the socially useful role of non-using ex-drug user.* [18]

Incidentally, AA traces it's beginnings in New Zealand to the late 1940s. In the 1970s AA was very much an adjunct to hospitalised treatment and was used by many as a mainstay of continuing/after care. Anecdotally, while there were small numbers of Māori attending AA, Narcotics Anonymous (NA) and Al-Anon[19] in the late 1970s and early 80s, the numbers appeared to be on the increase.

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[17] Personal communication from Dr. Fraser McDonald, Medical Superintendent, Kingseat Hospital, to the Committee on Drug Dependence and Drug Abuse. New Zealand Board of Health, Report Series 18 (1973).

[18] Personal communication from Dr. Dobson, Department of Psychological Medicine, Christchurch Hospital to the Committee on Drug Dependence and Drug Abuse. New Zealand Board of Health, Report Series 18 (1973).

[19] The Al-Anon family groups are a fellowship of relatives and friends of alcoholics who share their experience, strength and hope in order to solve their common problems. They believe changed family attitudes can aid recovery.

Queen Mary Hospital in Hanmer Springs had begun to specialise in the treatment of alcoholism, under Doctors Maling and Harrison, from the late 1960s and by the 1980s had also begun providing specific addiction training. As a national teaching hospital, Queen Mary attracted clients and trainees from around the country and a range of service settings.

The first methadone programmes appeared in the early 1970s and one of the first clinics was the non-hospital based National Society on Alcohol and Drug Dependence (NSAD) Wellington Clinic. The responsibility for the methadone programme eventually went back fully to the hospital and the provision of opioid treatment has predominantly remained the domain of hospital-based services since. In terms of the NGO sector, the Salvation Army had utilised Rotoroa Island in the Hauraki Gulf as a rehabilitation centre since 1910 and it had a number of other services in the community for those considered less chronic. Operating since the late 1950s, it wasn't until 1969 that the NSAD (at its Auckland centre) began to offer drug treatment and counselling as well as alcohol treatment and related services. Within five years all the other NSAD centres followed suit.[20] Generally, there appear to have been few Māori clients in treatment for substance misuse-related problems and there is little evidence to show that there were many specialist AOD Māori workers, let alone a Māori-oriented treatment centre or treatment philosophy.

A number of Māori were working in hospitals and mental health institutions and some worked there with people with alcohol-related conditions. Moe Milne for example worked with 'alcoholics' in units at Kingseat and Carrington hospitals and was involved in setting up domiciliary nursing services. She recalls that for some patients, domiciliary nursing was

[20] For more information on NSAD see Butterworth (2004).

supporting people with their sobriety. As one of the earliest AOD community workers, she and other workers at Wolfe Home[21] would follow up people when they were on leave from their programmes and for a period of up to three months after discharge.

Timoti George relates a slightly different experience than most psychiatric nurses from this era – in this account of taking methadone from Oakley Hospital to Cathedral Clinic (Parnell) in the early 1970s:

> *Methadone syrup was transported in a padlocked box. The key was held by the doctor and before we left the ward, the box would be handcuffed between us* [the nurses]. *We would walk to the hospital car – a two-door light blue 1968 Ford Anglia – under guard by hospital staff. When we were in the car, a police escort (two constables) took over. The police would put on the siren and lights and we would follow them to Parnell. On arrival at the Parnell clinic we had to wait in the car until the path and building was cleared by the police.*[22]

A review of hospital data from the years 1971–1990 by Pōmare and colleagues (1995) found evidence that the general health status of Māori was lower than that of non-Māori in terms of medical disorder, and that Māori substance-use morbidity (based on hospital admissions data) was about double that of non-Māori. Te Puni Kōkiri, in its publication of Māori health trends (1996), noted high rates of alcohol and other drug disorder. These publications confirmed what many in the community had been seeing and acting on for at least 10 years.

[21] Wolfe Home stood not far from where the present Pitman House is located in Point Chevalier.

[22] Timoti George, personal communication. Timoti currently manages Waitemata DHB's Whitiki Maurea Māori Mental Health and Addiction services.

This monograph, *He Tētē Kura*, begins with a focus on a history of the Māori addiction treatment sector in the 1980s, not because there was no history before this time, but rather, because it is from this time that we see a number of Māori working with whānau with addiction-related problems and others coming through treatment themselves. As a result, there began to be a collective response by Māori to addiction-related harm experienced by Māori.

Organisations and Significant Events

The year 1978 saw the first Māori representation on the recently created Alcohol Liquor Advisory Council of New Zealand (ALAC)[23] in the person of Mason Durie. While not specifically associated with treatment, this appointment signals the beginnings of Māori and Treaty responsiveness for ALAC. More importantly, it also heralded the contribution that ALAC would make to the development of the Māori AOD treatment sector over the next 20 years.

The following photo taken in 1999, includes the then ALAC council member Melody Robinson and future council member Anne Hobby. This group was brought together by ALAC to consider the review of the Community Development Act 1962.

L-R: Nick Pataka, Paul Stanley, Anne Hobby, Kayleen Katene, Terry Huriwai
Front: Peter Meihana, Melody Robinson and Cathie Whaitiri.

[23] Now known as the Alcohol Advisory Council of New Zealand.

The following table lists ALAC council members of Māori descent over the past 30 years.

ALAC council members

Name	Dates of Service	Positions held
Dr Mason Durrie	(1978 - 1981)	
Roy Te Punga	(1978 - 1979)	
Graham Latimer	(1981 - 1986)	
Harata Solomon	(1986 - 1989)	Vice Chair
Margaret Manuka-Sullivan	(1987 - 1988)	
Lorna Dyall	(1990 - 1991)	
Dr David Tipene-Leach	(1993 - 1995)	
Waimarama Taumaunu	(1995 - 1998)	
Judge Michael Brown	(1994 - 2000)	Chair
Melody Robinson	(1999 - 2002)	
Delaraine Armstrong	(2002 - 2004)	
Monica Stockdale	(2000 - 2006)	Vice Chair
Trevor Shailer	(2005 -)	
Anne Hobby	(2008 -)	

At the same time that ALAC was starting to include Māori in its thinking, an increasing community desire to meet the needs of Māori whānau, hapū and iwi started to draw individuals of a like mind together. This initial movement provided the foundation for the beginnings of the Māori addiction treatment sector in Aotearoa New Zealand.

> *Pre-1980, there were Māori working around the place. There was no real perception back then that they might have been working differently, there wasn't a sense of a Māori AOD sector either. There was nothing to pull them together like that.*
> ***Terry Huriwai***

The 1980s

The 1980s was a time of growth – emerging workforce, developing services, a climate of responsives and an increasing focus on Māori by ALAC. Certainly, the early part of this decade was the time of the volunteer and the beginnings of an identifiable Māori addiction treatment sector. Some of the people who came through this time, both as workers and as consumers of services, provided much of the infrastructure for consolidation in the 1990s.

The South Auckland Alcohol and Drug Committee

> *The starting point was simple; it was about being involved in Māori initiatives, in the helping field, right across the board.*
> ***Paraire Huata***

The early 1980s saw the coming together of people working in a range of different mahi - all with an interest in AOD-related things and / or Māori health. In Auckland, a small group of Māori with an interest in AOD issues began meeting – including Hemi Ransfield (Baptist City Mission), Donna Awatere (educational psychologist)[24], Dr. Henare Broughton (Middlemore Hospital) and Te Puea Winiata. This group was the seed from which the South Auckland Alcohol and Drug Committee grew. In turn, that committee became the kākano from which the Te Ara Hou Resource and Training Centre was to spring. This resource centre eventually developed into the residential treatment services Te Ara Hou and Te Atu Rama[25], with Te Ara Hou being the first residential Māori AOD treatment service[26].

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[24] In 1984, Awatere and colleagues began work on *Alcohol and the Māori People*, an important text in terms of being one of the earliest descriptions of the relationship Māori had with alcohol.

[25] A residential programme for women, Te Atu Rama was one of the first centres in the country to accommodate mothers and children. It was the sister service to Te Ara Hou.

[26] For more information about the early history of Te Ara Hou see Appendix 2.

Te Puea Winiata started work at the Salvation Army in Auckland in 1982 and, as most did in those days, she did her alcohol and other drug training (three month residential) at Queen Mary Hospital (hereafter referred to as Queen Mary) in Hanmer Springs, North Canterbury. Here she met Monica Stockdale, who was then a family group counsellor there.

> *In the early 1980s there was a small number of Māori who were concerned about what was happening for Māori. I can't remember anyone in Auckland who was Māori who was actually working in the alcohol and drug field. Later, after my training and through my connection with Mon* [Monica Stockdale], *we started to wonder who else out there was working in the sector.*
> ***Te Puea Winiata***

When Te Puea returned to Auckland in 1983 from Hanmer Springs, she was joined at the Salvation Army's Cornwall Lodge by Harry Pitman. Auckland now had at least two Māori working specifically in the AOD sector. Hemi Ransfield, another Queen Mary-trained worker, operated from the Baptist City Mission.

The Māori Support Group, Queen Mary Hospital

For Te Puea and a number of others working in AOD at this time, the training offered by Queen Mary Hospital was essential. In terms of the history documented in *He Tētē Kura,* training was but one element of interest at Queen Mary: significantly, there was the Māori Support Group and Monica Stockdale.

One of the earliest examples of explicitly working more responsively with Māori with AOD-related problems was Moutere (Mo) Standford, the postmistress at Hanmer Springs.

She provided awhi to Māori clients at Queen Mary to support them to stay in the programme, as there were a large number of Māori who were discharged early.

Te Puea Winiata and Monica Stockdale, Mangere, 1985

> *I remember when we were there* [Queen Mary Hospital]*; there was a large group of Māori who were discharged before their time. Mon* [Monica Stockdale] *and I were just sitting in this room trying to awhi these people who were waiting for the bus. I remember how sad it was.*
> ***Te Puea Winiata***

The Māori Support Group was encouraged by Hospital Superintendent Robert Crawford, partly as there were no 'trained' Māori therapists. The group started in approximately 1982 and involved Mo Standford, Mere Valenski (an occupational therapist at Queen Mary Hospital) and Monica Stockdale. This group initially met in the evenings on an informal basis, could be attended by Māori and non-Māori, and started as a voluntary group – although therapists were supposed to 'approve their patients' attendance. Its aim was to allow Māori on the Queen Mary programme to come together as a group to support each other.

> *There had been Māori that were coming into the mainstream programme* [at Queen Mary], *they were staying three or four days or a week at the most and then they'd go because, for a lot of reasons, but for most of them it was because there was the cultural sort of misunderstanding.*
> ***Monica Stockdale***

After Mo Standford left, Mere Velensky and Monica Stockdale formally assumed leadership. Although initially the group was open, after some discussion a decision was made that attendance at the group would be only Māori, those married to Māori and those of Pacific Island backgrounds referred by their therapists. The decision limiting the group to Māori reportedly did not meet with universal support and generated a lot of discussion among staff of Queen Mary as well as anxiety among patients (Māori and non-Māori).

> *I think their anxiety was because they didn't know what we were doing, or what it might mean for them. Some staff and patients saw no connection between what we wanted to do and treatment, especially as we weren't 'real therapists'. Some Māori were wary. Fear of the unknown.*
>
> ***Monica Stockdale***

Monica Stockdale and Mere Velensky felt a need to go back to the traditions and values of the marae and to utilise a holistic approach addressing taha tikanga, taha wairua, taha hinengaro, taha whenua and the restoration of mana and taha whānau. It was from these beginnings, and over the next three or four years, that the support group continued becoming more formalised. In 1985, Mere Velensky left and Carol Browning (another occupational therapist) took up a support role to Monica Stockdale. Writing in her introduction to the history of Narcotics Anonymous (NA) in New Zealand[27], Apihaka, who

[27] Aotearoa New Zealand Regional Committee of Narcotics Anonymous (2005).

attended the Taha Māori group in those early days, recalls that the group was only held once a week.

Partly due to lobbying by Monica Stockdale, the petition of whānau in Christchurch, and the support of Jock Sutherland (a medical officer and therapist at Queen Mary) a position was advertised in late 1986 for a social worker with an understanding of taha Māori. Monica Stockdale was appointed to the position. After five years of 'voluntary' operation, Queen Mary now had a paid staff member to work with Māori and to develop the Māori group into something more than a weekly group. In 1987 Geneva Hudson joined Monica at the programme[28] and a year later in 1988, after much negotiation and work behind the scenes, the Māori programme moved out of the 'back broom closet'.

ALAC National Māori Coordinator

In 1984, about the time the whānau unit at Tokanui Hospital was picking up momentum, Māori responsiveness within the AOD treatment sector gained impetus with the appointment by ALAC of a National Māori Coordinator – Ngamaru Raerino. Based in Auckland, Ngamaru had the brief to bring together a set of programmes specifically focused on Māori. In the main, he went about achieving this by establishing the needs of Māori in the community and then supporting and facilitating them to initiate their own 'recovery plan'. Part of that recovery plan was working with the likes of Paraire Huata to nurture and awhi fledgling services and groups such as Te Ara Hou and Te Ara i Rauhanga (more about these initiatives later).

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[28] The waiata 'Anei Ra te Whānau' that is so strongly associated with the Taha Māori whānau was actually an adaption of the graduation waiata for Geneva Hudson. It was first used by the group when they came to pay their respects to the young people who lost their lives in the 'Ferry Road fire'. So many people stood to tautoko the group, that the waiata that they used on that day became synonymous with the Taha Māori programme at Queen Mary.

When I was with the ALAC, I thought to myself: 'there's got to be a better way about having some kind of wellbeing for Māori people'. I went right through the whole of New Zealand talking to different groups about addressing the problem of drinking. I must thank ALAC, because a lot of the things I dreamed about, things I wanted to do, ALAC supported it.
Ngamaru Raerino

Three particular initiatives Ngamaru was involved in that are worth noting, and which will be expanded on later, include the Kua Mākona campaign, Te Ara i Rauhanga and a proposal to train volunteers to be Māori counsellors and therapists.

The above photo is of Ngamaru Raerino at Tangata Marae, Okauia, Matamata. The occasion was the evaluation of the Te Ara Ki Mana o Raukawa Addiction Services Waka Taua Wellness Programme. With him is the waka Te Timatatanga, Chulsa Tangaere, Terri Cassidy, Linda Gibson and Whaea Hiria.

Ngamaru was always around the country and doing what he did extremely well. He drove the stake that enabled the opportunity for Māori to have a say and the council supported that.

Margaret Manuka-Sullivan

To some degree, the increasing demand from the community for Māori-oriented help facilitated the creation in 1988 of an ALAC Māori advisor position. Margaret Manuka-Sullivan was appointed to this position, based in the Wellington National Office.

> *If you look at the development of Māori responsiveness in ALAC, it was like the growth of the AOD field. From a National Coordinator with Ngamaru, to a Māori Advisor and then a dedicated ALAC Māori programme. We were lucky to have had the support of Keith Evans* [CEO of ALAC at the time]. *In 1991, I became the Director of the Māori programme and until my resignation in 1999, ALAC played an active hands-on role in developing programmes that we hoped would influence whānau, hapū and iwi. After me, I think ALAC got more involved in policy and a particular focus on Māori seemed lost. Given addiction-related harm and Māori I think ALAC will revisit the relationship with Māori and with the treatment sector.*
> ***Margaret Manuka-Sullivan***

The ALAC Māori programme (Margaret Manuka-Sullivan, later joined by Kayleen Katene) worked to strengthen and empower Māori. This required them to work alongside the Māori AOD sector. They had a broad vision of the Māori AOD sector in terms of health promotion, treatment, research, workforce development and service development, which led to them working with a range of people and groups. Their aim was to support these people and groups to negotiate their own destiny and strategically set their own pathways – all with the minimum of direction from a government entity. The starting point for this was the mahi of Ngamaru Raerino with Māori communities and community groups. From the start, both Ngamaru Raerino and Margaret Manuka-Sullivan had a desire to help make the Māori community more aware of the problem in their midst – and for

them to take some responsibility for its resolution. While they knew that a broad public health approach was necessary, there was demand and energy for treatment services (the ambulance) that they had to respond to.

AA, NA and Al-Anon in Christchurch

Certainly one of the drivers of this demand and energy for treatment services came from those who had experience of treatment, and particularly experience of the 12-Step movement. As already mentioned, AA had been in New Zealand for nearly 40 years and had over the years been recognised as an important part of the 'recovery journey' for many experiencing AOD-related problems.

Although Christchurch was not unique in providing some Māori-specific meetings, in 1984 marae-based AA meetings started at the Ngā Hau e Whā Marae in Christchurch. Early reports state that attendance was consistently about 30-40 people per meeting with new faces each week. Hoy and Elvy (1984) in their report on Māori alcoholism in Canterbury noted that participants 'felt at home on the marae, experienced spirituality, and bonded'. They further noted the similarities to the Queen Mary Māori Support Group in giving a 'sense of unity and wairua'. As well as AA meetings, the marae hosted Al-Anon meetings. Although the development of

Anaru Mapa, Sam Kahui and Pukekawa Wehi, Palmerston North, 2008

specific Māori AA, NA and Al-Anon programmes, like many others around the country, was short lived, it provided a starting place for a number of initiatives and workers[29]. Nationally, various versions of the serenity prayer in Māori were appearing both in prayer and waiata form from within the ranks of AA and NA.

E Te Atua
whakaaetia mai te rangimārie
Kia rata au ki ngā mea e kore nei e taea au
i te huri te kaha
hei huri i ngā mea
e taea ana e au
me te mātauranga kia mōhio au
i te rerekētanga.[30]

Treatment Services

Due in large part to the passion, dedication and commitment of individual and collective kaimahi, but also to a funding and service provision environment that was more receptive to things Māori, Māori service development flourished in the period from 1985 to 1995.

In 1985, ALAC actively provided support to develop a number of community-based AOD initiatives around the country, in particular Te Ara Hou (Auckland), Te Kōtahitanga-o-Ngā-Mōrehu (Wellington), Te Rito Ārahi (Christchurch), Te Rapurapu Oranga (Dunedin) and Te Ao Mārama (Invercargill). The support took the form of information, advice, endorsement and

[29] Many Māori in AA, NA and Al-Anon have provided, and continue to provide, much valued support and sponsorship.

[30] From *Ki te Ao Mārama* (ALAC, 2006). Also see *Keeping New Zealand Clean* for another version of the prayer. The Taha Māori programme and Te Rito Ārahi also had a waiata version, 'Homai Ra e Koe'.

some financial assistance. ALAC also helped bring like-minded people together to support one another. Later, ALAC also invested resources in Te Tāwharau Social Services (Porirua).

In March 1986, Ngamaru Raerino stated in his ALAC National Māori Coordinator's report: 'These groups are all working to develop a Māori response to drinking problems. It is hoped they will provide much needed input to the Council's community-based activities.'

These initiatives were some of the first Māori AOD treatment services. Those involved in the various fledgling organisations and services spent a lot of time on the road supporting one another and attending various hui throughout the country supporting the development of Māori services.

> *Crazy stuff. To get to the hui in Rotorua, you'd take your family, jump on the bus or fill the van. You had busloads coming up from the South, all good stuff - but it was a huge sacrifice.*
> ***Hakopa Paul***

Most of these services were NGOs that were staffed mainly by enthusiastic volunteers. They tended to approach treatment from an abstinence focus (usually 12-Step), delivered within a tikanga Māori framework. Financial resources were often obtained by these groups (and in fact many NGOs) from a variety of sources, including Area Health Boards, the Department of Justice (Matua Whāngai seeding grants of $50,000), the Department of Social Welfare, the Inter-Department Committee, Community Organisation Grant Scheme (COGS), the Lotteries Commission, as well as ALAC. The 1980s and early 1990s was the era of multi-funding and multiple applications. Funding for NGOs, particularly Māori NGOs, was short-term and uncertain, and so innovation and creativity were necessary to survive.

Back then people were working for nothing, they were working long hours. I'm not saying that that was a good thing that we need to be highlighting, but there was certainly a passion and commitment that saw them go the extra mile and use whatever they could to the max.
Terry Huriwai

ALAC also became involved in the development and support of two more dedicated Māori AOD treatment units, namely Te Whare Ora and Te Utuhina Manaakitanga Trust. Te Whare Ora in Dannevirke was one of the first joint venture initiatives between iwi and ALAC as a Crown agency. Although it was relatively short-lived, some of the ideas and momentum generated by such an initiative influenced how ALAC advanced similar iwi-focused initiatives in the future. The Māori community, concerned at the impending closure of the hospital-based services in Rotorua, initiated Te Utuhina Manaakitanga Trust in 1988. It soon attracted the support of ALAC.

We went from having a NSAD general programme to Te Utuhina Manaakitanga – a kaupapa Māori programme. We ended up being the only service in town.
Peter Waru

Te Utuhina Manaakitanga (also known as the Addiction Resource Centre) began as a fragile organisation, but after a while became quite a prominent unit, serving not only the wider community in Rotorua, but also the Bay of Plenty. Unlike the other services under the ALAC wing at the time, Te Utuhina developed a health promotion and community development arm as well as a treatment service. Under Peter Waru's stewardship, it was actively involved in the development of the Drive Wise programme (a drink drive programme), Te Papa Tākaro (a competition between the hapū of Te Arawa that also

encouraged healthy lifestyles) and for a number of years was the only NGO provider of the methadone programme in the country[31].

While ALAC specifically supported a number of services in their development, there were other fledgling Māori treatment services struggling for their place in the sun as well, including Te Ara ki Mana o Raukawa Addiction Services (Te Awamutu), Pūangi Hau (Wellington), Te Ārahina Ora (Levin) and Te Huarahi ki te Oranga Pai (Invercargill).

The original staff at Te Ara Ki Mana Addiction Services included Tina and Mana Winikerei (who had both spent a number of years working at NSAD) and Faith Winikerei. All undertook Central Institute of Technology (CIT)[32] alcohol and drug counselling training during 1992-93.

Te Huarahi in Invercargill began as a stopping violence programme (early kaiawhina included Eddie Tauroa, Shirley Morehu and probation officers Joe (Glen) Tupuhi and Harry Moeke). It eventually consolidated as a substance use treatment programme, as the prevalence of substance misuse among the participants in the stopping violence groups was always high.

One of the characteristics of most of these early services was the involvement of individuals and whānau who had been in treatment, or who had been directly affected by substance misuse.

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[31] As mentioned, NSAD briefly operated a methadone clinic in Wellington in the early 1970s. Te Utuhina Manaakitanga Trust held a contract for methadone service for nearly eight years.

[32] Now called the Wellington Institute of Technology (WELTEC).

Te Ara i Rauhanga

A significant development for these dedicated Māori AOD treatment services and the Māori addiction treatment workforce was the establishment of the national network Te Ara i Rauhanga. Its roots, and that of many services spoken of already, lay in a national hui on alcohol and other drug abuse among Māori held at the Mataatua Marae in Mangere towards the end of 1985.

One of the key reasons for calling the hui was to look at the feasibility of setting up resource centres in Auckland, Wellington and Christchurch. It was considered that one vehicle to support the establishment and development of these services would be a network of like-minded Māori organisations – Te Ara i Rauhanga.

> *I think the reason why we moved into developing this national organisation was that we identified that each of our little groups would start developing something that would provide*

Mataatua Marae, Mangere, 1985

a whole, so Te Ara Hou for example, was originally established to be more about developing models of practice and doing research and gathering information.
Te Puea Winiata

Te Ara i Rauhanga comprised a number of groups, organisations and individuals from around the country. It was intended to be a network of centres of excellence for Māori development within the AOD sector. (For more comprehensive information on Te Ara i Rauhanga kaupapa and the core services involved see Appendix 2).

We were a real smorgasbord. Colourful characters, the whole lot of us. Some of us were addicts, some were in recovery, but principally it was because we were Māori.
Te Orohi Paul

The inaugural Te Ara i Rauhanga national hui, held in Christchurch in 1986, provided one of the first opportunities for Māori working with alcohol and other drug-related problems from around the country to come together and discuss relevant issues. (See Appendix 3 for a mailing list of some of the hui attendees). The national hui was not only an opportunity to see who was doing what and where, but also a chance to look at the aims, goals and objectives of those working in AOD. This hui helped to formalise the idea of a national body representing a Māori voice that many were calling for.

What impressed me about the national hui I went to was the range of people there, from places like Cromwell, the West Coast and Raetihi. Some worked in services, many were voluntary. We all talked about working with Māori and needing more resourcing – I guess that hasn't changed. [33]

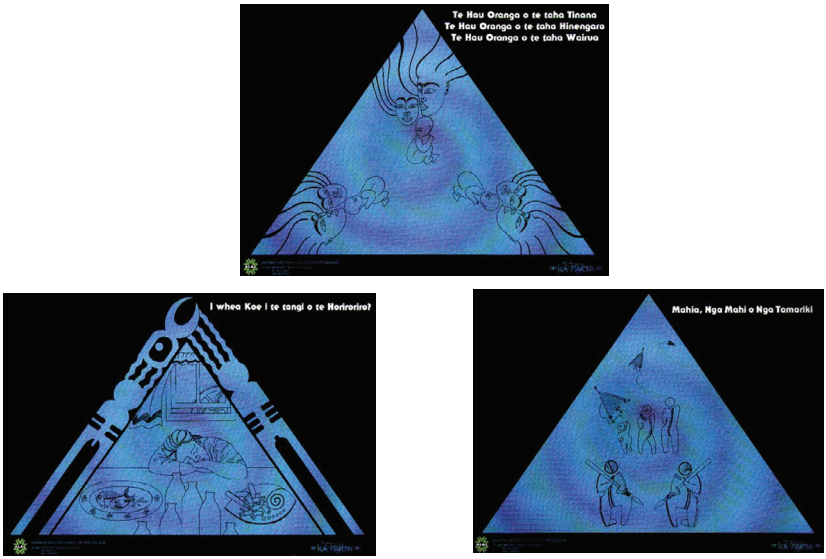
[33] John Paerata, personal communication cited in Huriwai and Robertson, (2000). John was a Senior Probation Officer in Christchurch who was the first liaison with Te Rito Ārahi.

A lack of infrastructure support (particularly a lack of dedicated funding and administration, and differences in the needs of the various groups and communities involved) saw Te Ara i Rauhanga fail to progress as a national voice or as a uniting body. Despite this apparent lack of traction, over the six year's of its development Te Ara i Rauhanga had contributed to the sector in a number of ways, mainly bringing together:

- people with a concern for alcohol and other drug issues
- people committed to ensuring there was a Māori choice in terms of treatment
- people calling for a united Māori voice.

Over the following years, a number of those who had been part of this development continued to work to achieve a collective vision and voice for the Māori addiction sector.

Kua Mākona and Manaaki Tangata



Kua Mākona Posters (courtesy of the Alcohol Advisory Council of New Zealand (ALAC))

Although the ALAC Māori Coordinator was heavily involved in supporting the development of treatment options for Māori, there was, as previously mentioned, an acknowledgement that a more preventative and awareness raising perspective needed to be made for the long term gains.

In March 1987, the Kua Mākona campaign was released under the auspices of the ALAC Māori programme. It became the umbrella term for ALAC's Māori projects but is most often associated with one of the first Māori-specific alcohol-related resources. The Kua Mākona resources were developed to increase awareness of the role of alcohol in the community and to promote a lifestyle that included alcohol use in moderation. The resources included a waiata preformed by Moana Maniapoto Jackson, a haka – 'Te Kai Kino', and later, a series of posters. The posters are still seen in a number of services around the country and the waiata 'Kua Mākona' is still heard on the radio today.

ALAC also sponsored a number of community activities under the Kua Mākona banner, including sports teams. The above photo is of one of the first winners of a Kua Mākona sponsored event – they were rewarded for conduct and dress (c1988).

Kua Mākona team

PRESS RELEASE

PRESS RELEASE

This year has seen the beginning of a new campaign aimed at promoting the concept of " Moderation " in alcohol consumption.
Under the name of " KUA MAKONA ", the campaign is aimed mainly at Maori people who drink in excess.

The campaign has focused initially on the production of a record, arranged and produced by Maui Dalvanius Prime, a well known and widely respected entertainer and record producer.

The song has been written in classical Maori and sung by Moana Maniapoto Jackson, a talented and well known singer.

A Video clip to accompany the song was designed to capture the imagination of young and old alike, plus a teaching video has been produced for use in Schools, Marae's, Training Programmes and in the home.

Marketing of the record will include the production of T. Shirts, Posters and Wall Planners. There is a small component of advertising in Cinemas, Radio and Television. This how-ever, will be very low key.

The phrase "KUA MAKONA" is a Maori phrase taken from classical and biblical usage that infers satisfaction gained from responsible consumption.

While this phrase is being used to highlight the problems associated with excessive drinking, it has a wider connotation in other areas such as smoking, drug use and food.

The video and record package is seen merely as a lead in to make the subject of Maori drinking an easier one to address, and will be the first step in an ongoing campaign that will include educational programmes for use in all areas, from the Kohanga Reo through to University.

Paul Carvell of Valdini Productions, who , with Maui Dalvanius Prime, was responsible for the "Poi E" video has been contracted to produce the video.

MOANA MANIAPOTO JACKSON

Moana Maniapoto is currently lead vocalist with Auckland's hot six-piece band Whitline. She joined the band over a year ago and now sings five nights a week at "Club 21".

During the day,Moana combines her skills as a Barrister and Graphic Artist by translating legal information into simple graphics to "demiystify" the legal system. These are distributed via the community networks.

The committment to community eduction coupled with her grasp of "Te Reo Maori" made her the obvious choice as Vocalist and focal personality for the "KUA MAKONA" campaign.

Kua Makona press release

By 1990, ALAC determined that Kua Mākona had reached its expiry date, however there was no clear replacement programme to continue to progress the objectives of Kua Mākona. The last hurrah for Kua Mākona was during the 1990 Sesqui celebrations[34], when ALAC sponsored several waka travelling to Waitangi. Although the waka carried messages relating to Kua Mākona, they were lost in the broader messaging and celebration around the event.

Mana Manaaki was an initiative developed in Tauranga in the mid-1990s that took into account customary Māori structures and values, as well as contemporary institutions – its emphasis was on both the marae and football cultures of the area. The lessons learnt by Orewa Barrett and her team in Tauranga, and Peter Waru and the Papa Tākaro team in Rotorua, highlighted the lack of Māori-specific AOD health promotion resources that could be easily adapted to suit the needs of the various communities.

Meeting held at Ruakiwi Rd Hamilton to discuss Māori alcohol health promotion messages 1994

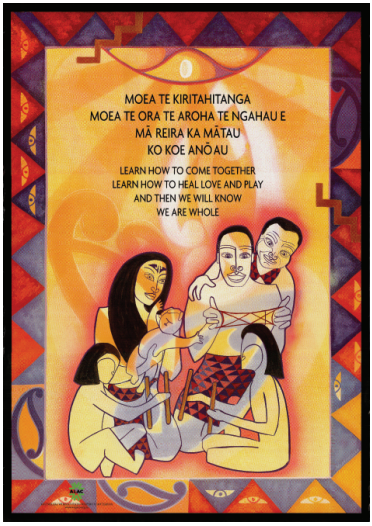
[34] Celebrations marking 150 years since the signing of the Treaty of Waitangi.

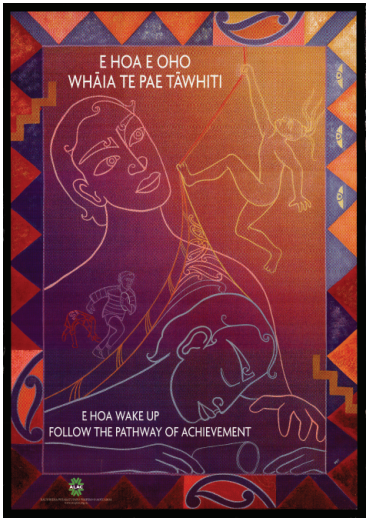
In 1994, a working party (including Kayleen Katene, Peter Waru and Orewa Ohia-Barrett) was brought together by the ALAC Māori programme to develop a strategy to promote safer drinking practices in homes, marae and Māori sports clubs. Launched in 1995, the Manaaki Tangata initiative has had varying degrees of success in terms of uptake.

Launch of Manaaki Tangata at the Beehive 1995.
Yvonne Stirling, Kayleen Katene, Hon. Whetu Tirikatene-Sullivan, Margaret Manuka Sullivan, Peter Waru and, Terry Huriwai.

Like Kua Mākona before it, Manaaki Tangata became a banner under which sponsorship, scholarships and resources could be given out. Manaaki Tangata, as a health promotion package, did not directly contribute to treatment service development or development of its workforce.

Although the impact of Kua Mākona and Manaaki Tangata on treatment referrals was not formally evaluated, they did provide Māori-specific AOD resources, media and promotions.





Manaaki Tangata Posters
(courtesy of the Alcohol Advisory Council of New Zealand (ALAC))

The 1990s

The early 1990s was a busy period in terms of Māori development. Events within the addiction treatment sector were marked particularly by the formal establishment of the Taha Māori programme at Queen Mary, the ALAC reviews of Māori AOD units in 1990 and 1994, and the development of ALAC-sponsored Māori manager positions within various community services. Other events included the development of the kaupapa Māori AOD training and the Healing Our Spirit Worldwide (HOSW) conferences. An increasing number of Māori attending training, sector meetings and conferences would suggest that during this period there were an increasing number of Māori working in the sector (in kaupapa Māori and non-Māori treatment services). Those working in services during this time anecdotally reported more Māori with addiction-related problems accessing treatment services.

Te Aroha Hau Angi Angi – the Taha Māori programme

From its humble beginnings as the voluntary Māori Support Group, Te Aroha Hau Angi Angi was opened in 1990 as an autonomous programme which would operate alongside the main programme at Queen Mary. The programme, under the guidance of Monica Stockdale, finally had a formalised place within the Queen Mary Hospital programme. The opening attracted a number of local and national Māori leaders including Hapi Winiata[35], Hohua Tutengaehe and Canon Wi Huata, all of whom had been stalwart supporters of Monica Stockdale and the programme throughout its development.

The programme, which incorporated elements of physical wellbeing, mental wellbeing, wider family kinship, spiritual

[35] Hapi Winiata designed the Te Utuhina Manaakitanga Trust logo.

wellbeing, and whānau, provided a positive context in which clients could feel and be comfortable as Māori. Individuals were able to engage with other Māori in a pro-social environment i.e. an environment free of such negative features as substance misuse, violence, etc. and this was particularly important for those who had limited experience engaging with the Māori world or whose only experience of it was a negative one.

> *It* was run by Māori, for Māori and they put some stuff around it that helped people to connect to each other and to who they were.
> ***Tuari Potiki***

Despite the Taha Māori programme's reliance on a base 12-Step philosophy, and use of such interventions as psychodrama, it still defined for many in the addiction treatment sector what a kaupapa Māori AOD service should be. For others, there was still the tension that the programme sat within a non-

Taha Māori team
Marie Potae, Carol Browning, Monica Stockdale, Mike Payne, Kevin Mahuika.

Māori institution, utilised non-Māori staff and did not have fluent speakers of the language. Despite these reservations, the importance of the Taha Māori programme at Queen Mary to the Māori AOD field cannot be understated.

Apart from the fact that it helped the recovery of many individuals and whānau, the programme explicitly utilised Māori values, beliefs and practices as a normal part of the treatment process. Additionally, in its early years it was accessible nationally and brought Māori from around the country together to focus on one kaupapa – recovery and wellness.

Another significant aspect of the programme was that it helped to create a critical mass of Māori in recovery to support others post residential treatment (recovery whānau), and also provided a pool of Māori with a personal stake in the AOD sector. Many of these individuals had a passion for this mahi and some were supported to move on to train as addiction treatment workers. Others provided support for whānau in ways which today would be seen as peer support activities.

Te Rito Ārahi in Christchurch benefited from the relationship with the Taha Māori programme as a number of graduates became supports to staff, and as part of the recovery whānau they were able to offer support to those entering and leaving treatment.

Many graduates of the Taha Māori programme made the journey back to Hanmer Springs to support 'step-out' ceremonies for those who had completed the Taha Māori programme. In many ways these recovery whānau created opportunities to live the reality of a healthy supportive whānau that many had never experienced before entering residential treatment.

> *One of the things that we got developed really quickly, and this had a lot to do with Monica* [Stockdale], *was creating the whole notion of recovery whānau, where they could come in and just support each other and things like that - and that quickly got duplicated all over the place.*
> ***Paraire Huata***

During the Nineties, the recovery or kaupapa whānau in the South Island held a number of hui and established the 'Recovery Olympics', where they could come to celebrate their recovery.

> *I remember there was a reunion and we held one for the Māori group before the main Queen Mary reunion. There were six of us and we went out and picked watercress. Elizabeth* [Beresford] *said not to worry because things would be different next year. She was right - there were a hundred the next year and the following year Pukekawa [Wehi] had the army doing the catering for 300. Really, the recovery whānau grew out of us picking watercress and thinking it had to be different.*
> ***Monica Stockdale***

A number of changes occurred at the Taha Māori programme from the time Monica Stockdale left to take up duties in the Hawkes Bay until its eventual closure. The changes were brought about as a result of changes in personnel as much as changes in the wider treatment sector. Tuari Potiki took over as manager of the programme in 1994 and he in turn was succeeded by Maraea Handley in 1997.

The mid-Nineties saw changes in funding to residential services and consequently, programme lengths changed. Although the Taha Māori team fought to keep their programme at eight weeks in duration, it, like most residential treatment programmes,

eventually shortened. While many of the key informants in this project acknowledged that the Taha Māori programme was in many ways the Hanmer programme run by Māori, they noted that what made it different was what the Māori staff wrapped around it. Normalising Māori beliefs, values and experiences meant that people learnt and experienced karakia, waiata, whanaungatanga, as well as the obligations and responsibilities of tuakana and teina roles.

> *It was what you did every day. It was a normal process or practice, not a specific group. It's like osmosis, hugely powerful for people.*
> ***Tuari Potiki***

In 2003, the Hanmer Institute (which had earlier taken over administration and responsibility for Queen Mary Hospital from Healthlink South[36]) merged the Hanmer programme and the Taha Māori programme to produce a 'multicultural' residential programme – essentially bringing to an end the Taha Māori programme.

The Hanmer programme (and to a lesser degree the Taha Māori programme) had seen a decline in referrals for a number of years due to an increasing number of local alternatives for people and changes in funding criteria which deterred referrals from outside the South Island.

By year's end, following two different reviews, the Ministry of Health had stopped funding and the company that had operated the Hanmer programme (both the residential centre in Hanmer Springs and the community services scattered around the country) went into liquidation. The Taha Māori programme's closure sparked an outpouring of grief and anger.

[36] Healthlink South was the predecessor of the Canterbury District Health Board.

Ara Te Whakaaro Pai

Meanwhile, in Te Tai Tokerau, Ara Te Whakaaro Pai – which had been a dream of a number of like-minded people – formally began in 1992. Those involved not only wanted to address the substance use-related problems in Te Tai Tokerau, but also address the recovery of tino rangatiratanga (particularly at whānau Māori and hapū levels). Initial drivers in this process were Moe Milne (who was part of the Northland Area Health Board), Hine Martin (Northland Area Health Board, health promotion), Titari Eramiha (Whakapiringa Trust), Te Miringa Huriwai (Te Rūnanga o Ngā Puhi), Masie Taylor (Ringa Atawhai) and Hone Pene.

> *The most important thing was we absolutely maintained our stance on rangatiratanga and that we had something to offer that was specific to Te Tai Tokerau.*
> ***Moe Milne***

Although those involved accessed the experience of Paraire Huata, Nau Epiha, and the Te Ara Hou team in Auckland, as well as Monica Stockdale from Hanmer Springs, it became clear to them that the programme being developed wasn't based in a broad Māori paradigm, but rather, one with its centre focused on the people of Te Tai Tokerau. The treatment programme devised for Ara Te Whakaaro Pai by Te Miringa Huriwai, Moe Milne and Hone Pene revolved around Māori counselling and was based on principles of tangi, tuku, kawe mate and whanaunga.

Some of the unique features of this programme were that it was run on a number of local marae, it had no formal funding and the counsellors for the programme were trained by Ara Te Whakaaro Pai.

Although the Ara Te Whakaaro Pai programme was short lived, one of the developments that it helped enable was the northern AOD network Ngā Manga Pūriri. The original hui for Ngā Manga Pūriri was at Oturei marae at which ALAC talked about how it could support efforts in the North. The hui attracted many new faces in terms of addressing alcohol-related harm, but others came to advocate for the activities and aspirations of the Ara Te Whakaaro Pai programme.

Tïtari Eramiha

Terry Huriwai and Titari Eramiha 2006

Some, such as Lill George and Gill Paki, had been involved in a number of initiatives in the North for a number of years, and Titari Eramiha and Nau Epiha again provided foundation support and whakaaro for the Ngā Manga Pūriri development. With the support of ALAC, they were able to formalise a network and gain resources for it to function.

A new-born old dream.

ALAC Service Reviews

During the 1990s there were two reviews of Māori AOD treatment service delivery worthy of mention. The first was the ALAC-funded review of three Māori alcohol and substance abuse centres: Te Rito Ārahi, Te Ara Hou and Te Tāwharau Social Services. Undertaken by Jo Spooner and Margaret Manuka-Sullivan[37] in 1990, the review explored the aims of the various programmes and examined their ability to operationalise their aspirations. A commonly stated aim of the various programmes was to help Māori with addiction-related problems feel better about being Māori.

> *The highest level of success is when a client who has experienced whānau, hapu and iwi alienation feels comfortable about returning to their tribal roots.*[38]

They also highlighted the need for a more professional approach to management of services as well as closer attention to governance. They identified the difficulties of operating under an uncertain funding environment and the danger of compromising the integrity of the founding kaupapa in the pursuit of contractual compliance and resources. Because of the review recommendations, ALAC continued to provide resourcing only to Te Ara Hou in Auckland and Te Rito Ārahi in Christchurch.

David Tipene-Leach and colleagues carried out the second ALAC review in 1994. They reviewed Māori treatment services and the needs of the Māori community as part of ALAC's review of its role within the Māori community and its response to Māori. The review team held hui around the country and met with a wide range of service providers, referrers and community

[37] Spooner and Manuka-Sullivan (1990).

[38] Spooner and Manuka-Sullivan (1990).

representatives. The reviewers noted in their report that there was a diversity of 'conventional and unorthodox treatment methodologies' among Māori providers, much as there had been in 'mainstream'[39] AOD services during the previous decade. They observed 'therapies that relied heavily on Christian philosophy, scientology teaching, on the psychologist and on the AA or Al-Anon approaches'. Some practitioners used reiki (and others mirimiri), some used rongoa (some described prescribed medications as rongoa) and some had 'innovations that purport to have a specifically Māori treatment modality'. The review team noted with interest the 'detoxification process' being developed by Tame Iti in the Urewera, using Te Whare a Mahuika and Ngā Tikanga a te Ahi.

The review found most of the Māori presenting at services were polydrug users and many were described as 'detribalised and deculturalised'. This tallied with the view held by many Māori that loss and separation from their lands, along with urbanisation, contributed to the breakdown of traditional tribal structures, as well as a loss of 'spirituality', and general loss of dignity, identity and respect among Māori.

The review noted that, for many, regaining Māori identity became the crux of treatment and that some clients appeared to make major steps towards minimising their substance misuse-related harm once this had been reconfirmed.

Some clinicians and clients interviewed in the 1994 review said culture, identity *and* strong clinical input were needed as complements to one another for successful treatment. Other clients were adamant that they did not wish to consider the issue of cultural identity at all.

[39] 'Mainstream' is a term used to often denote non-Māori things, however some in kaupapa Māori services consider themselves mainstream.

The following table lists different types of 'therapeutic models' Māori agencies said they used. It is from the 1994 ALAC Service Directory. The authors of this monograph are aware that some of the processes or models that were being used, but that were not detailed by various agencies, include mirimiri and rongoa (particularly for those undergoing withdrawal management), karakia and pōwhiri.

Models of Practice Listed in 1994	
• 12-Step (AA/NA) • Awhi, aroha and manaaki • Client-centered counselling (also Rogerian and person-centered counselling) • Client centred counselling incorporating kaupapa Māori • Client-focused goal setting • Cognitive behavioural approaches • Gestalt • Holistic (tinana, wairua, whānau and hinengaro) • Human development • Jungian counselling • Māori concepts • Māori kōtahitanga	• Motivational interviewing • Neurolinguistic programming • Pakiwaitara and whakataukī • Psychodrama • Psychosocial • Social detox • Social learning • Spiritual support • Te Aho Mātua • Te Ao Māori • Te Ao Māori Tipungatanga • Traditional [Māori] concepts • Transactional analysis • Traditional Māori healing • Wairuatanga • Whakawhanaungatanga

It is interesting to compare the list of models of practice in the above table with those models recorded in the 2004 review carried out by Abacus Counselling and Training Services Ltd. While there is still an acknowledgement that practitioners were using a mix of different models (Māori and 'western'), there were fewer listed. This may reflect a greater degree of training

and understanding within the sector in later years. Further to this, there are some interesting comparisons to those models said to be used by participants in the National Addiction Centre telephone surveys (Robertson, Gibson and Adamson, 2005). Again, there are probably more similarities than differences between services.

Midlands Maori AOD Network - 1994

Back: Toko Honetana; Harold Helmbright; Cate Cosgriff; Jan Ball; Peter Morrison; Myra Strang; Naiti Heurea
Front: Heather Swinton; Lyn Roberts; Te Uta Rolleston; Barry Bublitz; Rod Barker; Ruihi Haina; Linda Heurea; Lyn Godsmark; Greg Noda; Lena Radford

Appendix 4 lists dedicated Māori AOD treatment services that were listed in the 1990 and 1999 ALAC Service directories.

This collage is from the opening of Ngā Puna Aroha.
The photo of Monica Stockdale and Pukekawa Wehi (middle left)
was taken when Monica returned home to the Hawkes Bay from
Hanmer Springs to begin this development.

Developments in non-Māori specialist AOD services

While there were increasing numbers of Māori workers starting to work within Community Alcohol and Drug Services (CADS) around the country, few of these hospital 'owned' services were developing a specific Māori approach to their service delivery.

One of the exceptions was the Ngā Punawai Aroha programme based within the Hawkes Bay Addiction Service and established in response to the call of kaumātua who had a vision of a Māori AOD service based in Kahungunu that practiced whanaungatanga and tikanga in all aspects of the service. In 1995, under the leadership of Monica Stockdale, Lulu Robins, Paki Keefe, Ivan and Pat Emia, Tom Manaena, Rangi Stirling and Paraire Huata the vision was being made into reality. After what has been described as much hard work behind the scenes, Ngā Punawai Aroha opened in 1997.

> *It was hard work taking it* [the idea of a Māori service] *out to our people. At one hui it was lucky because Tame* [Iti] *was here so I got him to talk to the men because they were the most uncomfortable about owning our problems and he had been doing this mahi for a long time. He certainly challenged them, made them step forward – if a little reluctantly.*
> ***Monica Stockdale***

The name Ngā Punawai Aroha, reflected a strong focus on cleansing and wellness rather than illness. The elements of Te Puna (initial contact), Te Punawai (a six week day programme) and Te Puna Aroha (continuing care) represented a different stage on the healing journey.

The original clinical team comprised Monica Stockdale, Annette Harris, Rawinia Goldsmith, Cheryl Heremia, Puti Lancaster, Stan White and Nigel McRoberts. Development of the

programme (including some basic research and refinement of quality assurance systems) was supported by Denise Messiter, Marie Potae and Paul Hirini, and crucial to the success of the programme were the kaumātua.

Te Tauranga Kōtuku

At about the same time that Ngā Punawai Aroha was being established, similar moves were afoot to create a dedicated Māori programme and team in Auckland. The gestation period there, however, was longer and it began with the restructuring of AOD services in the Auckland Area Health Board (the separation of alcohol and other drug from mental health services). The regional manager (Carol Wilson) appointed a convenor to establish a Māori working party to address:

- gaps in the provision of AOD services to Māori
- how services to Māori should be structured
- resources needed
- other relevant issues pertaining to Māori needs in AOD services.

The report of the working party, Te Tauranga Kōtuku (1991), identified a system that did not provide a culturally safe service for Māori and which impacted on access by and retention of Māori. The report recommended the development of a relevant and appropriate programme under the regional manager of alcohol and drug services. To establish such a service they also recommended the appointment of a coordinator of Māori AOD services.

The coordinator was renamed a Development Officer and was expected to have a functional relationship with regional AOD services, the Māori advisory group on alcohol and drug services,

Te Whītiki ō Tāmaki Makaurau (the local Māori network), iwi and ALAC's Manager Māori programmes. Harry Pitman took on the position and in the first few years set about developing a primary intervention response that saw key Māori workers embedded in community alcohol and drug services (CADS).

After much discussion, increasing numbers of Māori working within CADS (particularly CADS South) and following the energy generated at the 1998 Healing Our Spirit Worldwide conference in Rotorua, the regional manager for AOD services, Cathy Menzies, signed off on the establishment of a dedicated team of Māori workers within the regional alcohol and drug service (RADS). Te Ātea Marino wasn't formally established until 2000 when, under the leadership of Te Puea Winiata, the team worked from Pitman House (named after Harry Pitman, who died in 1999) in Point Chevalier. The name Te Ātea Marino arose at a wānanga of the new team in 1999. As in previous times, and as he did with a number of other groups, Paraire Huata provided valuable guidance in this development.

The Te Ātea Marino team initially included Te Puea Winiata, Bernard Te Paa, Jeanette (Te Pare) Kingi, Morehu Kara, Laufoli Tulesi, Linda Gibson, Donna Blair, Ron Mariu, Violet Kahukura, Pet Teriaki and Pat Ruka. The logo was desined by Denal Meihana who was on placement with the team. For further information on the development of Te Ātea Marino see Haitana-Evans and Peita (2005).

Today, in 2008, the team has grown and includes a range of programmes, including a pre-contemplation and a more intensive closed poutama group. These are delivered across the metropolitan Auckland area as part of the wider Māori mental health and addiction services of Waitematā DHB.

Photos from Healing Our Spirit Worldwide Conferences in Canada and Australia

Photos from Healing Our Spirit Worldwide Conferences in New Zealand and Canada

Healing Our Spirit Worldwide

In 1992, the inaugural Healing Our Spirit Worldwide conference was held in Edmonton, Canada. The conference grew out of the lobbying by Maggie Hodgson (Carriere First Nations) of the International Congress on Alcohol and Addictions (ICAA) and World Health Organisation. At the 1990 ICAA conference in Berlin there was a special track for indigenous addiction issues which Harry Pitman attended on behalf of Margaret Manuka-Sullivan (ALAC).

From this conference, work began to bring together indigenous peoples from around the world, focused on alcohol and other drug abuse issues and programmes in indigenous communities. Since this time, Aotearoa New Zealand has maintained a key role in the Healing Our Spirit Worldwide conferences. A large number of Māori attended the inaugural conference and had the opportunity to show other indigenous peoples how they were working with their own people.

> *That was a big deal and a lot of people went* [to Edmonton] in 1992. They made their presence felt.
> ***Tuari Potiki***

Subsequent conferences have since been held in Sydney (1994), Rotorua (1998), Albuquerque (2002), and again in Edmonton in 2006. Māori have continued to make their presence felt behind the scenes as well as presenting at the front.

All the conferences have had an increasing number of Māori in attendance (and presenting), and have been preceded by all manner of fundraising activity including hāngī, balls, catering and art shows. These conferences have been important in terms of bringing Māori working in the addiction treatment sector together, supporting indigenous models and frameworks of health and for encouraging Māori to present their mahi and their whakaaro.

Although for many the conference held in New Zealand was a successful one, behind the scenes there were a number of problems experienced by the Spirit of 98 Trust – the local group who had taken on responsibility for hosting the conference. With the intervention of Te Kete Hauora (Māori Health Directorate, Ministry of Health), a number of years later the liabilities of the Trust were cleared and assets returned to the Trust. Unfortunately, some relationships between members of the Trust and with other organisations were severely damaged[40].

At the 2006 Healing Our Spirit Worldwide in Edmonton, the Henry Rongomau Bennett Leadership, Workforce and Scholarship programme sponsored a number of awards for outstanding contributions to the Māori addiction and mental health sector as well as a youth award. The awards went to Paraire Huata, Moe Milne and Pihopa Kingi, while the youth award went to Marewa (Missy) King of Te Rangihaeata Oranga in the Hawkes Bay.

Henry Rongomau Bennet awards at the HOSW conference 2006 went to Paraire Huata, Moe Milne, 'Missy' King and Pihopa Kingi.

[40] Following on from the experience in Australia and as a result of the situation in New Zealand, the HOSW committee formed an international sub-committee that now offers advise to those organisations hosting the next gathering.

At the time of writing, Barry Bublitz is the New Zealand representative on the International Indigenous Council of Healing Our Spirit Worldwide. This group is responsible for the organisation of the conferences and the work done to further the kaupapa between conferences. Barry had been a member of the Spirit of 98 Trust and his experience has been invaluable to the council.

National Centre for Treatment Development

The Māori Women's Welfare League Rapuora study (Murchie, 1984) provided some of the first empirical data to show differences in drinking patterns between Māori and non-Māori. This work, plus that of Awatere and colleagues (1984), helped to validate knowledge and understanding from a Māori perspective and suggest different ways to address the needs of Māori. Despite these works and the informative evaluations and surveys that Helen Moewaka-Barnes, Paul Stanley and the team at Whāriki[41] were producing related to alcohol and other drug use and harm, there was little or no treatment-oriented research occurring.

Through Ian MacEwan, ALAC supported the establishment of a clinically-focused AOD centre of excellence. Under the directorship of Doug Sellman, the National Centre for Treatment Development (NCTD)[42] was established as part of the Department of Psychological Medicine at the Christchurch School of Medicine (University of Otago). Terry Huriwai (Te Arawa and Ngāti Porou) was appointed as a lecturer at the

[41] Whāriki is a Māori health research group that was working in partnership with the Alcohol and Public Health Research Unit at the University of Auckland and is now engaged in an ongoing process of realising a research partnership with the Centre for Social Health Outcomes Research and Evaluation of Massey University.

[42] Now known as the National Addiction Centre (NAC).

NCTD in 1996 and Paul Robertson (Ngāi Tahu) joined the team in early 1997. The inclusion of a Māori-specific focus within the NCTD owes much to Margaret Manuka-Sullivan at ALAC.

One of the first areas of work for this team was to begin to investigate how cultural variables might relate to treatment outcomes for Māori, and how this might influence the development of training and education in the addiction treatment sector.

> *If you didn't have research happening, the field probably still would have developed – but not necessarily in the same way. Some of us were starting to ask the questions, 'what is different about Māori?', 'what brings them in?' or 'what do you do with them?'.*
> ***Terry Huriwai***

An important piece of research produced by Huriwai and colleagues (2000a), under the auspices of the NCTD, was known as the Optimal Treatment Study. This paper found a high endorsement of cultural factors in treatment among a clinical sample of Māori. More importantly, participants in the study felt that cultural needs should be addressed whether they were in a dedicated Māori AOD treatment service or a 'non-dedicated Māori' AOD treatment service. Additionally, this research emphasised the clinical application of Māori cultural input into the treatment/recovery process and encouraged the bridging of the perceived gap between cultural and clinical practices.

As well as the work generated by the Optimal Treatment Study, the NCTD also took the opportunity to examine clinician beliefs and practices in their inaugural and subsequent phone surveys. Robertson and colleagues (2001) found that there was strong

support by workers for consideration of the specific needs of Māori and adjustment of clinical practice when working with this client group. The survey indicated that a broad range of people in the AOD sector were making efforts to be more responsive to the needs of Māori clients.

While there have been a number of PhD and Masters theses looking at substance use, few have narrowed down the scope of their research to focus on Māori and addiction treatment. One of the earliest to do this was Marewa Glover (2000) whose doctoral thesis looked at the effectiveness of noho marae in smoking sessation. However, it wasn't until 2005 when Paul Robertson was awarded his Doctorate in Philosophy for his examination of the experience and beliefs of Māori men who had undertaken addiction treatment at the Taha Māori programme that there was a doctoral thesis relating to the mahi of an addiction treatment centre.

Another thesis centred on the programme at Hanmer Springs is that of Te Rangimaria Warbrick. His 2006 Masters thesis 'is

NCTD team Spring 1997. Paul Robertson, Terry Huriwai, Lisa Andrews, Alison Pickering, Doug Sellman, Raine Berry, Fraser Todd.

about Māori people with substance abuse problems and their journeys to the world of light.' It examines and describes the cultural components used at Te Aroha o te Hau Angi Angi and the journeys of a number of clients as well as the experiences of some of the therapists. Betty-Lou Iwikau, in her 2005 Masters thesis, explored the use of the aspirational Te Toi o Matariki model in the context of the residential treatment service Te Ara Hou. In 2007, Hemaima Hughes submitted a thesis uncovering key concepts that helped four Māori overcome their addiction - *Whakaohonga nā Kahungatanga Awakening from Addiction.*

Similarly, there have been few theses related to Māori and gambling. Only one thesis to date has an intervention focus. Ruth Herd's 2005 Masters thesis focuses on a programme developed for working with Māori women. That programme, Wāhine Tūpono, is described later.

While there may be other treatment-oriented theses completed and/or in the pipeline, the dissemination of the learning from these studies has had little impact on the wider addiction treatment and even mental health sector. The NCTD was one of the few institutions explicitly looking at the treatment of substance use-related issues for Māori and the dissemination of its findings has contributed to workforce development, proposals to funders and planning, and informed policy in health and other social service sectors. In terms of generating and disseminating research to help shape the sector, NCTD and its later incarnation, the NAC, has achieved one of its original goals.

The 21st century

Continuing on from the developments of the 1990s, a number of significant events have taken place in the first decade of the new century, including the ALAC-sponsored National Māori Alcohol and Drug Summit at Manu Ariki in 2000 and the Hui Whakakōtahitanga in 2004. From these came some momentum for practitioner competencies for working with Māori. In terms of treatment service development, the establishment of Māori-focused problem gambling intervention services is balanced by the closure of a number of AOD treatment services acknowledged as having a kaupapa Māori perspective.

While this monograph concentrates mainly on Māori services and workforce, it needs to be acknowledged that there has been an increasing number of Māori working in non-dedicated Māori services. An example of this includes Māori support groups in such places as the Higher Ground Drug Rehabilitation Trust. This group has been operating since the early 1990s and started as a result of resident attendance at the Māori meeting of NA. One of the early facilitators and developers of the support group was Marino Te Moana, who is on the Board of the Higher Ground Trust.

Many Māori workers in non-Māori services have contributed to increasing the Māori responsiveness (cultural fluency) of non-Māori colleagues and services, thus giving weight to the need to focus beyond specialist Māori teams or units.

> *You want to know they're* [whānau] *going to be safe and get the best, wherever they go. By far the majority in the field are Pākehā, and Māori are still going to Pākehā counsellors whether we like it or not. At some stage we have to awhi Pākehā in the sector to be more competent to work with Māori – not just do our own thing.*
> ***Tuari Potiki***

Service Closures

The Kahunui Trust, located in the Waiotahe Valley in the Eastern Bay of Plenty, was one of the oldest services in the country having been one of the first Therapeutic Communities (TCs) in the country. It wasn't until its last six or seven years of operation that it was acknowledged as having an explicit kaupapa Māori approach. The contract for services was withdrawn in 2005 due to a decrease in referrals, falling confidence in the programme and perceived management and governance issues. DHBs in the Midlands area have, however, called for a replacement regional kaupapa Māori residential treatment service. At the time of writing, Te Utuhina Manaakitanga Trust is the preferred provider for this service. It opened its Wellness Centre in September 2008 and it is anticipated that it will be operational by 2009.

Te Huarahi ki te Oranga Pai in Invercargill also had its DHB contract withdrawn in 2005, after a series of audits. The Southland DHB undertook to ensure that a suitable replacement Māori service would fill the gap left by the closure. The service that picked up the addiction services (including problem gambling) was Ngā Kete Mātauranga Pounamu Charitable Trust. The Trust has a number of staff with experience working in AOD, including Leslie Rewi, who for many years worked at Rhanna Clinic,[43] Tira Ririnui who worked at Te Huarahi ki te Oranga Pai, Carole Apiti, and more recently, Selina Elkington.

Te Rito Ārahi emerged from a 1985 Labour Weekend hui at Ngā Hau e Whā marae in Christchurch. It was a follow on hui from the national hui held earlier in Mangere, which proposed the development of a number of Māori resource centres around the

[43] Rhanna Clinic Alcohol and Drug Service is the hospital-based AOD service in Invercargill.

country (see Appendix 2 for more information on Te Rito Ārahi). Te Rito Ārahi closed its doors in April 2007 when the Canterbury DHB withdrew its contract. The closure of the service was due in part to a perceived increased responsiveness to Māori by other AOD services in Christchurch and falling confidence in the Te Rito Ārahi structure and service delivery. Despite no longer operating as a service provider the new chairman (interim) of the Trust, Mr Gilbert Taurua, is confident Te Rito Ārahi will rise again in some way, shape or form.

He Waka Tapu AOD team Nov. 2005.
Hemi Lewis, Brent Tohiariki and Selina Elkington

A series of Canterbury DHB audits also identified aspects of poor management and governance practice over time. At the time of writing, a new service is being contracted by the DHB, with the preferred provider being He Waka Tapu. He Waka Tapu is already operating a Mauri Ora programme, initiated in response to the gap created by the closure of the Hanmer-based Taha Māori programme. The addiction service team within He Waka Tapu initially included Brent Tohiariki (ex-WELTEC tutor and health worker), Hemi Lewis (ex-Odyssey House and Nova Trust worker) and Selina Elkington. The team had knowledge and experience of a range of services, as well as a strong service user perspective.

New treatment services and sector networks

In the previous decade, Māori NGOs had been primarily at the forefront of Māori responsiveness in the AOD treatment sector. NGOs continue to feature in the new century service development – particularly with the addition of problem gambling. As well as being new providers of AOD services, Ngā Kete Mātauranga (Invercargill) and He Waka Tapu (Christchurch) are also new problem gambling treatment providers. Nationally, a number of Māori services with AOD treatment experience took up the challenge of working to address gambling-related harm, including Te Rapuora o te Waiharakeke (Blenheim), Ngāti Koata Health (Nelson), Rangataua Mauriora (Porirua) and Hauora Waikato (Hamilton).

Although they had their genesis in the 1990s, two services that finally saw the light of day in the new century and were developed within the hospital service provider arm, were Ngā Punawai Aroha in the Hawkes Bay and Te Ātea Marino in Auckland.

Two other services were established during this period to deliver residential AOD treatment to adolescent and youth populations – Rongo Ātea (opened in Hamilton in 2002) and Te Whatuiāpiti (delivering AOD services in the Hawkes Bay from 2000). Te Whatuiāpiti now provides a range of services and is currently working with the local DHB to assume responsibility for Māori AOD services in the Hawkes Bay – including the Māori community-based AOD service Ngā Punawai Aroha which ceased operations in October 2008. Te Whatuiāpiti has also been supporting the running of WELTEC's marae-based education in the Hawkes Bay, and a significant number of its staff participated in the marae based addiction treatment training.

WELTEC Marae Based Education, Waireka Marae graduation 2007. Most of these students worked for the Te Whatuiāpiti TrustAOD service

Te Whānau Manaaki o Manawatū

In the 1990's two groups were formed in the Manawatū region. One of these recovery groups disbanded after about six years, the second consolidated and operates as Te Whānau Manaaki o Manawatū Trust. Based in Palmerston North, it is contracted to provide consumer support services. As a recovery group, its main concern is helping people who have been in treatment to 'learn to live', hence its vision is 'Te hokinga ki te ūkaipō, he orangatanga mō te whānau katoa'.

For the foundation members of the Trust, many of whom have been through treatment (predominantly the Taha Māori programme), they found their experiences had provided them with the skills to manage their addiction, but there was a knowledge gap around supporting their recovery or their whānau to live addiction free lives.

The service, under the guidance of Kim Whangaa-Kipa, has developed a network of workers around the central region – all dedicated to supporting recovery and all QBE (qualified by experience). They are currently working with recovery whānau in Auckland, Christchurch and other regions to begin formalising some kind of national body.

Hauora Whānui

Hauora Whānui is part of the Ngāti Hine Health Trust and is based in Kawakawa. While it offers a small AOD service, it identified the lack of residential AOD treatment options in the Northland region and established a small residential treatment service. Aware of the need to address withdrawal management issues, Hauora Whānui has also developed a 'bush-detox' programme.

Māori Networks

One of the oldest continuing networks of service providers is in the Midlands region. Originally known as Te Miria te Hinengaro, this iwi, whānau and provider network mainly supported the needs of mental health service providers. Its more recent incarnation, Ngā Purei Whakataa Ruamano,[44] was formed in 2001 and also includes addiction treatment providers.

In 2002, ALAC contracted with Hapai Te Hauora Tapui to form a network of Māori AOD workers in the greater Auckland region. The networking committee, Ngā Tahi Rā, provided a forum for Māori workers to come together to increase awareness among workers about different practices and create some cohesion within and between programmes, resources, methods and

[44] For more information on this network go to http://www.midlandmentalhealthnetwork.co.nz/page/midland_11.php

models of teaching. In particular, the network hoped to provide better services for rangatahi[45].

Te Whare Tukutuku is based in the South Island and is made up of addiction treatment providers (AOD and problem gambling) and some mental health providers. He Oranga Pounamu[46] was contracted by ALAC in 2003 to facilitate a series of hui with Māori AOD workers and communities in the South Island. Participants at the hui nominated He Oranga Pounamu to coordinate and develop a network of providers. After negotiation with ALAC, Tracey Potiki was employed as the first Project Coordinator for the network, Te Whare Tukutuku. Tracey has been succeeded by Jim Hauraki, senior manager at He Oranga Pounamu.

New Problem gambling treatment services

On 1 July 2004, the Ministry of Health assumed responsibility from the Problem Gambling Committee for funding and coordinating problem gambling services. This saw an expansion in the number of services contracted to deliver treatment, with many of the new services delivered by Māori providers. Some, like Te Waipareira Trust and Tui Ora, were existing health and social services – however they had limited experience in working with addiction-related issues. Through their mental health team, services such as Ngāti Porou Hauora had experience working in addiction and Te Kāhui Hauora Trust in Rotorua addressed its lack of experience by establishing a joint venture with Te Utuhina Manaakitanga Trust and later Te Rūnanga o Ngāti Pikiao.

[45] For more on this network refer to *Pupu Whakaaro* number 10 (Mental Health Commission, 2002)

[46] He Oranga Pounamu was established under the mandate of Te Rūnanga o Ngāi Tahu to focus on Māori service provider development.

Like Te Rangihaeata Oranga Trust in the Hawkes Bay, Ngā Manga Pūriri problem gambling services in Northland have a single focus – problem gambling. Unlike Te Rangihaeata, which was an established problem gambling service for some time before the Ministry of Health took responsibility for gambling, Ngā Manga Pūriri had no previous history of service provision of any kind. Both services are supported by an active taumata of kaumātua.

Monica Stockdale literally started Te Rangihaeata Oranga out of the boot of her car. Eventually she received funding from the Problem Gambling Committee and soon after became a member of the Committee where she advocated for greater Māori responsiveness – and a more public health approach. Te Rangihaeata Oranga has been able to utilise a range of skills and experiences from the AOD and mental health sectors throughout its development. In February 2008 Monica Stockdale relinquished governance of Te Rangihaeata Oranga with that responsibility going to a new Trust, chaired by Terry Huriwai. Monica has stayed on as manager of the service.

One of the first contracts for a dedicated Māori problem gambling treatment service was with Te Ātea Marino in Auckland. Unfortunately, the team found it actually had to raise awareness within the community of problem gambling before it could delivery treatment services. The contract eventually went to Hāpai te Hauora Tapui. Collaboration between Hāpai te Hauora and the Oasis Problem Gambling Services saw the development of the Wahine Tūpono programme, a kaupapa

Māori intervention programme for Māori women. Ruth Herd and Diane Richards developed the programme utilising the Te Ngaru Learning Systems Pōwhiri Poutama framework. Wahine Tūpono incorporated Māori models of practice and understanding as well as 'western' models[47], and delivered a mix of support and therapeutic groups.

Appendix 6 lists Māori services with AOD or AOD and problem gambling contracts at the end of 2006.

National Māori Alcohol and Drug Summit 2000 and Hui Whakakōtahi 2004

In 2000, nearly ten years after the last national hui for Māori working in the addiction treatment sector (Te Ara i Rauhanga in 1991) some 200 people attended a summit at Manu Ariki marae, Taumarunui.

The purpose of this gathering was to provide an opportunity for Māori involved in AOD to discuss issues of mutual concern, share their learnings and experiences, and contribute to the development of the workforce as well as the quality of services they provide.

Although the major sponsor was ALAC, the Health Funding Authority (HFA) and the Ministry of Health also contributed funding. The advisory committee included Paula Snowden[48] and Kayleen Katene (ALAC), Takarangi Mete-Kingi (Te Ngaru o Maniopoto), Pam Armstrong and Delaraine Armstrong (Ngā Manga Pūriri).

[47] For more information on Wahine Tupono see Herd & Richards (2004).
[48] Paula Snowden was manager of the Māori Programme and later Deputy Chief Executive Officer at ALAC.

One of the main issues to arise at the hui was the lack of a consistent competency framework to assess the delivery of kaupapa-based treatment interventions and services.

It was envisaged that this competency framework would be able to accommodate existing Māori models of treatment practice and assist in workforce development. Other issues covered at the summit included the fundamentals of kaupapa Māori services, workforce development and the needs of kaumātua.

Throughout 2002 and 2003 there were a number of regional hui, as well as the pre-Cutting Edge conference caucus at Waitangi. These fora provided a platform for the 2004 Hui Whakakōtahi, at which ALAC launched the new taumata or leadership group and the draft cultural concepts framework (Mete-Kingi and Broughton, 2004)[49].

The hui in Rotorua also saw the inaugural Harry Pitman scholarship initiative launched by the Henry Rongomau Bennett Scholarships and Grants Scheme. Four years later, Te Atarangi Whiu, ALAC's manager of Māori whānau programmes, described the focus of the hui as leadership, Māori models and solutions.

Iwi providers

This monograph has tracked some of the developments in the Māori AOD and problem gambling sectors since 1980. There are a number of services, initiatives and people that have not been mentioned in the preceding text, however many of are recorded in the provider lists appended to this monograph. Perusal of these, and the list of submitters in the *National Alcohol and Drug Services Funding Strategy: Analysis of Submissions* (Ministry of Health, 2001a), confirms that many iwi groups have contributed to the development of addiction treatment services for Māori.

[49] Eventually launched by ALAC in 2005 as *Te Piringatahi*.

Workforce Development

Workforce development is essential for the effective delivery of treatment programmes, and the growth in Māori service development over the last two–three decades cannot be viewed in isolation from initiatives in workforce development. The history of Māori treatment service development has been strongly influenced by those in recovery and/or those who have experience of addiction-related harm.

Waldron and colleagues (1996) carried out one of the first reviews of the Māori AOD workforce, which identified that there had been a drive to have a clinically qualified workforce as well as a culturally competent one. This section is something of a pot-pourri of activities and developments that have shaped workforce development in the Māori addiction treatment sector. In closing, this section provides a brief snapshot of the workforce and clientele, as gleaned from recent surveys of practitioners.

ALAC capacity building

Training

In late 1985, Pip Winiata prepared a discussion document for ALAC Māori coordinator Ngamaru Raerino relating opportunities for Māori voluntary community workers to train as counsellors and therapists in the field of alcohol abuse.

The discussion document examined the rationale for the training, possible training course content and the desired competencies. The second phase of the project was to be the development of policy statements and strategies for industry recognition and market penetration for the national Māori Coordinator position.

The discussion document quoted the nine month report of the ALAC Māori coordinator, which indicated that while there was a high incidence of problem drinking among Māori, few were presenting for assessment and treatment. Further, it stated that there were insufficient Māori counsellors and therapists and that Pākehā counsellors and therapists were insufficiently skilled to deal with the needs of Māori.

The document proposed the creation of a pool of Māori volunteer counsellors and therapists, able to give a Māori dimension to the treatment and assessment models operating at the time and increasing the understanding of the Māori psyche and dimension. This would make assessment and treatment more attractive to Māori with alcohol-related problems. The first priority was to be a series of courses tailored for voluntary community workers (with strong cultural and language skills) of Māori descent.

> *It is essential that applicants realise being Māori and having a knowledge of the Māori dimension is a qualification in itself. THESE ARE THE PEOPLE THAT WE REALLY NEED! People already working in this field as volunteers, but who may not have the necessary skills to operate as counsellors and therapists in Pākehā terms.*[50]

Winiata felt the pool of course candidates would be drawn from such groups as court workers or Friends of the Court, Mātua Whangai, the Māori Wardens Association or penal institution support groups. It was hoped that course costs and course attendance payments would be included in the 1986/87 ALAC budget. The proposed marae-based training did not happen. However some of the ideas, particularly those pertaining to the creation of a competent Māori workforce that would increase access and retention of Māori clients in treatment, have been incorporated into subsequent Māori workforce training.

[50] Winiata (1985).

Development positions

In 1991, ALAC replaced the provision of core funding with the funding of a number of development positions in a range of services around the country. The pilot projects involved the resourcing of particular positions within a number of AOD services. Having at least one guaranteed salary meant a degree of stability for host services, allowing the development of initiatives that could be applied across the whole Māori AOD sector. These positions also offered the services and individuals involved access to a number of national and regional fora and the opportunity to try and influence service and policy development for Māori.

The positions were initially held by Harry Pitman, Jacob Paul, Peter Waru, Yvonne Stirling, Kayleen Katene, Brenda Lowe and Tony Taurima. Harry Pitman's position, in Auckland, focused on the development of training for community-based early intervention workers, while Peter Waru, as manager of Te Utuhina Manaakitanga Trust, focussed on ensuring the long-term viability of the service as well as developing treatment, prevention and service initiatives.

Yvonne Stirling, in the Hawkes Bay, facilitated a number of hui for kaumātua and kuia with the view to creating informed role models and mentors for AOD workers, Māori communities and those using treatment services. Kayleen Katene's role at Ora Toa was to investigate and develop a marae-based AOD service, although what developed out of the community needs assessment and consultation was a health promotion focus rather than a treatment-focussed service. The photo below of the 'team' includes Maragaret Manuka-Sullivan, ALAC council member Harata Solomon and local kaumātua Mark Mete-Kingi.

The position in Invercargill, at Te Huarahi ki te Oranga Pai, was an opportunity for Tony Taurima to develop a Māori management package. Managers Brenda Lowe (Te Rito Ārahi)[51] and Jacob Paul (Te Ara Hou) had briefs to ensure that their treatment services could not only survive, but could develop specific interventions appropriate to Māori.

Development Positions
Back: Tony Taurima, Brenda Lowe, Hakopa Paul, Kayleen Katene, Peter Waru, Yvonne Stirling.
Front: Te Orohi Paul, Mark Mete Kingi (Kumatua), Margaret Manuka-Sullivan (Manager ALAC Māori Programme), Harata Solomon (ALAC Council), Harry Pitman.

Over the next five years, the development team changed as organisations withdrew from their relationship with ALAC or personnel changed. What didn't change was the desire for a national vision and a collective Māori voice advocating for and promoting Māori interventions. The ALAC Māori programme actively brought together those holding these development positions as well as other Maori working in the sector. The following photo was taken at a meeting at the Waipuna Lodge in Auckland and includes the majority of what would become the Te Ātea Marino team.

[51] A position later filled by Terry Huriwai, and then Jim Gillanders.

Waipuna Meeting
Te Puea Winiata, Kirk Mariner, Te Pare Kingi, Laufoli Tulesi, Bernard Te Paa, Donna Blair, Ron Mariu, Morehu Kara, John Larkins, Paul Robertson, Peter Waru, Harry Pitman, Monica Stockdale.

> *If you weren't in the clique you wondered what they were doing. Being accountable for ALAC money was a part of it, but if you think about it now, it was probably a way of getting things done. The alternative was to try and include everyone and get nothing done or argue all day about what should be done. I also think she* [Margaret Manuka-Sullivan] *needed support from the field because she was in an isolated position in ALAC. She was the only Māori.*
> ***Tuari Potiki***

By 1997, with changes in the health system and to ALAC's priorities, the funding of these positions had ceased.

ALAC did continue to support Māori development in other ways though, sponsoring hui and including strong Māori themes and images in a number of resources such as *Ki te Ao Mārama* (ALAC, 2006) and *Bewildered* (ALAC, 2006a).

Three years after ceasing to fund the development positions, ALAC seconded Tuari Potiki to its Māori unit in 2000. Tuari, who was a graduate of the CIT certificate programme, had worked at Te Rito Ārahi, Christchurch CADS and the Taha Māori programme (succeeding Monica Stockdale as manager). In mid-2001 he left ALAC to take up a position as Social Development Manager for the Ngāi Tahu Development Corporation, but returned to ALAC in 2006 to take up the position of Southern regional manager based in Christchurch. In 2008, Tuari was appointed ALAC's Strategic Operations Manager and moved back to Wellington.

Kaumātua workshops and hui

Kaumātua at Ruahapia Marae

In the early 1990s, and with the support of Margaret Manuka-Sullivan, a series of kaumātua wānanga were held in the Hawkes Bay. The wānanga were developed and delivered by Dick Johnstone and Yvonne Stirling of the local addiction treatment service, and aimed to facilitate kaumātua knowledge of addiction issues so they could provide more support to the service. They also served to develop a platform from which a

dedicated Moāri AOD service could be advocated from. The photo was taken at one of the first of these hui and was at Ruahapia Marae in about 1994.

Based on the learning from this and similar initiatives, Paraire Huata, supported by ALAC, facilitated a series of kaumātua wānanga at Queen Mary Hospital. In the mid 1990s he helped Monica Stockdale facilitate further wānanga for kaumātua in the Hawkes Bay region.

Kaumātua at Wallaceville

One of the first hui for kaumātua working in AOD services, which was not about training, was held in 1995. The ALAC Māori programme team talked to kaumātua about their programme and promoted those services where development positions were based. The photo was taken at Wallaceville and followed the official opening of the the ALAC Māori Unit.

In response to the call of the national Māori summit in 2000, Paraire Huata facilitated a number of kaumātua hui for ALAC throughout 2002-2004. A constant theme at those hui was the call for some validation of the use of Māori practices and beliefs in the course of treatment. However, there was also a call for consistency of practice by Māori services and practitioners.

In late 2006 a pilot Harry Pitman presentation skills workshop was held for kaumātua at Te Rangihaeata Oranga regional problem gambling service in the Hawkes Bay. A number of the participants had taken part in previous workshops run by Te Rangihaeata Oranga in the 1990s as well as some of the national fora. One difference with this workshop was that it was designed to upskill kaumātua rather than raise their awareness of addiction-related harm. The aims of the workshop were to explore how kaumātua could better support practitioners and services – especially when making presentations, and how they could be more responsive to the Māori media. Building on the success of the pilot, another workshop was undertaken at the Te Aranga Marae in Flaxmere in 2007. The above photo is from that workshop and includes the facilitators Tony and Jenny Scott, Damiane Rikihana and Wena Tait.

Central Institute of Technology – Kaupapa Māori stream

As noted, many people in the late 1970s and early 1980s undertook their basic AOD training at Queen Mary Hospital. In many respects Queen Mary was a teaching hospital, and even after the development of a national qualification in alcohol and other drug studies it continued to offer a residency-training

component for medics, clergy and those in allied professions. The development of the alcohol and drug certificate by the Central Institute of Technology (CIT) opened up the sector to a wider range of practitioners, especially as it was taught at various locations around the country, and was the first step in the development of a 'professionalised workforce'.

After a short time, there was concern that not enough Māori were enrolling in the certificate course, or were not completing it. In 1988, ALAC commissioned Carol Thomson to review the CIT course. She found that the style of training and course content was not conducive to Māori learning styles or relevant to working within a Māori kaupapa. As a result, CIT (with support from a number of agencies, including ALAC) initiated the kaupapa Māori stream with a two-year A&D counselling certificate programme. In 1990, the CIT contracted Paraire Huata to establish and teach a kaupapa Māori AOD certificate.

CIT kaupapa Māori pilot.

L-R: Dick Wharerau, Maurice Keeopa, Akanihi Dawson, Rahera Falwasser, Adrian Te Patin (rear), Puti Lancaster, Steve Moananui.

L-R: Kumeroa Mathews, Puti Lancaster, Dick Wharerau, Steve Moananui, Adrian Te Patu, Akanihi Dawson, Paraire Huata, Hapi Wihiata (Kaumatua). Front: Terri Cassidy, Maurice Kereopa.

In August 1991, Paraire piloted a 10-week residential programme, Introduction to Counselling Skills and Addiction, at Queen Mary. The course aimed to emphasise working with Māori clients in a Māori way, and in a Māori setting.

The course was restricted to 10 people and based on the CIT Employment Rich[52] courses. Some of the graduates from this course moved straight into the second year of the CIT A&D certificate in 1992 (see Appendix 6 for a list of some of those who attended the course).

The CIT kaupapa Māori stream was very successful in enrolling Māori, particularly those in recovery. Over a number of years, course graduates boosted the number of Māori working in the sector considerably. They were generally more confident in working with western intervention models, increasing their capacity to be more responsive in working with Māori with AOD-related problems.

> *Within the first two years of getting going I took my first lot of graduates - I had 21 enrolled. Of the 21, I took 19 through to completion. Not only were we developing kaupapa Māori whakaaro, but I also made them do the Pākehā course at the same time. So, they did the double and quickly we increased the numbers of those working in the AOD field. In the time when I had started, it was really evident, that there were only a few paid workers under the heading of AOD that were Māori. There were many volunteers but no one was seeing this as a career. Within five years, there were 110 Māori working in a paid capacity under the heading of AOD.*
> ***Paraire Huata***

[52] The panui for the course explains that the term 'Employment Rich' is used because the helping field, especially in addiction, is one with a steady demand for workers.

H E P A N U I

E NGA MANA,E NGA REO,E NGA KARANGA MAHA

TITIRO WHAKARONGO KORERO

The Central Institute of Technology Wellington, and Queen Mary Hospital Hanmer Springs, are running a 10-week residential course beginning August 5th 1991.

The course will be known as:-

"Introduction to Counselling Skills, and Addiction"

The course will give emphasis on working in a Maori setting and is aimed mainly at those who wish to work in a Maori way with Maori.

The course is restricted to 10 places and we are hopeful that these places will be filled from Whanau,Marae or Hauora groups already working in the Drug and Alcohol field.

The course is based on the present "Employment Rich" courses currently being run at CIT in Wellington.

("Employment Rich": the term is used because the helping field, especially in the addiction field, is one where there is a steady demand for workers... that doesn't mean that we can guarantee you a job, or that a job will necessarily be available in a particular geographic location....").

This is a full-time programme running from 9.00am - 4.30pm each weekday. Students are expected to complete weekly written assignments.

COURSE FEES--per student-- $325.00, this will cover handouts, pens, markers, etc, including photocopying.

Accomodation: $30.00 per week for shared room in the hospital flat.
Food costs are additional to this - either self cater using kitchen in hospital flat, or buy hospital meals, which cost as follows (depending on what is eaten):

Breakfast	$2.70
Lunch	$1.50 to $6.30
Evening Meal	$5.50 to $7.20

(These prices are current as at 17/6/91. Prices are subject to alteration without notice).

STUDENTS MAY NEED TO APPLY TO THE DEPT. OF SOCIAL WELFARE FOR A TRAINING INCENTIVE ALLOWANCE: OR TO IWI TRANSITION FOR A TRAINING GRANT.
For further information, contact:

Dr Robert Crawford
Medical Superintendent
Queen Mary Hospital
HANMER SPRINGS
Telephone/Fax (03) 315-7016

or

Paraire Huata
Course Tutor
AUCKLAND

Telephone (09) 3091-720

The Panui for the course

The CIT kaupapa Māori stream addressed lack of access and lack of retention on the course by overcoming barriers to engagement with learning and enhancing people's motivation to learn:

> *He would* [Paraire] *just re-contextualise it in Māori settings with a Māori world-view. Instead of empathy, there might be another word - aroha, tautoko, awhi. He'd just seemed to grab something that the CIT were trying to teach and sit it on its head and present it as a Māori thing or a Māori-friendly thing. I think that was most of what he did because the kaupapa Māori CIT students needed to be as clinically sound and competent as anyone else so there wasn't any sort of standards dropping - it was just about doing it differently.*
> ***Tuari Potiki***

As well as increasing the pool of trained Māori workers (in terms of skills and knowledge) the CIT kaupapa Māori AOD stream also provided an opportunity to develop Māori-specific ideas and training styles.

Graduates on the early CIT Kaupapa Māori courses.

L-R: Carrie Albrecht, Wiki Daley, Terri Cassidy, Puti Lancaster.

Graduates on the early CIT Kaupapa Māori courses.

L-R: Raneka Thompson, Takarangi Metekingi, Rick Boaza, Faith Winikerei, Paraire Huata

> *They wanted a place where they could name their practice and name it in a way that was comfortable to them. What was intrinsically different about kaupapa Māori was creating a robust enquiry around how tikanga works – not traditionally, but in a way that is current because the context will always change.*
> ***Paraire Huata***

A lesson learned in the establishment of the CIT kaupapa Māori stream, and reinforced during the development of later courses such as Te Ngaru Learning Systems, was that the credibility of the messenger was essential. Regardless of how good the content of any course is, unless it is 'fronted' or endorsed by the 'right' people, engagement in the training is limited. Credibility, for many Māori, is not just dependent on academic qualification. Another lesson learnt was that sometimes the process was more important than the destination.

After Paraire Huata left his role as tutor for the course, Matiria Pura-Hollings became the coordinator, and eventually there was a team of tutors facilitating the stream.

The CIT revisited responsiveness to Māori when it restructured its diploma and degree programme to offer only one stream of study. Although there were a number of Māori undertaking undergraduate study, there were still many who were not. Recruitment of Māori to the treatment sector also appeared to be slow. In recent years, particularly through the work of Aroha Puketapu-Dahm, WELTEC (which replaced the CIT) has reintroduced marae-based training in a number of locations.

The success of these marae-based education (MBE) courses has been very dependent on enlisting the support and mandate of local Māori services, and, at least in terms of the mechanics of the courses, revisiting a 'tried and true' formula for engaging Māori. The MBE courses were open to all and celebrated their first graduands in 2007 in the Hawkes Bay (supported by Te Whatuiāpiti Trust) and Whangārei (supported by Ngā Manga Pūriri). The students completed Certificates in Alcohol and Drug Youth Work (level 5), Certificates in Alcohol and Drug Studies (level 5), and Diplomas in Alcohol and Drug Studies (level 6). The oldest graduate of the MBE course was Ngā Manga

Mataraua CIT kaupapa Māori AOD stream 1993

Murihiku CIT Photo 1995 - Pera, Terry Huriwai, Moana-o-Hinerangi, Jill Matiria, Pura Hollings, Leslie Rewi.

Pūriri's Mere Piripi, who was 90 years of age. The graduation ceremonies for these courses were sponsored by Matua Raki as a means to celebrate achievement and to promote ongoing study.

Unfortunately, 2008 has seen WELTEC cutting back on the MBE courses due, in most part, to financial pressures.

Te Ara Whakaaro Pai, and Te Wero me Te Aranga

In the Far North, Cristina Lyndon, Druis Barrett and Hine Martin kept workforce development issues to the fore in an essentially under-served region (across a range of sectors). As mentioned earlier, Te Ara Whakaaro Pai utilised the experience of a number of people to help inform the development of their Kaupapa te Tai Tokerau treatment programme, a programme based in the recovery of tino rangatiratanga (as understood by those involved – as people of Te Tai Tokerau and as kaitiaki of the Treaty of Waitangi). They also made use of the experience of others in the fine tuning of the counsellor training.

> *We took control of that* [the training] *because we wanted something that was unique to Tai Tokerau. We wanted something that would work for our people, both the people providing the service as well as those receiving the service. They're all our whānau.*
> ***Moe Milne***

Te Ara Whakaaro Pai trained 24 people 'wānanga style' (utilising noho puku and Te Ao Tawhito) with emphasis placed on rangatiratanga and a Māori counselling approach. The training was delivered with little financial support for either Te Ara Whakaaro Pai or the students who spent five days at a time on marae. They were required to bring their own food and cook for themselves.

> *One of the times I was there, it was the turn of Puti Lancester to cook. There was all this beautiful vegetarian kai and these* '*fullas*' *were enjoying it.*
> ***Moe Milne***

During the late 1990s addiction-related workforce development in the North was further championed by the involvement of Pam and Delaraine Armstrong, who helped energise and mobilise the Ngā Manga Pūriri network. The network was instrumental in the development and implementation of the training initiative Te Wero me Te Aranga. The Te Wero me Te Aranga training initiative was held at various marae in Te Tai Tokerau. The course was two days a month for seven months and the Dynamics of Whanaungatanga[53] model provided the backbone for a range of components, including karakia, healing, waiata, case management, treatment planning, and assessment.

[53] See Peri (1995).

We realised that what we wanted was to have everybody who was working in the North grounded as a foundation in most things Māori i.e. what wellness was from a Māori perspective. We wanted to know that we all had at least a foundation and we talked about some of the models and things Māori, so we were on the same wave length.
Pam Armstrong

Participants came from a range of health and social services from through-out Northland. In one intake, a contingent from Taranaki (mainly from Tu Tama Wahine Inc) came up to participate.

They taught us in the North a big lesson. They came every month for eight months, they were never late, were always well presented and set a high standard.
Pam Armstrong

The 2004 ALAC annual report notes that approximately 160 people had completed at least one module and 20 people had completed all modules of Te Wero me Te Aranga. Unfortunately, both the Te Ara Whakaaro Pai and Te Wero me Te Aranga, training was only recognised locally. Those who undertook the training were often snapped up to work in 'mainstream' services, recognised for their strong Māori and clinical foundations. The vulnerability of the Māori NGO sector at times meant that kaimahi often worked within non-Māori organisations, to ensure financial security for them and their whānau and a sense of greater job stability.

My disappointment was we trained to fortify Māori hauora. The mainstream put the dollar in front of our trainees and whipped them away.
Titari Eramiha

Te Ngaru Learning Systems

> *I'd had a reccurring dream and part of it was about poutama, and part of it was about transitions. Ngamaru* [Rarino] *and I were in wānanga on our own and we began to draw on some stuff, started to put some elements together. I took the kōrero north because they'll debate and test the kaupapa, that's one of their traits. So, Te Ngaru developed out of a moemoeā – a dream of the seven waves of Tangaroa.*
> ***Paraire Huata***

While the genesis for Te Ngaru Learning Systems lay in the mid-1980s, it is considered the third wave in the Māori addiction sector genealogy. The first wave was the first cycle of CIT students that Paraire Huata tutored. It is here that a mātauranga Māori approach to AOD and models of practice started to be created. The second wave was the second intake of CIT students, considered to be a 'āhua wairua'-oriented group that helped further refine the kōrero. They became known as the 'Ngaru Roa'[54].

Te Ngaru Learning Systems courses at Arowhenua Pa.

[54] The ngaru roa was the wave that took Kupe back to Hawaiki.

Te Ngaru Learning Systems' courses at Rehua Marae and at Ngā Punawai Aroha.

The third wave was Te Ngaru Learning Systems. Using the Pōwhiri Poutama model as a methodology, Paraire and a team of practitioners facilitated Kete (stage 1) and Whāriki (stage 2) wānanga throughout the country. The Te Ngaru courses attracted a range of participants. For those in the AOD sector, it was the one training that not only validated their knowledge and experiences as Māori, but asked them to operationalise that knowledge in the contexts in which they worked.

The fourth wave was concerned with practice and drew heavily on Takarangi Metekingi at Te Ngaru o Maniapoto in Te Kuiti. Here, a number of the models and the kōrero were tried and refined.

> *One thing that bothered most people about Te Ngaru is that there was no written resource. Absolutely nothing and that was deliberate. We didn't worry about intellectual property rights, it was just in the hearts and minds of the people.*
> ***Paraire Huata***

The Te Ngaru training is most often associated with the two courses Te Kete and Whāriki, however they also developed other wānanga, including the pilot Te Ariari o te Oranga workshops. 'Te Ariari o te Oranga' describes the work related to coexisting mental health and addiction related problems. ALAC and the Ministry of Health requested Te Ngaru Learning Systems to assess training and assessment needs following the release of the 1999 NAC guidelines,[55] The workshops had over 200 attendees and identified a raft of workforce development issues. The team included; Paraire Huata, Claire Aitken, Eru Potaka-Dewes, Fraser Todd, Timoti George and Takarangi Metekingi.

[55] *See Todd, Sellman and Robertson. (1999).*

Although developed under the umbrella of Te Ngaru, this work was later spearheaded by the Moana House Training Institute (Claire Aitken and Takarangi Metekingi), which was again able to utilise the talents and experiences of people such as Paraire Huata (operating under Koha Aroha te Ngaru), Paul Robertson and Fraser Todd (the National Addiction Centre) and Wi Huata (Te Whare Hauora o Ngongotahā). While the aim of this contract was similar to that undertaken by Te Ngaru Learning Systems earlier (finding out what the training needs of people in the sector were), Moana House was also expected to provide training and evaluation.

Te Miria te Hinengaro

As mentioned earlier, 1998 saw the development of Māori service specifications for purchasing 'by Māori, for Māori' services, at least for mental health services. As a result of this development, the need arose to identify and address Māori workforce needs. Miria te Hinengaro, a collective of Māori mental health service providers in the Midland region, initiated a project to develop a training needs assessment tool for Māori providers (Tangitu, 1998).

In 1999 and 2000, wānanga were held in the Midland region around developing a Māori model of practice for Māori mental health workers. The wānanga were facilitated by Te Ngaru Learning Systems. The HFA contracted NETCOR[56] to manage training brokerage for the assessment, development and purchase of Mental Health education and training needs in the Midland region. NETCOR collaborated with Te Ngaru Learning Systems to provide a mainstream and kaupapa Māori mental

[56] The New Zealand Education and Tourism Corporation (NETCOR) was contracted to administer a National Training Grant for applicants enrolled in the National Certificate in Mental Health Support Work.

health training programme to deliver the National Certificate in Mental Health Support Work (Rangiaho, 2003).

Māori models of practice were based on the Pōwhiri Poutama model (developed by Te Ngaru Learning Systems Ltd, which was sub-contracted to deliver the kaupapa Māori component of the training). The organisations who participated in the training included both DHB and NGO providers.

Phyllis Tangitu, Paraire Huata and Takarangi Metekingi were contracted to develop a framework[57] and prepare an implementation plan to identify training needs. Te Ngaru Learning Systems was identified as the training provider for the assessment team evaluating the implementation of the framework. The training programme was considered successful by participating organisations as it met service provision needs and the NZQA framework qualifications required by their contracts.

Heke Mātauranga Mauri Ora

In 1999, Te Wānanga o Raukawa, with the support of the ALAC Māori programme, introduced an AOD-related course as part of its mental health papers. The Heke Mātauranga Mauri Ora course was initially tutored by Nau and Wendy Epiha who brought in a number of 'guests' to take various aspects of the course. The course was delivered within the context of whānau, hapū and iwi and, like other courses at the wānanga, had a large component of te reo Māori, hapū studies and tikanga.

> *When Leslie* [Rewi] *came back to Rhanna* [Clinic, Invercargill] *and told me that I'd be doing this Māori course, I didn't think it was for me. But it changed my life – culture, identity and the relevance of whānau, hapū and iwi – it's all*

[57] He anga Māori hei paerau arotake i ngā mahi whakangungu.

there. Leslie knew that when I finished I wouldn't stay in Murihiku, but that I'd go home. Best thing I ever did.
Rawiri Evans[58]

Moana House Training Institute

Moana House Training Institute was established in 2002 in response to requests for AOD training from a range of health and social service providers in the Otago and Southland regions. The directors (and main tutors) are Claire Aitken, Sean Manning and Paraire Huata and it is registered as a private training establishment with the New Zealand Qualifications Authority. Up until 2008, the Training Institute offered two courses – Te Aka and Te Rea – which have been combined to provide a two-year Diploma in Applied Addiction Counselling (Level 6) that will be available nationally from 2009. This relatively recent course has attracted a number of Māori, many with recovery backgrounds. The learning style is wānanga and the courses are marae-based. The course appears to provide an entry point to working in the addiction treatment sector for a number of Māori that otherwise might not have entered the workforce.

Matua Raki and the National Addiction Centre

In 2004 the Ministry of Health[59] contracted the National Addiction Centre (NAC) to develop the National Addiction Treatment Workforce Development Programme (NATWDP). A ten-year strategic plan to develop the addiction treatment sector workforce was written in consultation with the sector (Matua

[58] Rawiri (Dave) Evans entered Queen Mary in 1978 and over the next 10 or so years he worked at the NSAD, Sir Charles Burns Trust, Queen Mary (as a recreation officer), Colyers Island and Rhanna Clinic in Murihiku.

[59] The contributions of Arawhetu Peretini, former manager of the Māori Mental Health team of the Ministry of Health who helped establish the addiction-focused workforce development programme, are acknowledged.

Raki, 2005). The late Takarangi Metekingi described the vision of the programme as 'Matua Raki – the highest of the heavens, representing a striving for excellence'. He acknowledged the passion and commitment of the sector and the strategic plan, which he saw was motivated by the quest for greater excellence. With the support of various Māori in the sector, and following discussion by kaumātua at meetings in Auckland and Gisborne, Matua Raki was adopted by NAC as the name for the NATWDP[60].

The programme had a specific Māori stream from its inception, however it wasn't until July 2006 that Terry Huriwai took up the position of project manager to work alongside Ian MacEwan and the team at NAC on workforce development. Between 2004 and 2006 the Māori leadership in the programme was shared between Paul Robertson and Pam Armstrong. Within the Māori

Matua Raki and NAC at Porto Bello, Otago peninsula.
LR Terry Huriwai, Paul Robertson, Fraser Todd, Doug Sellman, Daryle Deering, Karen de Zwart, Simon Adamson, Leah Stone, Lisa Andrews, Sue Platts, Ria Schroder, Tammy Cave, Lyndsay Atkins.

[60] For more detail on Matua Raki and its activities see www.matuaraki.org.nz

stream, a leadership group (the Kaiwhakatere group) was formed to act as a reference committee for the project manager. The composition of that group reflected key areas of interest, including AOD, problem gambling, mental health, service and workforce development, as well as research.

In February 2008, Matua Raki entered a new phase of development. Although there are ongoing projects with the NAC, the temporary hosting of a Matua Raki team has transferred to Te Rau Matatini. In October 2008 the Ministry of Health will be deciding the final host for the National Addiction Treatment Workforce Development Programme.

Māori Practitioner Competencies

A key project for Matua Raki has been the development of a Māori competency framework. Durie (2001) suggests that cultural competence and cultural safety are similar in that they are both about the relationship between the 'helper' and the 'client'. Cultural safety, however, centres on the experience of the client while cultural competence focuses on the capacity of the practitioner to contribute to whānau ora by the integration of cultural and clinical elements within their practice. Jansen (2002) expands on this, saying that cultural competence requires that providers have a willingness and ability to draw on Māori values, traditions and customs and work with kaumātua and other knowledgeable Māori to communicate and develop responsive interventions. The notion of cultural competence outside of Aotearoa New Zealand has been promoted for many years as being concerned with increasing the cultural responsiveness of non-indigenous services and practitioners rather than enhancing the competence of indigenous workers from a particular cultural paradigm.

Support for the development of Māori practitioner competencies has come from a number of quarters, but most significantly from the AOD sector. In the late 1990s ALAC sponsored the Alcohol and Drug Treatment Workforce Development Advisory Group which, after two year's of consultation, drafted clinical practitioners' competencies for AOD workers. Stewardship of these competencies passed to the Drug and Alcohol Practitioners Association, Aotearoa New Zealand (DAPAANZ). While there is a companion set of competencies for Pacific people, no specific set of Māori practitioner competencies exists.

Since the 2000 Summit at Manu Ariki, there have been increasing calls within the Māori addiction sector for service and practitioner standards that relate to working with Māori and/or working from a kaupapa Māori perspective.

In 2003 problem gambling practitioner competencies were published, which contained a number of competencies relating to working with Māori. In 2005 ALAC published *Te Piringatahi*, the result of a series of consultation hui undertaken by Nevin Broughton and Takarangi Metekingi (supported by Nellie Rata of Ngā Manga Pūriri) looking to articulate what standards and practices might guide Māori services. In many ways *Te Piringatahi* replicated the work of Moe Milne, who was contracted by the Ministry of Health in 2002 to develop a Māori best practice framework.

The framework, *Ngā Tikanga Totika*, came about as a result of 28 hui throughout Aotearoa New Zealand. A number of providers have used the document to guide developments within their services, but few have actually developed and implemented a competencies framework approach.

TAKARANGI COMPETENCY FRAMEWORK Development Group
L-R: Titari Eramia, Nellie Rata, Moe Milne, Delaraine Armstrong,
Te Puea Winiata, Paul Robertson, Slyvester Leef, Pam Armstrong,
Terry Huriwai (photographer).

In 2005, Matua Raki and Ngā Manga Pūriri began work on a competency framework for Māori working in the addiction treatment sector, utilising the previous work and experiences of the working group. The ensuing Māori Practitioner Competency Framework (also known as the Takarangi Competency Framework) was piloted in 2007 in collaboration with Auckland DHB Māori Mental Health Services[61]. The pilot included AOD, problem gambling and mental health services from a range of NGO and DHB provider arm settings.

The takarangi pattern represents the integration of all elements within practice (cultural and clinical) and again reminds us that we need to see the whole person rather than just a diagnosis or presenting problem.

[61] The resourcing of the pilot by Te Puea Winiata manager of ADHB Māori Mental Health services has ensured traction on the implementation path.

Takarangi Northern Region Pilot Hui and Wānanga

While the Takarangi Competency Framework was initially developed for Māori practitioners working in the addiction or mental health sectors, it could be utilised for all people working with Māori, including other health and social service sectors. It provides a clear learning pathway for working with Māori - Māori responsiveness, and takes people beyond providing 'culturally congruent'[62] processes and services, to more actively facilitating interactions likely to contribute to positive outcomes for Māori.

Māori telephone survey – a 2004 workforce profile

The national telephone surveys undertaken by NAC randomly select dedicated[63] AOD practitioners for an anonymous telephone interview. To date there have been two surveys, with the most recent (which for the first time includes problem gambling questions) being carried out at the time of writing. The interviews look at practitioner characteristics as well as information about the clients they are working with. In the first survey (Adamson et al, 2006), those participants who indicated they were Māori had a follow up interview in order to look more closely at their demographic profile models of practice. In many ways, analysis of the survey data illustrates 'how far' the Māori workforce has come.

In terms of demographic representation for Māori, there was a 50/50 split in gender, the average age was 47 years, and the average length of time in the AOD sector was 7.5 years. In comparison, non-Māori were more likely to be female (62 percent), working in the sector for around eight years.

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[62] Huriwai (2002) and. SAMHSA (2006).

[63] Dedicated is defined as paid workers who spend at least 70 percent or more of their time with AOD clients.

Over half (55 percent) of the Māori practitioners worked in the five main centres[64], and 50 percent said they worked in DHB services (about half working in a kaupapa Māori setting). Of the non-Māori respondents, 73 percent worked in DHB services and 69 percent worked in one of the five main centres.

In terms of professional roles, the vast majority of Māori practitioners said they were counsellors/therapists (74 percent) while 11 percent had a social work background and 7 percent listed nursing as their profession. For non-Māori, 18 percent listed nursing and only 47 percent said they were counsellors/therapists.

Of Māori interviewed, 37 percent had completed an AOD-specific qualification, and 21 percent were engaged in AOD-related education. Over half of those interviewed (56 percent) were enrolled in some type of formal education and at least a third indicated a willingness to pursue post-graduate study. In comparison, 37 percent of non-Māori said they were undertaking some form of study.

A key finding from this data is that, although greater proportions of non-Māori had tertiary qualifications, equal numbers of Māori and non-Māori had specialist AOD qualifications. The survey also identified some of the Māori models of practice most commonly used by Māori practitioners. These were:

Models	**Percentage Utilised (%)**
Te Whare Tapa Whā	77
Powhiri Poutama	44
Te Wheke	27
Whanaungatanga	18
Rangi Matrix	10

[64] The five main centres are Auckland City, Hamilton, Wellington, Christchurch and Dunedin.

Other models used by Māori practitioners included:

Models	Percentage Utilised (%)
Motivational interviewing	50
Person-centred counselling	46
Cognitive behavioural approaches	42
Psychotherapy	36
12-Step	10

The relatively low utilisation of the 12-Step model is interesting given that in the early years of service and workforce development, the primary treatment milieu was a 12-Step residential approach.

Qualitative data collected during interviews suggested that passion for and commitment to improving Māori health were key factors in decisions to enter into and remain in the addiction treatement sector.

> "*Passion to see our own people get well.*"[65]

The telephone surveys are unique in that they not only look at practitioner characteristics but also seek information about clients accessing services, helping to inform training needs. Analysis of the survey data show that Māori clients were over-represented in the client group when compared to the wider population. They also used cannabis more often and were less likely to live in a large city. Those engaged in treatment following an initial assessment were more likely to be female, non-Māori and opioid users, although it was noted by Adamson et al that 'kaupapa Māori' services appeared to be more successful in retaining Māori clients.

[65] Robertson, Gibson and Adamson (2005).

Professor Ross McCormick and colleagues, in an editorial in *The New Zealand Medical Journal*, writes:

> *This finding alone would suggest that the choice of a Māori alcohol and other drug habilitation service should be readily accessible, or at the very least, there should be increased Māori responsiveness in non-dedicated Māori services. The further development of 'kaupapa Māori' services should be encouraged and supported.*[66]

Henry Rongomau Bennett Workforce, Leadership and Scholarships Programme

Since 2003, the Henry Rongomau Bennett Workforce, Leadership and Scholarship programme[67] (hereafter known as the HRB programme) has aimed to increase Māori leadership within mental health and addiction through the development of highly qualified and well trained mental health practitioners.

In 2003, the Mental Health Directorate of the Ministry of Health provided resourcing to the HRB programme to pilot a workplace secondment programme in the addiction treatment sector. Te Puea Winiata and Terry Huriwai, who were both in the directorate at the time and who were instrumental in supporting the uptake of addiction-related initiatives by the HRB programme, saw the secondment programme as an opportunity to:

- Establish a mechanism for experienced practitioners and services to access specialist addiction treatment personnel as well as specific addiction-related skills, knowledge and contexts.

[66] McCormick, Kalin and Huriwai (2006).

[67] The initiative was named after Henry Rongomau Bennett, the first Māori psychiatrist. As well as being the Medical Superintendent at Tokanui Hospital he was, more importantly (in the context of this history), one of the first trustees of the Te Utuhina Manaakitanga Trust in Rotorua.

- Identify the workforce development issues to be addressed in order to build effective services for Māori.

A secondment approach to workforce development in the Māori addiction treatment sector was unique, and evidence gained from the early evaluation of the pilot programme pointed to obvious benefits of such an approach that had not been evident in other forms of workforce development. The pilot included practitioners and services from AOD and problem gambling.

> *Although many secondments have occurred in health before, this programme was different in that the values base was more explicitly Māori, it was designed and run by Māori and was aimed at Māori leadership. It was well resourced – for hosts and those on placement, it had a dedicated coordinator in Denal* [Meihana] *who made it happen. It felt like there was more of a mentoring perspective to this which led to extended relationships occurring after the placements had been completed.*[68]

In 2006, the Northern Regional Mental Health Workforce Development Plan adopted a secondment programme, based on the HRB programme, for use in the mental health and addiction sector. These placements, and those currently being conducted by HRB, have been rebranded as the Rauhī Mai programme and are now coordinated by Tauni Scott of Klub Ngaru Consultants (who had undertaken the early review of the HRB secondment programme). This programme has also influenced the development of secondments and internships by Te Rau Matatini for Effective Interventions[69].

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[68] Klub Ngaru evaluation of the HRB secondment programme (2006).

[69] Effective Interventions is a Ministry of Justice led suite of initiatives to impact on the rates of imprisonment and to reduce reoffending. Alcohol and other drug use has been identified as a changeable factor in offending and the secondments and internerships are to enhance the capacity and capability of the addiction treatment sector.

HRB secondments and Harry Pitman workshops

The second initiative undertaken by the HRB programme was a series of scholarships, named for Harry Pitman, to encourage Māori to attend and present at national and international fora. The scholarships programme has, after initial review, beeen replaced by a presentation skills workshop that draws on the media and communications experience of Damiane Rikihana.

In a previous incarnation, she also provided media and PR support to the organisers of the 1998 Healing Our Spirit Worldwide conference held in Rotorua. Damiane, supported by Te Puea Winiata and Terry Huriwai, presented a range of basic and advanced level courses around the country for people working in a range of Māori addiction services, as well as tailored courses for service users and one specifically for kaumātua.

The workshops were highly rated by participants, a number of whom have presented on regional, national and international stages. In 2008 the workshops entered a new phase of development under the stewardship of Tauni Scott.

> *There are not many opportunities to see people in the sector in this context – testing their abilities, stretching their wings, exposing their potential and thinking about how they can change the world.*
> ***Te Puea Winiata***

Both of these workforce development programmes have their genesis in the addiction treatment sector and continue to have this sector as their primary target group. In recent times, however, application within the wider mental health sector has been explored. Te Rau Matatini (TRM), the Māori mental health workforce development organisation, now hosts the Henry Rongomau Bennett Workforce, Leadership and Scholarship Programme, initially coordinated by Rawiri Evans.

Problem gambling

> *At least a third of funding available to address gambling-related harm should be ear-marked for Māori workforce development and capacity building and the provision of gambling treatment services. This figure reflects, as a minimum, the needs of Māori.*[70]

In November 2003, Ngāti Porou Hauora hosted the first Māori workforce development conference for problem gambling in New Zealand. Held at Pākirikiri Marae in Tokomaru Bay, the hui was a chance to discuss and consider planning for future initiatives that would enhance the development of practitioners and services that work with individuals and whānau experiencing gambling-related problems. As had happened at various hui to address the issues of the Māori AOD sector over the previous 20 years, discussion included mobilising the community, more effective use of kaumātua, use of Māori models of practice and training focused on the Māori dimension.

[70] Abbott and Volberg (2000).

With the exception of a Te Rangihaeata Oranga-initiated workshop for Māori involved in public health approaches to problem gambling, there has not yet been a national hui to address workforce needs. Individual practitioners and services have utilised AOD and mental health-related training to upskill themselves.

In late 2006, Abacus undertook a survey of the problem gambling workforce on behalf of the Ministry of Health. About 43 percent of people interviewed identified as Māori practitioners, with about a quarter of the total workforce having had previous experience in the AOD treatment sector. This suggests a strong cross-over between AOD and problem gambling workforces (Abacus, 2007).

Summary

The first part of this monograph records and presents a number of 'strands' that make up part of the history of the Māori addiction treatment sector and a series of snap shots taken by a number of people. The development of a Māori addiction treatment sector in New Zealand over the last 25 years has been shaped by dedicated and passionate people and stories of opportunity and innovation.

Practically every service has a collection of 'hamuhamu' stories, stories of hand-me-down typewriters, second-hand furniture and of doing the rounds of garage sales – all of which illustrate the commitment and passion of those people involved

> *It was all hand-me-downs. Monica* [Stockdale] *went away and bought the bloody carpet squares herself, and they made that place into a whare with very little resource from the hospital.*
> ***Tuari Potiki***

These stories are largely beyond the scope of *He Tētē Kura*, yet they need to be acknowledged. Although there has been much to celebrate, including the individuals and whānau supported into and through recovery, not everything has been rosy.

Most services also have stories of staff and clients relapsing, of governance and management problems, of philosophical hard times as the kaupapa is revisited against the backdrop of service reorganisation and of on-going struggles to gain credibility and traction in the wider addiction and mental health sector. It will fall upon other storytellers to continue to record the celebrations, agonies and strategies of establishing, maintaining and developing Māori programmes and services recorded.

Despite the multiple challenges, the last two and a half decades has seen the Māori addiction sector adapt to changes in funding and policy environments and continue to grow. Initially, drivers for the development of Māori services included a perceived lack of services operating from a Māori perspective and a lack of Māori working in the sector. These factors were considered to be barriers to Māori accessing and staying in treatment. Thus, for some individuals involved in the Māori AOD treatment sector development, providing better treatment for whānau was a central motivation. It was also very clear that working with addiction-related harm was seen in the broader context of oranga rather than being a sole focus.

What drove people to do the work that they were doing – often voluntarily and on the smell of an oily rag? While the so-called Māori renaissance in the wider New Zealand society provided a more conducive environment for the pioneering of those early services and initiatives, a stronger force was the significant number of people with their own experiences of substance-related harm and recovery. Although data is limited, it appears that around 1980 there were increasing numbers involved in treatment and the support of recovery.

ALAC has had a significant role in facilitating and supporting the development of a number of community-based iniatives. It was also a conduit for Māori development within the treatment sector. In particular, it promoted a systemic and strategic approach to building a national infrastructure to sustain Māori services and practitioners. The fact that there has been limited long-term traction in the building of a national infrastructure is due to a number of factors, including limited funding – which has inhibited participation and collaboration. Events such as Healing Our Spirit Worldwide, national summits and conferences have provided ad-hoc opportunities to develop a collective.

More recently, services and practitioners have found new champions for furthering addiction treatment kaupapa to their local funders and planners – organisations such as the National Addiction Centre, Matua Raki and Te Rau Matatini. This has allowed services and practitioners to concentrate more on salient individual issues, as well as service and regional issues.

From the earliest days of the sector, there has been an expressed desire to develop training in Māori competencies and practices. This has competed at times with a wider sector demand for 'clinical professionalism' – particularly from dominant culture institutions. In this context, courses that have had the best traction with Māori students have understood the importance of process, attending to differing learning styles, as well as providing credible course tutors and venues. Validation of a Māori paradigm not only helps attract people to the sector but in many cases helps improve job satisfaction and thus retention in the sector.

A key milestone in the development of the sector, and identified by the key informants, was the ALAC service reviews of the 1990s. As one of the first reviews of Māori services, they called for accountability of management and governance structures. Further, both reviews indicated that outcome and safety were issues that services would need to address if they were to survive in the future.

Over the years a number of initiatives have been piloted or seeded, however many have floundered due to limits in management or vision or both. Although the conclusions were in part shaped by the ALAC (and some would argue 'western') perspective of what treatment was, there was a genuine attempt to be inclusive of the need for Māori service and workforce development.

Historically, the services with the best longevity appear to be those who were aligned to, or were developed within wider iwi-based health and social services or networks.

Although the problem gambling sector is young, it shares a number of similarities with the AOD sector – other than the clients. A number of those working in problem gambling have a background in AOD and basic models of practice (Māori and 'western') are the same. In many ways, problem gambling is to AOD what AOD was to mental health – often forgotten or marginalised.

Overall, there has continued to be some responsiveness to cultural issues for Māori within the addiction treatment sector. An increasing body of New Zealand literature over the last decade, with relevance to Māori and addiction, has acted to elucidate broad issues, validate Māori health practices and demonstrate the clinical relevance of cultural input into the treatment of addiction-related problems for Māori. There is, however, still a dearth of Māori-specific treatment data and research.

Changes within the health sector over the last two decades have seen Māori exert increasing influence over the shape of the health services that they receive and deliver. Key informants have highlighted many different initiatives within the Māori addiction treatment sector where development was driven in response to the needs and aspirations of Māori, including Māori-specific treatment research and Māori-focused workforce.

Conclusion

The Māori addiction treatment sector is less than 30 years young. As a unique entity within the wider addiction treatment and mental health sectors, the Māori addiction treatment sector is still growing and consolidating. With its origins strongly grounded in recovery, whānau ora and voluntary work, both service and workforce development has had to understand and utilise these in order to grow. This process has occurred in a context which has not always been responsive to the needs of Māori

The second part of this document presents some insights and themes identified by the key informants. Many expand on emergent themes from this first part of the history.

PART II:

Mai i Te Whakaatu, Ka Mōhio – Insights and Understanding

Introduction

In Part I of *He Tētē Kura*, a number of 'creation stories' were recounted. When taken together, they form a whāriki on which the current and future Māori addiction treatment sector now stands. In Part II of this monograph, we examine some of the themes (recurring and/or strongly expressed thoughts, ideas and experiences) that emerged from the interviews with key informants (Appendix 1 lists the key informants and outlines the methodology used to gather and analyse information). These interviews provide the basis for Part II of this monograph, 'Mai i Te Whakaatu, Ka Mōhio'.

What is clearly illustrated in the history of the addiction treatment sector provided so far is the commitment and passion of a number of people over a long period of time – commitment to Māori health and wellbeing, as well as a passion to address addiction-related harm. These characteristics will be explored further in the following section, as will insights relating to Māori values, beliefs, and practises, changes in the sector, and the challenges of working in the Māori addiction treatment sector – past, present and future. In this context, some specific commentary is provided here on leadership and workforce development.

The primary aim of the interviews was to track development of the Māori addiction treatment sector through the eyes of a number of pioneers and founders of Māori addiction services and initiatives. Other voices that have contributed to the telling of this story were part of the movement, the critical mass that has brought the sector to where it is today. Many of the insights offered by the key informants have been shaped by 'beginnings', however comment is also offered based on experiences of the wider health and social service sectors – including experience of management and policy development.

Passion and Commitment

> *There were some committed people; passionate, that's the word I would say, passionate. They saw what addiction was doing to our whānau, our hapū and our iwi. I think beside the word 'passion' would have to be the word 'courage'. They had courage to make a difference.*
> ***Titari Eramiha***

Passion for and commitment to kaupapa were some of the strongest themes to emerge in all the interviews. Managers and kaimahi of early services, as well as individuals working in other areas of health and social services, have all been driven by a passion, commitment and dedication to improve the health and wellbeing of Māori whānau, hapū and iwi. Most were spurred on by the need to address perceived gaps in service – particularly for Māori affected by addiction-related harm. Ultimately, it was a passion for helping Māori communities, whānau, hapū and iwi that drove the sector and provided momentum to programme and service development, as well as attracting and keeping a workforce.

> *What sustained the development of Māori dedicated services has been the passion of the people. It's how you harness all those passionate people to get things done that is the issue for the future. People were passionate in all sorts of different ways and have varying skills, knowledge and experiences. Despite the differences there has always seemed to be one uniting kaupapa – hauora Māori.*
> ***Terry Huriwai***

In the early days this passion often emanated from a strong recovery presence in the sector. Motivated by a desire to give something back, many who had come through treatment themselves entered the addiction treatment workforce.

Others in the workforce were motivated by experiences of substance use-related harm in their whānau and a desire to be part of the solution. The commitment to contributing to the recovery of whānau, hapu, iwi was evidenced by the fact that much of the early work in the development of the sector was undertaken by volunteers and others who worked for little or no remuneration.

> *And it was all voluntary, we didn't get paid for doing that. We just did it as our contribution. There were all these other people who were out there doing the work. We were there to support, to make it happen.*
> ***Moe Milne***

The passion and commitment of early workers was further evident in the creativity and innovation that was a common response to a lack of resources and funding – sharing and recycling of resources became essential.

> *You just did it. I think a lot of the early development was really creative. It had a lot of energy. Now we've become organised, the energy sometimes feels less intense and less creative.*
> ***Monica Stockdale***

> *You become really creative when you have nothing – so we were really creative.*
> ***Pam Armstrong***

The terms passion and commitment were used almost interchangeably in the interviews. Commitment to helping and enabling Māori communities faced with addiction-related problems ranged from the personal commitment of individuals to improving the lot of Māori, to the long-term commitment of people focused on the development of organisations and structures to help Māori with addiction-related issues.

> *Our greatest resource was people, you know the Ngāi Tahu people and the Ngāti Kuri people, and they were always there to support us. I don't know how many times, Hapi* [Winiata] *and Pihopa* [Kingi] *and that would come down. So, you know, our greatest thing was people.*
> ***Monica Stockdale***

A great deal of 'blood, sweat and tears' was poured into the early development of the sector, and this sometimes came at a cost, impacting heavily on the families of some of those involved. For others, the personal costs borne included deteriorating health or relapse.

> *People made that sacrifice, just to get others involved, committed. We started from 12 people meeting in Rotorua and then the next meeting was 220 and the next one was about 400 and you could see the field grow. My family were all involved, my children grew up in that. It was 110 percent or nothing.*
> ***Hakopa Paul***

Even though some of those interviewed were no longer working in the Māori addiction treatment sector, they still had an ongoing commitment to and connection with the kaupapa of Māori health and well-being. The commitment to help Māori (whānau, hapū and iwi) with addiction-related issues was still a strong driver for working with people marginalised by society (and in a sector often marginalised within the wider mental health and social services).

Māori Values, Beliefs and Practises

Interviewees clearly identified that the passion and commitment demonstrated by many of their contemporaries was expressed within a range of Māori values, beliefs and practises that have underpinned the development of the Māori addiction treatment sector in Aotearoa New Zealand. In fact they underpin an overall philosophy of health and well-being for Māori whānau and communities.

Whanaungatanga

Not surprisingly, all interviewees highlighted the importance of relationships. Whanaungatanga is kinship in its widest sense and reinforces the commitment and connection people have to each other as well as their responsibilities within these relationships. Consequently, there is often a feeling of belonging, value and, to some degree, security in being part of these relationships.

Defined as inter- and intra-family relationships, whanaungatanga describes the dynamic process of establishing and maintaining links and relationships (Huriwai et al, 2001). There was broad and varied discussion in the interviews relating to how, in reality, whanaungatanga was demonstrated across a range of situations.

In the early days, whanaungatanga was quite clearly shown in the collective action taken to establish and operate services, for example the Mangere hui of 1985, and the kaupapa of Te Ara i Rauhanga.

> *They came together, people with a shared interest – Māori. Plus, they were wanting to do something about treatment – a choice. That was the beginning. Whanaungatanga brought*

them together as Māori, and as Māori who had their own experiences – they had a 'take' with alcohol and other drugs. A lot of them then moved into working formally in the sector.
Terry Huriwai

Today, the term whānau is often used to describe groups who have no kinship ties but have come together around particular kaupapa. They are bound by common purpose and have adopted co-operative and collective values (including responsibilities and obligations) that align with traditional concepts of whānau. Two examples that illustrate this are found in the first part of this history: whanaungatanga underpins the bond between the people who held ALAC development positions and those associated with the recovery whānau.

The recovery movement that gained momentum in the early 1990s provided a caring environment and a safe 'substitute' for whānau for many in recovery – a kaupapa maintained today by groups such as Te Whānau Manaaki o Manawatū.

Whanaungatanga linkages are also quite clearly seen in relationships built around shared experiences (such as treatment or recovery) which, when overlayed with a whakapapa focus, could be very powerful.

If the network in Tai Tokerau asks Moe [Milne] *to do something then she does it, because this is where she's from and this is where her heart still belongs. That's where that powerful link of whanaungatanga comes into play.*
Titari Eramiha

A variation of this was utilised in the North when Ngā Manga Pūriri was recruiting trainers for its Te Wero me Te Aranga training courses.

> *We did that whole whanaungatanga thing, 'who's related to who and does anybody have any good hook-ups?' We were asking people to get their 'whānau' to come up North and help the people. 'Tell them we got no pūtea, but gee, we'll just love them forever'.*
> ***Pam Armstrong***

We also saw in Part I the importance of nationally focused whanaungatanga as a method to spread news, to bring important issues to people's attention and to promote various causes within the collective. The principles of whanaungatanga and the ability to rely on the relationships with and within networks continue to support the development of Māori services and the wider Māori addiction treatment and mental health sectors today.

> *It's good to see Matua Raki stepping up and taking a national leadership role, bringing us together, keeping us informed, creating opportunities to discuss, plan and change the world. If they don't, who will?*
> ***Te Puea Winiata***

A number of those interviewed felt these relationships could not be taken for granted – needed to be fostered, and required people to have agreement around the needs of the sector, not just the needs of individual services or practitioners. One of the solutions to addressing the diverse needs of the sector was to hold national hui, workshops and fora where commonalities could be agreed.

> *Sometimes I wonder if there is a Māori alcohol and other drug sector. There are heaps of Māori workers now, but I don't think there has been, at least not lately, any sort of unanimous agreement about what or how we are – other than broadly kaupapa Māori.*
> ***Tuari Potiki***

In recent years, attempts to try and develop agreed national standards and competencies for working with Māori and for kaupapa services has tapped into a Māori collective – with limited success. Some of the key informants felt that many services and providers now concentrate on local and regional concerns and finding local solutions.

This has contributed to some ambivalence about the benefits of being part of a wider collective; in some cases this appeared to relate to suspicions about perceived agendas that underpin national initiatives.

> *There's talk about national leadership again. It might work this time because it isn't just an ALAC thing. They'll need a reason to belong though, and something to work towards.*
> ***Tuari Potiki***

Kaumātua Hui, Owhata marae to review the Takarangi Competency Framework

Manaaki

The concept of manaaki was most often expressed as a desire by kaimahi and whānau to host, support and care for whānau, hapū and iwi and achieve wellbeing for Māori as a whole.

> *We were going to do something for Māori. We were going to do something to change addiction in Tai Tokerau.*
> ***Titari Eramiha***

In regard to Māori addiction treatment service delivery, the imperatives of manaaki and whanaungatanga often meant that treatment services were very accessible – clients were often able to 'come in off the streets' and often services went where the clients were. It also saw many providers willingly work with offenders within the criminal justice system and inside people's homes – the important thing was they were working with Māori. In part, this stemmed from an understanding that they had to work differently than non-Māori services if they were to increase access and retention in services, and ensure Māori values, beliefs and practices impacted positively on outcomes for whānau.

> *It doesn't matter whether they're bad, sad or mad. If they're Māori - we'll work with them.* [71]

For some practitioners and providers, the basis of their interventions was the desire to help rebuild mana.

> *Ultimately, it's about the people you work with. So, to whakamana the field and the workers, we actually have to give mana to the clients as people - those who need help.*
> ***Tuari Potiki***

[71] Pukekawa Wehi cited in Huriwai and Robertson (2000). Pukekawa (also known as Pukekawa Harris) was a Te Rito Ārahi whānau member and counsellor. She also worked as Whaea at the Taha Māori programme.

Awhi and aroha

Awhi and aroha have been inextricably linked with both manaaki and whanaungatanga. Both awhi and aroha were identified as underlying principles that guided the service delivery of many Māori AOD treatment services. Key informants talked of services, such as Te Rito Ārahi, that employed the values of awhi and aroha in their work with Māori. This contributed to an inherently Māori approach in those early stages of service development. To some, however, it appeared that these services were strong on support and short on a strong clinical focus.

> *There was heaps of aroha and heaps of awhi and it worked for people. What they used to do at Te Rito Ārahi was get people ready to go to Hanmer and do the programme up there, then look after them when they came out. It felt like it was very strongly Māori, but not a lot of clinical expertise at that time.*
> ***Tuari Potiki***

The Workforce Development section in Part I outlines the changing needs of services and the workforce as the sector grew. Those who had a strong background in the 12-Step movement (whether as volunteers or paid workers) began to have greater demands placed on them with the increasing expectation of intervention in community settings rather than in residential treatment centres. However, a number of the key informants suggested some practitioners and services became too 'clinical' at the expense of basic values and practices such as awhi and aroha. The wero for many workers in recent times has been to embed their clinical training into the strong foundation that is Māori values and practice.

Rangatiratanga

Rangatiratanga is seen as a central theme in many of the 'creation stories' of services, as well as in the battle to validate a Māori approach to treatment and recovery. Rangatiratanga was primarily discussed by interviewees in relation to:

1. The Treaty of Waitangi and connections to the Māori renaissance and thrust for self-determination.
2. Challenges faced in terms of service delivery, where non-Māori were often responsible for determining Māori needs, aspirations, processes and the foci of treatment services.
3. Current progress in being able to control and determine future directions and foci.

Key informants recalled utilising the Treaty as a vehicle to drive development and as a point of leverage when lobbying for resources and funding for 'by Māori, for Māori' services. As a result, the 1980s saw more opportunities for the development of Māori AOD treatment services than any other time.

> *At that stage the Treaty wasn't included in anything, so it became a vehicle to drive some things. In those early days, we'd try to hammer home things like the Treaty relationship and that we were working for or with iwi. It was a way to try and get what we could from Crown agencies and anyone else willing to fund us. If you didn't have those hooks I think it would have been much harder to get an in.*
> ***Terry Huriwai***

Some of the key informants noted that for some non-Māori, the provision of Māori services was more about providing the choice of a brown face (doing the same thing as non-Māori) than an understanding of the therapeutic benefits of utilising Māori

models of practice. There was also a common assumption (for Māori and non-Māori) that being Māori was in itself sufficient to ensure an effective treatment. Those interviewed felt that Māori had to demonstrate to whānau that they were different to non-Māori services and that they were effective.

Despite a call in some quarters for the parallel development of dedicated Māori services alongside the broader AOD treatment sector, a perceived shortage of skilled Māori addiction treatment workers, along with a lack of organisational infrastructure, saw some areas introducing bicultural services instead. For many, these units threatened the ideal of rangatiratanga for which many Māori had strived.

> *The development of bicultural services or the grafting of Māori units onto Pākehā institutions has, in Māori experience, seen very little shift of control or power.*[72]

One example of this was the Taha Māori programme at Queen Mary in Hanmer Springs (its development and demise is outlined in Part I). It was noted by interviewees that the review undertaken by Paraire Huata and Tahu Potiki in 1995 recommended a budget separate from the general Hanmer resourcing in order to achieve programme autonomy and integrity. The call went unheeded.

Likewise, difficulties were recounted around non-Māori determining the processes and foci of Māori services – particularly by way of contracts and funding.

> *It was diluted actually, so what they* [the Crown] *pictured Māori needed was about prisons and offenders – not whānau. So they redirected the money to go towards looking at how we reduce the prison numbers.*
> ***Te Orohi Paul***

[72] Spooner and Manuka-Sullivan (1990).

Māori working within the NGO sector were well aware of systemic issues that resulted in a loss of rangatiratanga and marginalisation, however it was felt that for Māori AOD treatment providers it was even harder.

> *We were accused of working on an ideology. But we happened to think that because we lived here, we worked here, we were actually subject to all the needs on the day-to-day basis, because it was within our own whānau as well as the community as a whole that we were the best judges of what needed to happen here.*
> ***Moe Milne***

Māori values, beliefs and practices represent more than a conceptual framework. Ultimately, they reflect the lived reality of Māori in the sector and provide a firm foundation in the often shifting sands of the health and social sectors.

Some of the key informants made the point that without the support of a number of non-Māori, many initiatives and services would not have progressed. Many of these people understood the importance of rangatiratanga and the status Māori have as tangata whenua, and key informants believed that was because those people were not threatened by it.

Sector Changes

In the first part of this monograph we provide a snapshot of the social and political context in which Māori AOD and more recently problem gambling services were established and operated. Through the stories of key informants, we are also able to see some of the impacts of these developments, including the increasing number of Māori in the addiction treatment sector workforce.

Other aspects of change described by the key informants offer some understandings at a 'micro–level'. Three of the most significant changes identified relate to shifts in practice rather than in systems. These are

1. A shift from the predominant AA model of practice to more eclectic and multi-dimensional Māori models of intervention.
2. Relatively fewer Māori AOD practitioners coming from and practising a recovery approach as the sector faced increased demands for 'professionalism' and a qualification base.
3. A move from residential treatment as the primary mode of intervention to increasing use of community-based treatment programmes.

Models of practice

In the early history of the sector, many dedicated Māori AOD services used AA and promoted Māori cultural values as an adjunct to the therapeutic/recovery process. This was made easier by the fact that core Māori values were seen to align with the 12-Step philosophy – for example, the importance of spirituality and collectivity.

> *There weren't Māori around who had been through anything else. The ones who had got through their alcohol and drug problems were in recovery. Te Rito Ārahi back then was 12-Step, it was based on AA. 12 steps were on the wall and the counsellors worked the steps, and part of it was about linking people into AA, because they were AA or Al-Anon themselves.*
> ***Tuari Potiki***

With time and increasing Māori participation, a 'brown' version of the 12-Step programme began to emerge – essentially, the core programme with cultural enhancements.

> *For those of us working in the field at that time, we could only think about a brown version of the AA programme. We hadn't really been able to think much beyond that other than building capacity for Māori to work with Māori. We weren't quite sure what that was going to evolve to, we just had to trust the process.*
> ***Te Puea Winiata***

Ultimately, the limitations of the 12-Step programme and other 'western' models, particularly deficit and medical models that predominantly underpinned treatment, were recognised. The early 1990's saw Māori begin to take more interest in what treatments were working for their own people, AOD interventions became more directly informed by broader developments, including Māori models of health such as Te Whare Tapa Whā (Durie, 1994).

> *There were more Māori workshops than anything else* [Healing Our Spirit Worldwide, Edmonton, 1992] *and we were way, way ahead of the game because we decided that, rather than the disease model and the AA model, we wanted to use Māori models.*
> ***Te Orohi Paul***

Another key change in the development of Māori addiction treatment services has been the movement towards greater integration of clinical and cultural elements in Māori practice models. Māori processes and concepts of wellbeing, integrated with a range of therapeutic and learning processes from other cultures, have been accounted for in frameworks such as the Dynamics of Whanaungatanga, Pōwhiri Poutama, Rangi Matrix or the Meihana model[73]. Māori models of of assessment and treatment have continued to advance as Māori addiction treatment workers continue to apply and refine these models in their practice.

> *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.*
> ***Margaret Manuka-Sullivan***

The use of these various Māori models by some practitioners has not necessarily reduced the use of AA or other 'western models' (Abacus, 2004 and Robertson et al, 2005). As was pointed out by a number of the interviewees, AA and NA-like groups continue to contribute to people's sobriety and recovery.

Recovery workforce

Parallel to the development of Māori models of practice, the Māori addiction treatment workforce has also undergone changes as the sector has grown. Generally speaking, early Māori addiction treatment approaches grew out of a personal understanding of recovery. For most who had come through this journey, the main focus and vision was abstinence.

[73] Pitama et al (2007).

The introduction of the CIT certificate in alcohol and drug studies and the kaupapa Māori stream of the certificate in 1992 encouraged a large number of kaimahi to gain new knowledge and upskill. It also created an opportunity to infuse cultural milieu (the Māori dimension that many said they had) with the 'clinical' elements of AOD-specific treatment training. A number of the key informants noted that it was often difficult to achieve a balanced integration of Māori values, beliefs and practises with other clinical aspects of addiction treatment practice in the workforce.

> *There was a real push on to train up and get some* ['western'] *clinical skills. Initially the Māori AOD field was aroha - heaps of aroha and bugger all else. They were all voluntary and something seemed to work. Then it swung and everyone was training, and it was very clinically focused – to the detriment of the Māori stuff in many cases.*
> ***Tuari Potiki***

Another concern raised by some informants related not so much to the workforce in recovery but to the consumer movement. There was an increasing feeling that some service users saw their treatment and their recovery through the eyes of a 'consumer' rather than as a Māori who may or may not use services.

> *You know, we were whānau - with all that goes with that. Then mental health came along and suddenly we're consumers with rights rather than whānau with responsiblities and obligations to one another.*
> ***Te Orohi Paul***

While there was sympathy for the marginalisation of consumers in the health system (as noted by Dr. Fraser MacDonald in Part I) it was felt that this potentially was a red herring to asserting a Māori world-view.

> *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 we go through.*
> ***Moe Milne***

'*Deinstitutionalisation*'

The term 'deinstitutionalisation' originates from the mental health sector and refers to the shift from primarily institution-based care in mental health hospitals to a range of outpatient services. This movement from residential to community-based treatment services[74] was identified by key informants as a significant change within the sector. Deinstitutionalisation, along with the 1995 findings of the Core Services Committee (later to become the National Health Committee) review of AOD treatment, helped shift the priority and weight of resourcing from residential to community-based services.

Community-based services generally had acted as the go-between for clients on waiting lists for residential services or had provided awhi for those clients leaving residential treatment; now they were being expected to provide treatment. This resulted in a need to increase the capacity and capability of community-based services in order to assess and manage

[74] Community-based is considered by some to be a misnomer, as the services offered often were still based in institutions. The impact of deinstitutionalisation in the addiction treatment sector was the reduction of the contracted numbers of residential treatment beds.

a wider range of people and conditions. It also meant that residential programmes such as Queen Mary found themselves competing with community-based services for clients. This competition for clients, coupled with a funder preference for non-residential options, contributed to the closure of a number of residential services[75]. At the time, the closure of Queen Mary Hospital generated much comment nationally. However, the feelings of anger and grief felt by many Māori at the closure of the Taha Māori programme are still significant for some today.

> *So when you talk about the Taha Māori programme, I think people have, including me, hugely awesome memories of that place. The programme would have benefited most people, not just 'alcoholics' and 'drug addicts', because it was eight weeks in an incredibly cool environment where you had no worries. People who have gone through and made changes are always going to be grateful, pretty staunch, and pretty defensive of the place.*
> ***Tuari Potiki***

Ultimately, deinstitutionalisation and the establishment of District Health Boards provided increased opportunities for community-based providers and saw the development of a more localised approach to service provision. This presented difficulties for some providers who held national contracts (and who could accept referrals from anywhere in the country) who now had to prioritise local or regional demand for services. In terms of Māori residential services, the development of local Māori addiction treatment services was seen to negate the need for referral to Queen Mary and the Taha Māori programme was placed under particular pressure.

[75] Although the a number of AOD residential services have closed over the last 20 years, the number of 'beds' in the sector has increased as has the amount of Health dollar allocated.

Challenges to Development

In addition to those sector changes already noted, the Māori AOD sector has, over the years, faced and overcome many challenges to its development, in particular:

- funding
- marginalisation and discrimination
- NGO vulnerability.

Funding

Despite the dedicated Māori AOD sector having its roots in Māori self-determination (Māori wanting to care for their own people), in the early stages a great deal of funding was derived from non-Māori sources, Crown agencies and institutions. While there were benefits for the establishment of kaupapa treatment services, for many it presented major drawbacks – both philosophically and operationally.

> *We had this hui about how restricted we were in how to provide this kaupapa Māori service. They wanted us to meet their criteria, they wanted us to do things in the way they thought Māori should behave. They wanted us to have outcomes that they said were important. We said to them 'no way, no way, no way'.*
> ***Moe Milne***

> *We all got funded, and suddenly we became really clinical and decided we were all going to be recovering - we were Māori before then.*
> ***Te Orohi Paul***

For teams and programmes within larger organisations, especially 'mainstream' organisations, there was often a perception that funding was 'disappearing' or, despite being tagged for Māori development, was being used for other purposes.

> *Hanmer was like that. A lot of money was being generated by our programme but we only got a small part of that. The money was just being siphoned off to keep the rest of the hospital going really.*
> ***Monica Stockdale***

Some of the informants identified a lack of awareness by funders and planners as to their responsibility to prioritise Māori. It was a possible two-edged sword however, as prioritising Māori might mean increasing the cultural fluency of non-Māori (or 'mainstreaming' Māori services) rather than enhancing the dedicated Māori part of the Māori responsiveness spectrum.

An observation made by a number of key informants was that many NGO services were part of larger health and social service groups – particularly iwi groups. While this was probably one reason for service's survival, there was also the potential for addiction services to be marginalised by other areas of Māori health and social service development, reflecting the broader marginalisation of addiction and 'addicts'. It is also a possible explanation for addiction resources being used on other areas of health altogether.

Marginalisation and discrimination

Key informants discussed the many different contexts in which they had encountered prejudice, discrimination and marginalisation. For those working in non-Māori institutions, examples were often blatant.

> *People would say, we don't want the pots being used because it* [pūhā and watercress] *would contaminate them. No real knowledge or understanding of why having kai together was therapeutic - it was just an excuse to say no, a chance to keep us in our place.*
> ***Monica Stockdale***

Other examples of discrimination within non- Māori environments highlight the uncertainty that people had about working in a Māori service. In several instances this appeared to reflect tensions related to 'professional' roles.

> *Even the Māori working there didn't think we should have our own programme. They were mainly nurses and they also worked against it. When they came over they found they really liked it and stayed. There was a lot of prejudice and I think it was because they had preconceived ideas of what we did, and they didn't want their role changed.*
> ***Monica Stockdale***

Many of the key informants acknowledged that, without a ring-fenced budget for Māori it was hard to exercise rangatiratanga and it seemed at times that Māori were less of a priority than others within some organisations.

> *We never seemed to get new stuff. We always seemed to get everyone else's seconds when they got their new computers or whatever.*
> ***Tuari Potiki***

At a broader level, key informants talked about marginalisation in and of the sector as a whole. Most often experienced was the marginalisation of power in terms of participation and decision-making processes (or rather, the lack of participation). This was often seen as a reflection of the Māori addiction sector

being 'on the outer edge of the broader addiction treatment sector. Interestingly, those in the addiction sector often feel 'on the outer' within the mental health sector and many in mental health feel on the fringes of the wider health sector.

> *Lumped as the third or second pōhara cousin of the other pōhara cousin that belongs to the pōhara family of mental health services. Even now, after 25 years, it's [addiction] still the pōhara cousin of the pōhara cousin.*
> ***Te Orohi Paul***

Despite this feeling of marginalisation it was noted, to some extent, that the so-called ring-fenced mental health funding has meant there is some accountablity for the Vote Health mental health spend. Unfortunately, because there is no ringfencing of addiction funding or, within that, of funding for Māori, key informants felt it was essential that Māori sit at the table (at whatever level of decision making) to ensure an equitable share.

A subtler margnalisation identified by some interviewees was the relegation of Māori providers, programmes or interventions to 'cultural add-on'. This often meant being brought in for Māori expertise but not being party to wider discussions around planning and development, implying a lack of confidence in the knowledge and skills of the Māori addiction treatment sector. This and other aspects of marginalisation also contributed to the vulnerability of a significant number of the NGOs that deliver Māori addiction treatment services.

Vulnerability

The vulnerability of the Māori NGO sector emerged as a key barrier to further sector development. Key informants commented on how fragile the Māori NGO sector could be and how prone it was to policy, funding or organisational changes, as well as events in the wider socio-political environment. For example, policies brought in by the National Government had a major impact on the Māori AOD sector in the early 1990s.

> *You know the National Government cut the benefit, so we lost a huge lot of our people who were coming voluntarily – they couldn't afford to come any more. They couldn't afford to be a support person for somebody who was actually having difficulty. All those sorts of things had major impacts because we were still just a network.*
> ***Moe Milne***

Over the last two decades, changes within the wider AOD sector relating to infrastructure, policies and funding requirements impacted heavily on the Māori NGO sector – with risks to sustainability, development and maintenance of rangatiratanga.

> *Just noticing the low capacity that there is within the NGO Māori AOD sector to hold onto what they've got, it seems the goalposts keep changing. So they're being thrown all of this stuff and instead of continuing to invest in the NGO sector, and Māori AOD in particular, it seems it might just be another excuse to slip the rug from underneath their feet, to shut them down and to bring services all back into the DHBs.*
> ***Te Puea Winiata***

The vulnerability of the Māori NGO sector tended to have a flow-on effect, impacting on the retention of kaimahi within Māori

addiction treatment services. In times of crises or particular vulnerability in the NGO sector, kaimahi chose to work in non-Māori organisations in order to ensure financial security and job stability.

In considering the challenges to the development of the broader Māori addiction treatment sector, key informants also highlighted specific issues affecting the development of both services and the workforce. These include:

- a lack of sound governance and management practice within Māori NGOs
- a perceived lack of clinical expertise within the Māori addiction treatment workforce
- a lack of Māori addiction treatment workforce capacity
- a lack of training in the application of tikanga and Māori models of practice
- a lack of consistency in training for kaimahi Māori.

He Putunga Mea Momo Kē

In the course of the various interviews undertaken for *He Tētē Kura*, and through the remembering and retelling of histories a number of main themes emerged. A number of other issues were expressed by the interviewees that should be recorded, and these are presented in the following pages.

Attitudes

A number of observations were made by key informants which may reflect their current 'observer' status in the sector. While most saw themselves as part of the 'establishment phase', many still contribute in various forms today.

> *I think we had a can-do attitude because we had nothing to lose and everything to gain. Now I'm not so sure. We are still fighting the same fight but we're also trying to hold on to the gains we're made over time.*
> ***Te Puea Winiata***

While the passion and commitment of the sector and many of the people in it has been clearly articulated in this monograph, there was some discussion around perceived attitudinal shifts.

> *There were no resources. You had to share, recycle and be innovative back then. I think today, some services and providers don't actually recognise that, they seem to want everything before they start, or they let it be a barrier to doing anything.*
> ***Te Orohi Paul***

Around workforce development, the participation of a contingent of people from Taranaki in the Te Wero me Te Aranga programme was raised as an example of commitment, role modelling and more importantly, attitude.

> *At the end they told us that this* [Te Wero me Te Aranga] *had been such a taonga for them. They then told us that some of us are really ungrateful, and don't realise what a taonga we have. Awesome kōrero.*
> ***Pam Armstrong***

Outcomes

Some of the key informants felt that while treatment might be the management of symptoms or improved health and social functioning, healing and recovery was more than that. At the end of the day, the establishment and development of kaupapa

Māori services was only a means to an end. The ultimate goal was healing and whānau ora.

> *How far have we come? We've got more choice. I think we are getting better access and people are staying longer. But are we getting any better outcomes? We need to be able to show we are making a difference.*
> ***Moe Milne***

In a similar vein, a number of those interviewed expressed encouragement of research and evaluation in order to demonstrate that they were making a difference. It was clear, however, that evaluating the effectiveness of Māori practice was not about a comparison with non-Māori but about quality assurance.

> *We have to stop being scared of having our practice scrutinised. If we're good, what's the problem? We need to show our whānau that they can have confidence in referring to us and confidence in what we do.*
> ***Terry Huriwai***

Problem gambling

Only a few of the key informants mentioned the recent development of problem gambling treatment services and workforce. The prevalence of problem gambling is relatively small, and the true impact of gambling still remains largely hidden. This lack of awareness of the impact of problem gambling on whānau and Māori communities contributes to a dismissal by some in the Māori AOD sector and many in the wider mental health sector of problem gambling as an issue to address. This perception is perhaps helped by a perceived lack of integration with mental health and AOD at the policy, funding and workforce development interface.

It's a bit like where we were in AOD about 10-15 years ago. We have a chance to be innovative, but also to learn from what happened in AOD. Problem gambling does cause problems for our whānau, it can coexist with AOD and mental health problems. Many of the skills we use are common to AOD and problem gambling. Maybe our way forward is to forget the diagnosis and do it all – especially if they are Māori.
Monica Stockdale

The problem gambling sector offers another pathway for development within the addiction treatment sector for some workers and services who have mainly been working in AOD. Potential opportunities may present themselves as greater integration between alcohol and other drug, problem gambling and mental health is promoted.

Research

In the mid-1990s, the Core Services Committee reviewed the evidence related to various AOD treatment models in order to make recommendations for funding. One of the findings from the review of the literature, and supported by submissions from around the country, was that there was no evidence to support greater effectiveness of residential treatment programmes compared to community-based services. The review also found there was no evidence that residential programmes longer than three weeks in duration were more effective for most people. As a result of the review, most residential services had to cut the length of their programmes (although the Taha Māori programme at Queen Mary held out for some time). While the decision of the committee affected Māori and non- Māori providers alike, it was feared that unless Māori services could show they made a difference, they risked being cut or lost.

> *I think that was why we had to do that thing with Terry* [Huriwai] *and our Optimal Treatment for Māori study – to prove there was a need and that they made a difference. We did that, we showed that Māori services aren't irrelevant. It's where you feel safe and comfortable and believe that you are going to get better*
> ***Tuari Potiki***

There continues to be a dearth of Māori-related research around addiction treatment. A contributing factor to this state of affairs might be the lack of Māori researchers who have an interest in or passion for the work of the sector.

Whānau groups and services

Some informants talked about issues of contract compliance that impacted on many services. This, they felt, sometimes inhibited practitioners from looking outside the box. Given that many services had come from a support background, it seemed some approaches that had been recognised as a strength no longer seemed to fit within the scope of service specifications and so were not seen as part of service contract.

> *I think we underestimate the power of awhi and whanaungatanga, of just having a group of people together in a semi-structured way, not in a clinical group way, just to awhi each other. It'll happen again. People will hear and they will come*
> ***Tuari Potiki***

A number of services and support groups work with whānau members as well as those directly affected by addiction-related harm. Although there is increasing support for the efficacy of this kind of holistic approach many service specifications and contracts are individually focused. A number of informants noted that whānau ora challenges all those who plan and fund services to think holistically.

Summary

At the beginning of this section we compared the history of the Māori addiction treatment sector to a whāriki, on which current and future developments continue to be built. The themes that emerged during the interviews were influenced, in part, by the experiences and insights of the people within this history. The emergent themes are not mutually exclusive or even conclusive, however two in particular emerge strongly throughout the interviews – transition and change, and passion and commitment.

Transition and change was influenced by external factors such as funding criteria, policy shifts and changes a workforce with growing knowledge and skills as well as expanding numbers. Adaptating to the changing environment and workforce presented opportunities but also raised concerns – around quality assurance and how to maintain the integrity of kaupapa Māori services and practitioners. Obvious solutions included maintaining supportive relationships (whanaungatanga), strong leadership and vision, self determination (rangatiratanga) and an ongoing belief that doing and thinking in a Māori way was valid and made a difference.

The history of the sector as outlined in Part I: Te Aka Roa mō te Oranga shows a bringing together of a number of people who were 'beavering away' at similar initiatives and with a similar vision. In that unity of a common goal – doing something for those with addiction-related problems – they provided support and tautoko for one another. Passion and commitment were clearly identified as a foundation for developments in the Māori addiction treatment sector and emanated in large part from primary Māori beliefs, values and practices. Rangatiratanga provided an anchor for developmental activities in the sector. In this context, core concepts and practices

of whakawhanaungatanga, awhi, manaaki and aroha were integral to the early endeavours and the building of services. These, along with the underlying and unifying component of being Māori, created a momentum and critical mass that would 'make things happen'.

While some things changed over the period under review, some things didn't. There are still concerns about recruitment and competence. Although there are more Māori working in addiction treatment now, and more have addiction-appropriate qualifications, one of the questions raised was whether an overly professionalised or educational pathway will dissuade those with experience of addiction-related harm from entering the sector – time will tell.

There was and is ongoing concern that Māori involved in addiction still aren't sitting at the decision-making tables or are marginalised by non-Māori making decisions that impact on Māori policy. While there has been an increasing commitment to whānau ora, a number of the informants noted an apparent lessening in passion for addiction and working with those affected by addiction-related harm.

Part III: Haere Tonu – Ways Forward, considers that which is beyond the horizon and the potential pathways towards these goals, as well as some of the ongoing challenges. In a sense, the key informants have not only been the navigators but also the kaihoe on the journey to date. Some of the insights shared during the interviews give us some perspective on the history but also beg a number of questions:
What have we learnt from our past?

How will the next generation of navigators and kaihoe step –up?

PART III: Haere Tonu – Ways Forward

Introduction

> *'Nā te ngaru i kawea atū, nā te ngaru i hokia mai' – always in a place of transition and that's the only constant.*
> ***Paraire Huata***

In Māoridom, we are often taught that history is what moves us forward – we must look back to advance into the future. However, as well as learning from our past it is imperative that we are able to anticipate and adapt to changes that the future might bring. Therefore, this final part of *He Tētē Kura* reflects on the lessons, issues and ongoing challenges identified by the key informants in the context of the current addiction and mental health environment. Specifically these revolve around:

- validation of Māori practice
- defining kaupapa Māori services and their constituent elements
- workforce development
- leadership and vision

The Context – 2008

In preparing to go forward it is important to know where we are starting from, as well as where we are going. Unlike the picture of the 1980s described in Part I, in 2008 we know much more about the nature and extent of addiction-related problems for Māori and there are now a number of policy documents at national and regional levels that appear to support addiction- and Māori-related issues.

Te Rau Hinengaro: The New Zealand Mental Health Survey

The recent New Zealand Mental Health Survey[76], [77], [78], [79] provides the most recent information on the prevalence of substance use-related disorders among Māori. This information, combined with data about those presenting at services and Māori population demographics, will be useful in helping to inform future planning and funding decisions. While Te Rau Hinengaro covers the prevalence of more common mental health disorders (including substance misuse), it does not include problem gambling.

Te Rau Hinengaro shows that Māori experience greater prevalence and severity of mental illness (including substance misuse) and a greater lifetime risk of developing mental illness, than other groups in New Zealand. Māori as a population experience similar rates of mental health-related problems (including substance use disorders) whether they live in urban centres or in rural communities. The survey also confirmed that there is an urgent need to address substance use-related needs for Māori.

As well as looking at prevalence, Te Rau Hinengaro also investigated individuals' level of contact with services. They found fewer than one in three Māori with a mental health need had contact with services. This could not be explained by the youthfulness of the Māori population or socioeconomic status.

[76] Oakley Browne, Wells and Scott (eds) (2006).
[77] Baxter (2008).
[78] Wells, Baxter and Schaaf (eds) (2007).
[79] Baxter et. al (2006)

Problem gambling

As stated earlier, Te Rau Hinengaro did not cover problem gambling. It is a small enough sector, however, to have had a number of national surveys completed and to have a centralised service database.

Abbott and colleagues (1999 and 2004), in their national gambling survey, reported high rates of problem gambling for Māori and poorer prognosis for males not of European descent. In terms of demand for services, there had been an increase in the number of Māori seeking help for problem gambling over the five years 1997–2002. The Problem Gambling Committee's 2002 help-seeking data showed Māori making up over 25 percent of new problem gambling service clients[80]. At June 2004, it was reported that Māori experience gambling problems at a rate six times greater than other New Zealanders, with Māori making up 30 percent of new callers to the Gambling Helpline and 33.3 percent of new face-to-face counselling clients[81]. Co-existing problem gambling and substance misuse and-or mental health conditions appear to be the norm rather than the exception.

Policy directions and mechanisms

There are now a number of national policy documents that provide support and direction for addiction and Māori initiatives. These provide leverage for leaders and opportunities for services to grow. The New Zealand Health Strategy (2000) and the New Zealand Disability Strategy (2001) both identify Māori and mental health as priority areas for action. Korowai Oranga (Ministry of Health, 2002) locates whānau ora as a central component of mental health/well-being and recovery, and more importantly, informs other Ministry of Health strategies and policies.

[80] Paton-Simpson et al (2003).

[81] Problem Gambling Purchasing Agency (2004).

Te Tāhuhu, the national mental health and addiction strategy,[82] explicitly identifies addiction and Māori mental health as some of the leading challenges to be addressed. The associated mental health and addiction action plan, Te Kōkiri[83], identifies the key actions, stakeholders and lead agencies required to implement the national strategy.

The development of national workforce development plans by Te Rau Matatini and Matua Raki, a national Māori mental health and addiction research agenda[84] and a revised Te Puawaitanga Māori Mental Health National Strategic Framework[85] all go some way to creating a landscape relatively more conducive to growing a strong Māori addiction treatment sector.

In 2008, and going forward, we have better information about our population, we have specific policy drivers to support and sustain the Māori mental health and addiction sector, and we have specific roles and organisations chanrged with advancing addiction and Māori-related issues.

The Ministry of Health has a dedicated addiction treatment analyst and will soon establish a further position with the particular brief of addressing Māori addiction-related issues. With the establishment of Matua Raki and Te Rau Matatini there is now specific attention being paid to workforce development and both organisations are building bridges between the Māori mental health and addiction sectors.

With the current addiction and mental health context outlined, the remainder of Part III reflects on the lessons, issues and ongoing challenges identified by the key informants.

[82] Ministry of Health (2005)
[83] Ministry of Health (2006)
[84] Ngā Papapounamu Amorangi (Ministry of Health, 2008) *in press*
[85] Te Puāwaiwhero (Ministry of Health, 2008)

Validation of Māori practice

A long-time struggle for Māori in a range of sectors has been the battle for recognition of things Māori and interventions that work for Māori. In the early history of the AOD sector, Māori tended to be marginalised and key informants were keen not to see the same patterns emerge in the future.

> *The only way I see us ever going ahead is getting recognition for being tūturu Māori. We can't afford to whisper in the corner that 'I'm a Māori' and stand up and do the action in English.*
> ***Titari Eramiha***

This type of comment arose specifically in reference to models of practice that had been developed and used successfully by Māori, but which failed to gain acceptance in the wider AOD sector. Often this has raised challenges around knowledge validation which has characteristically been determined within and by dominant cultural processes and practices.

> *The scary thing is that the only way they get to recognise the model is if it's been taken into an academic field and they've done some research, and some bright masters student uses it for their thesis. Next thing, the model is recognised and it's new, even if the models have existed in Māori communities for a long, long time.*
> ***Te Orohi Paul***

Despite potential issues of non-acceptance, Māori practitioners have continued to make use of values and practices that have served them for generations. The development of the Takarangi Competency Framework (referred to in Part I), has provided a means for some Māori working in addiction and mental health to be able to consistently articulate their practice, as well as providing clear pathways of learning for individuals, teams or entire organisations.

Thinking about our models of practice, I think that what we got by on was actually what I used to know at home on the marae. Feed them and then ask them to clean up the whare. If they could do it differently, we'd show them.
Monica Stockdale

More recent developments include the utilisation of kaupapa Māori theory, which has provided a platform for the validation of things Māori in contemporary society. This approach privileges Māori world views, as well as associated practices and aspirations. This has allowed the voices and perspectives of Māori to be acknowledged and promoted in contexts previously dominated by 'western' scientific traditions.

Now we have a kaupapa Māori theory, which is a theoretical base upon which we can have validation and justification of what we do as Māori people. Before that, anything Māori was rubbish, not worth even discussing. Now it's becoming credible.
Ngamaru Raerino

There is, however, some increasing dissatisfaction with the concept of kaupapa Māori among some practitioners and services in the sector. This dissatisfaction is partly due to the use of the term being seen by some as a means to further marginalise Māori rather than provide opportunities.

Kaupapa Māori is a term that is quickly outliving its usefulness. Funding bodies are continuing to encroach on this concept by insisting on criteria around who is kaupapa Māori and who isn't. Kaupapa Māori is now not about a point of difference or a Māori kaupapa - it's about identification of a system based on ethnicity rather than philosophy. Kaupapa ake is a term that may better serve Māori initiatives at this time.
Paraire Huata

Kaupapa services and practice

Since the early development of Māori addiction services, there has been considerable debate about the definition of kaupapa Māori and just what the constituent elements are of such services. Early kaupapa Māori services developed out of a desire to simply have more responsive services for Māori with addiction-related problems. These services had a clear foundation in Māori realities, however the exact nature and structure of these weren't necessarily identified until after programmes were up and running.

> *We really developed out of a need to have a different service. We didn't really talk about how those services were going to be delivered, other than to say, 'we'll run it on a kaupapa that was Māori'.*
> ***Terry Huriwai***

The National Māori Alcohol and Drug Summit at Manu Ariki in 2000 went some way to establishing a broad consensus around some of the elements of kaupapa Māori treatment services (ALAC, 2000). There was a lot of synergy between the discussions at Manu Ariki and the generation of policies in which kaupapa Māori services were defined (such as the Blueprint for Mental Health Services[86]), mental health service specifications (and more recently, the problem gambling dedicated Māori service specifications) and discussions around what defines kaupapa Māori research.

> *We just formed a network and it was hard, because we wanted it to be just Māori. You know, just kaupapa Māori services, no one else. Then of course, 'well what does that mean?' In the end it came down to the kaupapa, that we were about making*

[86] Mental Health Commission (1998).

a difference and we had a key focus on addiction, and if you were in with the kaupapa and passionate about it, then you were in with Ngā Manga Pūriri.
Pam Armstrong

Rather than focus on prescribing kaupapa Māori and its exact components in terms of service delivery, there has been a return to the basic focus of helping Māori with addiction-related problems, in whatever setting. It has been this kaupapa that has held these groups, organisations, services and kaimahi together.

We waste our time and energy debating what a kaupapa Māori service is. It shouldn't matter that they're based in a DHB, pan- tribal NGO or an Iwi service. At the end of the day, are they seeing Māori people and importantly delivering from a particular philosophical paradigm which is Māori-centred? Are they helping to reduce addiction-related harm? Surely that's the kaupapa and it isn't about contract compliance.
Terry Huriwai

While there appears to be less focus on defining kaupapa Māori in 2008, the impact of contemporary values on the application of kaupapa Māori services, as well as the increasing numbers of practitioners coming from a 'theoretical' rather than an experiential kaupapa Māori base, continues to be a concern for some.

I suppose this is some of my criticism about what's happening now in kaupapa Māori services. We've now got a learned Māori - I don't mean from academia or whatever - a lot of them are not coming from a tikanga base or from a kaupapa base.
Moe Milne

In a similar vein a number of the key informants also voiced a need for caution in the implementation of competencies for working with Māori. The comments relate to the development of culturally congruent practice, referred to in Part I, and the need to ensure that workers understand the principles underpinning practice and don't just 'go through the motions'. There was also concern around whether Māori would retain rangatiratanga over such frameworks. A number of people interviewed made the point that current practice and service delivery needs to better integrate a range of elements and tools.

> *It's more than just having a competency to say you're okay to work with Māori or that you understand karakia. That's something we trot out. Is it more important to start each session with a karakia or help people connect up to their own wairua, whatever that is? Some would say that process is karakia.*
> **Tuari Potiki**

Rather than being a set of rules, kaupapa Māori is best represented as a way of being and operating across a range of different areas.

> *It's not what is tikanga, but rather, how is it operationalised in this setting, or in this context – those things change.*
> **Paraire Huata**

More fully and clearly developing the parameters for operationalising kaupapa Māori was seen as a key element of workforce development by a significant number of the interviewees and crucial to the sustainability of the Māori addiction treatment field.

Workforce

Workforce development was a theme that came up in many of the interviews, particularly the need to increase the capacity and capability of the Māori workforce. Capacity in terms of numbers and capability in terms of delivering a Māori-responsive service that makes a difference.

As already mentioned, in the early days of the Māori AOD sector much of the workforce was made up of individual Māori who had been through treatment or who had been touched in some way by substance misuse. What sustained the development of this workforce was the passion of people who frequently came into the sector via treatment programmes and then into Māori-specific addiction training and courses.

> *A lot of the people doing CIT had been through treatment themselves, were in recovery, so it was sort of a pathway. I'm not sure how people get into the field because back in my day, CIT was quite easy to get into – two years clean and a desire. It was part-time over two years, so, you know, there weren't barriers just to get in. But there are now.*
> ***Tuari Potiki***

Increased priority given to an educational ('professionalised') pathway has resulted in the traditional pathways of recovery into the Māori AOD workforce being reduced. This in turn has affected the critical mass of potential kaimahi entering the addiction treatment sector. One of the current challenges for the sector is addressing workforce capacity and the factors influencing the recruitment of kaimahi into the Māori addiction workforce. Concerns were voiced by key informants over the lack of career options and advancement once Māori are working in the addiction treatment sector.

> *And then it's a bit of a dead end field at the moment. Where do you go once you're in AOD? Senior practitioner? Then what – very senior? Where do you go, maybe to mental health or problem gambling? What's the career pathway? Where do you end up? DAPAANZ and the AOD competencies at least give something to aim for as a practitioner.*
> ***Tuari Potiki***

A possible way forward for career pathways in the Māori addiction treatment sector might be via the role of 'whānau ora worker'. This might be a particularly useful role in enhancing a service's capacity and might help address both the harm minimisation and well-being (whānau ora) aspects of recovery.

A number of the key informants identified the challenge that competency frameworks will pose for some in the sector. Keeping the integrity of the frameworks so that Māori remain in control of monitoring and ongoing development will be paramount; however it is about quality assurance, not gatekeeping. There was some discussion relating to the increasing need to ensure non-Māori are somewhere on the framework – moving beyond cultural safety, cultural competence and cultural fluency to achieve actual Māori responsiveness.

> *But Terry's* [Huriwai] *study showed ages ago that it didn't matter where Māori went, they still expected to be treated as Māori and that's the important thing.*
> ***Tuari Potiki***

Leadership and vision

Workforce development in general rests on sound leadership, which affirms the passion and commitment to the kaupapa of workers in the sector and provides a vision for ongoing development. Underpinning many of the foundation stories was a commitment to and passion for the kaupapa, however those in leadership roles have had particular responsibilities for using their knowledge and skills to establish and consolidate services. As well as managers, kaumātua were identified as having a leadership role in the sector – often being essential components of quality assurance mechanisms for kaupapa services.

> *I don't think there's enough vision. I mean, we're still talking about developing treatment, which is important, but then what does that mean? We know what works and we do have models that give meaning to what we do.*
> ***Monica Stockdale***

The need for leadership and vision was clearly identified as a challenge that the Māori addiction sector needs to continually address if it is to consolidate, adapt and grow. A number of key informants suggested that the leadership of the sector, be it at a service delivery or national level, needs to be adaptable and ready for the 'long haul'.

> *We also need to think about where we are going, actually place ourselves twenty to twenty-five years out and ask, 'what does that mean and how will we get there?' Everybody is so busy that most don't actually take the time to do that visioning. Someone has to, and we need young ones coming through. If we're still doing what we're doing today in twenty-five years time, then we will have failed.*
> ***Moe Milne***

Another aspect of leadership touched on briefly in this history is recognition by the key informants that while establishment of services was one thing, maintaining them was another. Without sound management and governance a number of services were at risk – internally and externally.

Key informants described how poor management and internal politics played a part in the demise of a number of services in the Māori health and social service sector. For this reason, supervision and mentoring were identified as key requirements, not only to prevent leaders from burning out or losing their way, but to grow the next generation of kaumātua.

Those interviewed also believed that stronger kaumātua involvement in the Māori addiction treatment sector is also required if the sector is to grow and be sustained.

Most believe that kaumātua and kuia need to be good role models and also need to be supported to increase their knowledge of the mahi and services they work with and support. More importantly, they need to be more than figureheads; they need to be actively supporting kaimahi and the kaupapa.

> *One of the things we're asking for now is that Māori stand up. Kaumātua, kuia stand up! That's what I want, kaumātua and kuia who walk the talk and who are willing to be there supporting the workers through thick and thin. Let's throw some rocks at you and see if you're still there tomorrow. That's my long-term vision - kaumātua and kuia standing beside and behind our young ones who are doing the mahi.*
> ***Titari Eramiha***

The poster below of Ngāi Tahu Taua, Elizabeth Beresford was released circa 1994. The sentiment '***no matter who you are, enter,***' epitomises the spirit that was a part of the development of early Māori addiction treatment services and workforce. Taua Elizabeth was not afraid to challenge other kaumātua and she definitely walked beside and behind those in recovery, as well as the fledging workforce in Christchurch.

This poster is reproduced courtesy of ALAC.

Key informants also identified a need for the Māori addiction sector to become more politically 'savvy'. Lobbying was put forward as one means to achieve a stronger political presence. However, rather than lobbying to get recognition, as was the case in the early history of the sector, key informants believe that Māori in the sector should now be lobbying to protect and expand what they have. Again, this was closely linked to developing leadership and a collective within the sector.

> *I think one of the things we need to go forward is to have a stronger lobby platform for Māori. In the beginning we lobbied for mere existence. This time it's different, because there's a lot of integration, a lot of relationships and a whole lot more people. Advocacy to move Māori mental health and addiction treatment - Māori addiction needs to have a position, even a political position. I guess part of that is developing our leadership role.*
> ***Hakopa Paul***

Strong and proactive national leadership was identified as a key requirement for the realisation of aspirations for future services and the workforce.

> *It's wishing that we had a group that would stand up and say 'this is what's happening over here and what do we need to do about it' – maybe more of a political arm. Trouble is, those trying to do this are often doing it on top of all their other mahi. Sometimes it might seem easier not to get involved – it won't go away though.*
> ***Monica Stockdale***

While leadership was clearly identified as a key issue, the focus was not restricted to traditional or clinical expertise. There was a clear expectation by the key informants that everyone in the Māori addiction treatment sector needs to contribute, albeit at differing levels.

Rangatiratanga

There was, finally, an emphatic call by interviewees for greater rangatiratanga over the development of the mental health and addiction treatment sector. Key informants expressed their vision for a more autonomous and independent Māori sector, able to determine the nature and direction of future developments. This was seen as crucial to the development of a sector truly responsive to the needs of Māori affected by addiction-related harm.

> *I think the vision is to develop the sector so that it actually has its own research, its own tikanga, and its own psychiatrists – but in Māori terms. Māori mental health and addiction needs its own autonomy to develop, so people feel really proud. I think people used to feel really proud to work in our sector.*
> ***Monica Stockdale***

Conclusion

The stories, kōrero and whakaaro at the centre of *He Tētē Kura* represent only a part of the history of the Māori addiction treatment. One of the purposes for undertaking the writing of *He Tētē Kura* was to capture and record history as it was, however there is innovation and exciting developments happening in the current course of history.

The 'bush detox' of Hauora Whānui, the community outreach programme of Pai Ake Solutions, the Waka Taua Wellness Programme (Te Tīmatatanga) of Te Ariki Mana o Raukawa Addiction Services and the Waka Ama programme of Rangataua Mauriora are all examples of programmes and services we hope will be recorded and included in future publications. The purpose of recording some of the stories and aspects of the whakapapa of the Māori addiction sector has been to not only document history, but also to provide some indicators for future development of the sector.

A number of important themes emerged from the interviews, which clearly contribute to a foundation for ongoing growth and development in the Māori addiction treatment sector. One of the key messages to emerge is that, despite a number of challenges faced by the early pioneers of the sector, and not withstanding some limitations, there has still been expansion and growth. This has, for the most part, been based on passion, commitment and an ongoing belief that individuals and whānau deserve the best.

Findings from a recent survey (Robertson et al, 2005) confirm that a passion for working in this sector continues for many if not most Māori in the sector. However, it also suggests that this passion may differ from that displayed by those involved in the early development of the sector, many of whom came

from a recovery background. Regardless of the nature or source of the passion, a key task is developing a sector and service infrastructure in a manner that ensures that intrinsic passion is fostered and sustained over the longer term.

Another constant theme to emerge is the essential role of whānau, hapū, iwi, and community and how those links have anchored the sector throughout its development. While this sense of cohesion between whānau, hapū, iwi, community and the sector seems to have waned in more recent times, the central importance of the collective remains.

There is a risk that if workers become overly focused on professionalisation, and services become more driven by contract and contract compliance, then a vital and core element of Māori-focused addiction treatment will be lost. Therefore, in order to ensure a continued collective foundation there is a need to continue to:

- build, strengthen and maintain links between whānau, hapū, iwi, community and the sector around the country
- explicitly foster a collective whānau approach in the Māori addiction treatment sector and workforce
- work more as a unified and collective sector to achieve whānau ora for Māori with addiction-related issues and problems.

As well as contributing to the maintance of the unique nature of the Māori addiction treatment sector, this focus will also assist in maintaining coherence in the face of ongoing challenges and changes that occur. Strong leadership in a range of areas, including policy, research, management and clinical development, is integral to the continued growth and development of the sector.

This leadership needs to occur at a number of levels, so that explicit mentoring and succession planning is able to take place. This leadership role is not, however, limited to a few well-known figures in the sector, but rather falls upon everyone – even if only in terms of ensuring ongoing personal development.

> *I think that we all have a key role to play and I think we just can't sit back. It's clear there's a real need in the field, and so everyone's going to be getting a call it's important. We will be called on to help to push the kaupapa forward with and for the leadership – because that's what's needed and it can't happen without people like us. Even if we all just commit to personal and professional development – that's a start, that's something.*
> ***Pam Armstrong***

A number of specific developments have contributed to the growth of the Māori addiction treatment sector. The Taha Māori programme at Queen Mary is espoused as one of the most successful initiatives, but there have been other models of service and treatment delivery around the country that have also succeeded in providing positive outcomes for Māori.

As development in this area continues, the sector must draw on a broad range of resources in the development of models of practice, rather than relying on a single source. Continued engagement with research is also crucial to ensuring that development in this and other areas evolves in a systematic and rigorous way.

> *So that's my aspirations - we've described the dream upon the dream upon the dream and it's always been constant: that Māori deliver the service to Māori in a kaupapa Māori way, that we're resourced adequately to do that, and we're good enough to make a difference.*
> ***Moe Milne***

Current workforce development provides a framework for addressing many of the issues above, although ultimately, the ongoing development and success of the Māori addiction treatment sector rests with the passion and commitment of the workers within it. This in turn emanates from the values, beliefs and practices that have defined us as Māori and that continue to provide the parameters of our work and our lives.

'Mate atu he tētē kura,
ara mai he tētē kura'

THE END

APPENDIX 1: Method

Key Informant Interviews

In total, 14 participants agreed to be interviewed for the project, including:

- Moe Milne
- Titari Eramiha
- Pam Armstrong
- Delaraine Armstrong
- Ngamaru Raerino
- Te Puea Winiata
- Hakopa Paul
- Te Orohi Paul
- Peter Waru
- Monica Stockdale
- Margaret Manuka-Sullivan
- Paraire Huata
- Tuari Potiki
- Terry Huriwai.

These key informants were identified through a review of primary source documents and initial discussions with a range of people in the Māori addiction treatment sector. All participants were asked to sign a consent form prior to their involvement. Seven in-depth interviews and one focus group interview were conducted and all interviews were audiotaped. These interviews lasted between 60 and 120 minutes and provide the basis for the bulk of this monograph. Subsequently, follow up interviews with some key informants and others where relevant, were conducted to clarify and expand on some of the material elicited in the interviews.

All interviews with the key informants were done kanohi ki te kanohi (face to face) using a semi-structured interview schedule that identified specific areas to be explored. These areas of focus were developed to enable collection of the data necessary to record the history of dedicated Māori addiction services and the Māori addiction treatment workforce in Aotearoa New Zealand.

Timoti George, Terri Cassidy, Faith Winikerei, Cathy Tawera and Rawiri Evans provided additional historical information. Photos and a number of documents used come from the private collections of Monica Stockdale, Margaret Manuka-Sullivan, Barry Bublitz, Terri Cassidy, Tracey Potiki and Terry Huriwai.

Analysis of the Key Interviews

All key informant interviews were transcribed verbatim in their entirety, either by the writers or by a professional typist. All transcripts were compared with audiotaped recordings of the interviews to ensure accuracy, with changes being made as appropriate. Transcripts were then sent out to participants to be checked and, if required by participants, adjustments were again made on the return of the transcript.

Qualitative data from the transcripts was analysed using thematic analysis (Silverman, 2000). This involved multiple readings of transcripts in order to identify emergent themes. Key findings were coded and the codes were sorted into commonalities and merged using new codes. These new codes were then labelled as key headings and arranged as sub-headings under central theme titles.

APPENDIX 2: Te Ara i Rauhanga

In 1986, Ngamaru Raerino, ALAC Māori coordinator, was tasked with helping organisations establish associations and providing networking facilities – essentially to enable community mobilisation. One strategy to support this was the development of the network Te Ara i Rauhanga. It was an important initiative for Māori alcohol and other drug treatment workers and although it was a short-lived (about four years), it was influential in the development of many services and workers. Formed as a national body for Māori working in the AOD field it had its base in Auckland but tried to centre its activities around key services (centres of excellence) in the regions. Funding for the group's activities came through Inter-departmental Committee for Substance Abuse and ALAC resourcing as well as contributions from membership organisations.

In its later days there was a feeling within Te Ara i Rauhanga that it should alongside ALAC as a Māori or Treaty partner. Its key role was working with Māori to develop appropriate training, resources, services and policy to reduce alcohol- and drug use-related harm to Māori and their whānau. The reasons why the vision of a national organisation encompassing three Māori centres of excellence (Te Ara Hou, Te Tāwharau and Te Rito Ārahi) did not work related to accountability and control. Some members believed their accountability needed to be to their communities rather than Te Ara i Rauhanga in the first instance. Others working in the sector did not believe they needed to work through the centres, nor did they believe they needed to be subject to those centres or receive their funding through them.

Founding sub groups and members of Te Ara i Rauhanga are listed below.

Te Ara Hou

Te Ara Hou the resource centre grew out of the South Auckland Alcohol and Drug Committee, a small group that met infrequently as to discuss and plan for responses to Māori alcohol (and drug) misuse in the Auckland area. Early whānau members included Vic Calteaux and Paraire Huata (Presbyterian Support Services), Lynette Stankovich, Pip Winiata, Māori Marsden, Albie Tahana, Wally Te Ua, Aroha McDowell, Margaret Purkis and Harry Pitman.

Initial Committee office holders were Rau Kapa, Te Puea Winiata (secretary) and Lily Heihei. The resource unit was to continue to provide coordination, communication and support for individual workers, committees and alcohol and substance abuse agencies – particularly in the Auckland and Northland region. Te Ara Hou was the coordinating body for Te Ara i Rauhanga and initial inquiries about the 1986 Te Ara i Rauhanga national hui were referred to Margaret Purkis at the resource centre, based at 10 Boston Road.

Hakopa (Jake) Paul and Takarua Tawera, Owhata Marae, 2007.

Te Ara Hou the treatment service provider was established in 1985 to provide training and services for the prevention, assessment and treatment of substance abuse. The Presbyterian Support Services and ALAC jointly funded four Māori positions, filled by Te Orohi Paul and Wendy Davis at Te Ara Hou and Nau Epiha and Manurere Dimitroff at Presbyterian Support Services.

Te Orohi Paul took on the coordinator's role and the first team included Te Orohi and Hakopa Paul, Bruce Hamiora and Hinewehi Mohi. The second team comprised Te Orohi, Hakopa Paul, Takurua and Catherine Tawera, Nau Epiha (kaumātua), Norma Tango, Arthur and Tui Watene. The desire was the instilling and implementing of Māori values, principles and procedures in all spheres of their operation and communications. They also stated the service was to support individuals or groups with a Māori perspective or those who used a kaupapa Māori approach.

In 1997, family the trust that established Te Ara Hou formally handed over the service to Te Raukura Hauora o Tainui Trust. In 2004, Betty-Lou Iwikau (Senior Team Leader A&D Services), Te Orohi Paul (Board of Trustees) and Hakopa Paul (Kaitito o Te Toi O Mataariki) received a highly commended award at the Ministry of Health Whānau Ora awards ceremony on behalf of Te Raukura Hauora O Tainui. The award was for their Te Aka a Tane project. This was a new initiative that focused on assisting clients who have completed the Raukura Hauora's 12 week residential or community alcohol and other drug treatment programmes.

Te Aka a Tane uses the Te Toi O Mataariki model – well known as the 'awakening model' works on the concept that in order to realise your need for change, you need to realise you need for change, who you are as an individual and then your understanding of your cultural values as Māori.

After total immersion in the 12-week programme, the Te Aka a Tane project provides additional knowledge as well as the opportunity for whānau to be part of the client's journey of discovery.

Te Kōtahitanga-o-Ngā-Mōrehu

This NGO not only placed emphasis on a Māori approach to service delivery, but also saw that the Church had an important role providing a retreat for Māori whānau groups. The service had a short operating life, however the sentiment behind the programme – that there was a need for greater pastoral care for those experiencing addiction-related harm – continued. In 1997, there was encouragement by Ratana Pa for church workers to gain some knowledge of alcohol misuse so they could be more effective at a primary care level (Makowharemahihi, cited in Durie, 2000).

Te Rito Ārahi

Based in Christchurch, this NGO was established as a training centre that promoted Māori counsellors proficient in handling youth substance and other drug abuse. Members of the Māori community in Christchurch, with wider Māori support, formed Te Rito Ārahi.

Following on from the hui at Mataatua Marae in Mangere, people from around the South Island (including John Hippolite from Nelson and Cherry Wilson from Invercargill) met at Ngā Hau e Whā marae (where AA meetings took place) during Labour weekend of 1985 and formalised the call for an agency in the South Island.

The kaupapa was AOD; specifically, counselling and rehabilitation programmes with an emphasis on Māori-based solutions and methods. People attending the hui recognised the need for Māori to become involved in all aspects of healing, counselling and support for the growing numbers of Māori 'alcoholics', 'drug addicts' and 'substance abusers'.

Having lost confidence in the 'traditional' services available to them, who many believed only dealt with symptoms rather than causes and who were staffed by non-Māori who they could not relate to, the only recommendation that could come from such a hui was for a service of their own. It was felt that this service would be a guide for both the 'tender new shoots' in recovery but and those supporting recovery. Ted (Mita) Te Hae is often credited with the naming the service Te Rito Ārahi.

Some of the first committee office holders included Arthur Kapa (chair), Te Rangihiroa (Manny) Rehutai and Hohepa Hona (treasurer). Other active members of the whānau in the early years included Whio Sadlier, Jim King, Sam Kahui, Pukekawa Harris and Anaru (Joe) Mapa. Te Rito Ārahi began as an incorporated society and in the first four to five years was managed by a committee, with input from the whānau (essentially supporters of Te Rito Ārahi including service users). While there was limited clinical experience among the early committee members, there was a wealth of practical experience.

Throughout 1992-93, Te Rito Ārahi underwent something of a transition. Although it continued to operate (and still had the same aims and objectives), in terms of accountability it moved under the umbrella of Te Runanga o Ngā Maata Waka (a local pan-tribal organisation).

The new Te Rito Ārahi advisory committee comprised Taua Elizabeth Beresford and Anaru Mapa (whānau representatives), Norman Dewes (Ngā Maata Waka), Tui Epiha and Terry Huriwai (Department of Corrections), Daryle Deering (Healthlink South) and Jim Gillanders (Christchurch Polytechnic, bringing a management perspective).

Opening new Te Rito Arahi offices, Jane Manahi and Hohua Tutengaehe.

In 1994, Te Rito Ārahi again became a trust in its own right with the advisory committee members becoming trustees (except for Terry Huriwai, who was seconded from the Department of Corrections[87] to replace Brenda Lowe who resigned as manager).

In 2007 Te Rito Ārahi ceased operations and the trust has gone into abeyance.

Te Rapurapu Oranga

Te Rapurapu Oranga, an NGO based in Dunedin,specialised in dealing with youth and their whānau who were interfacing with Courts, Police and other crown agencies. Sharryn Barton was a particularly energetic personality in the development of this service.

[87] Terry Huriwai was seconded to Te Rito Ārahi under a Department of Corrections iwi secondment scheme. Unfortunately, no resources came with this particular secondment, so Ngā Mataa Waka had to work with ALAC to make the secondment viable.

Te Ao Mārama

This service provided assessment services delivered by dedicated Māori, themselves in recovery, who worked out of Kew Hospital in Invercargill. Early pioneers included Eddie Tauroa and Cherry Wilson. Eddie was also integral in the development of Te Huarahi ki te Oranga Pai in later years.

Other Members of the Te Ara i Rauhanga

Another key player in Te Ara i Rauhanga (at least in the South) was John Hippolite, based in Nelson. His dream was to set up an outdoor pursuits programme for Māori and he provided mentorship to a number of the younger members of the network at that time.

There have been many individuals and groups who have been involved in Te Ara i Rauhanga committees and hui over the years and only some have been mentioned here. In 1988, towards the end of its time, the national committee included:

- June Potts (Kaitāia)
- Elaine King (Auckland)
- Monica Rodgers (Auckland)
- Rangitukehu Paul (Wellington)
- Te Rangihiroa Rehutai (Christchurch)
- Hohua Tutengahe (Christchurch)
- Arthur Kapa (Christchurch)
- Lillian Morgan (West Coast)
- Ben Samuels (Dunedin)
- Sharryn Barton (Dunedin)
- Cherry Wilson (Invercargill).

APPENDIX 3: Te Ara i Rauhanga National Hui Mailing List 1986

Northland

June Potts (Whitiora Dependency Officer, Addictions, Kaitāia Hospital)
Paihere Hopa Paraone, (Addictions, Kaitaia Hospital)

Auckland

Lily Waipouri
Monica M. Rogers
Julie Ratu
Elaine Kingi
Tui Watene
Te Orohi Paul
Nau Epiha

Midlands

Zarnia Tipene (Dept of Justice/DSW)
Sharon Barlow
Ronnie Arapeta
Dorrie Henry
Jane Poutu (Thames Hospital)
Duke Tamaki (Justice Dept, Waikeria)
Titihia Rewita (Whakatane)
Margaret Tamaki
Arthur Flintoff (Taupo)
Puawai Te Nana
Mereana Wiking
Turuariki Boaza (Mātua Whangai)
Ngaire Dinsdale (Mātua Whangai)
Aroha G. Biel (Mātua Whangai)

Central

Darcy Mill (Justice Department)
Hemi Mill (Justice Department, Raetihi)
Marius Joseph (Wanganui)
Mere Tipu (Wanganui)
Yvonne Marshall (Palmerston North)
Charlie Nicholson (Dannevirke)
Rosemary Cassidy (Shannon)
Stella Mill (Justice Department, Raetihi)
E. D. Maihi (Wanganui)
Helen Mcgregor (Māori Warden, Wanganui)
Kahu Maremare (Wanganui)
Jenny Ellison (Dannevirke)
Tainui Witere (Māori Affairs, Dannevirke)

Te Arahina Ora Alcohol and Drug Centre (Levin)
Kathy Paul (Te Tawharau, Porirua)
Ada Foster (Lower Hutt)
Jon Te Au (Wellington)
Bev Mccombs (Tuku Aroha Trust, Wellington)
Ben Fox (Wairarapa Māori Executive, Carterton)
Rangitukehu David Paul (Te Tawharau, Porirua)
Elaine Annandale (Porirua East)
Carol Marino (Puangi Hau, Brooklyn)

Canterbury

Monica Stockdale (Hanmer Springs)
Val Hunia (Kaiapoi)
Dora Renfield
Hilda Bain
Te Rangihiroa Rehutai (Te Rito Ārahi)
Cilla Douglas
Tui Epiha (Probation Services)
Terry Huriwai (Probation Services)
Pukekawa Harris
Joanne Harris
Merle Karipa
John Paerata (Probation Services)
Malo Polata
Sue Tuhakaraina
Te Aoturoa Roberts
Pat Holland (Kingshore Girls Home)

Te Tai Poutini

Leone Campbell
Hamuera Williams
Gale Namana
Eileen Ngahuia Royal
Pihira Tainui
Trevor Thomas (Ngahere)
Lillian Morgan
Guide Parkin (Al-Anon Family Group)

Otago and Southland

Kely Gosling (Oamaru)
Ngahuia Katahi (Dunedin)
June Fittes (Cromwell)
Polly Paul (Southland)
Alec Waihirere (Invercargill)
Cherry Wilson (Invercargill)
Connie Hassan, Waitaki Hospital (Oamaru)
Paul Tamati (Mātua Whangai, Cromwell)
Paulette Paramenter Cromwell)
Christina Karaitiana

APPENDIX 4: Some Dedicated Māori Treatment Services 1994 and 1999

A number of treatment services listed in the 1994 ALAC Service Directory were described as providing services specifically for Māori, as were those listed in the 1999 New Zealand Database for Alcohol and Drug Services. There were other services which might have fitted into this list but their description in the directory or data base indicated that services were for Māori and non-Māori as opposed to primarily for Māori. Te Aroha Hau Angi Angi is included, despite usually being listed as part of Queen Mary Hospital. It is possible that some services have changed their name and so are not accounted for in the 2007 directory.

	Location	1994	1999	2007
Aronui Whānau Centre	Auckland	☺	☺	
Homai te Rongo Pai	Auckland	☺	☺	
Houhanga Rongo Drug and Alcohol Unit	Opotoki	☺		
Kaipara A & D Services	Dargaville		☺	
Pūangi Hau	Hastings		☺	
Te Ara Hou	Auckland	☺	☺	☺
Te Ārahina Ora	Levin	☺		
Te Ariki Mana o Raukawa Addiction Services	Tokoroa	☺	☺	☺
Te Aroha Hau Angi Angi	Hanmer	☺	☺	
Te Aturama	Auckland	☺		

	Location	1994	1999	2007
Te Awhina Kaha	Picton	☺		
Te Hau Ora Tinana	Wellington	☺		
Te Huarahi ki te Oranga Pai	Invercargill	☺	☺	
Te Ngaru ki Maniapoto Addiction & Education Centre	Te Kuiti		☺	☺
Te Rāngimarie Trust	Te Puke	☺	☺	☺
Te Rito Ārahi	Christchurch	☺	☺	
Te Roopu Manaaki Tairāwhiti Inc	Gisborne	☺		
Te Tai o Marokura Health and Social Services	Kaikoura		☺	
Te Uri e Powhiri Ana Inc	Auckland	☺		
Waiheke A & D Services	Waiheke		☺	

APPENDIX 5: Māori Addiction Treatment Services 2006

The following services held contracts with DHBs and/or the Ministry of Health for delivery of a range of addiction treatment services (alcohol and other drug/ problem gambling) up until the end of 2006. Some contracts are for as little as 0.5 FTEs. Those marked with an asterix (*) are DHB provider-arm services. While all providers state they have a primary approach that is Māori, their services are not exclusively for Māori.

Service	Affiliation or Mandate	Location	Descriptor
Puawaitanga	Te Rūnanga o Te Rarawa	Kaitāia	AOD
Hauora Whānui	Ngāti Hine Health Trust	Kawakawa	AOD
Ngā Manga Pūriri		Whangārei	PG
Te Ha o Te Oranga o Ngāti Whatua		Wellsford	AOD
Wai Health	Te Whānau O Waipareira Trust	West Auckland	PG& AOD
Piritahi Hauora Trust		Waiheke Island	AOD
Te Ātea Marino*	Waitematā DHB	Auckland region	AOD
Te Ara Hou	Raukura Hauora o Tainui Trust	South Auckland	AOD
Waahi Whānui	Waahi Whānui Trust	Huntly	AOD
Pai Ake Solutions Ltd		Waikato	AOD
Hauora Waikato	Hauora Waikato	Hamilton	PG & AOD
Rongo Ātea	Te Rūnanga o Kirikiriroa	Hamilton	AOD
Te Ngaru o Maniapoto		Te Kuiti	AOD
Te Ara ki Mana o Raukawa	Ngāti Raukawa Trust	Tokoroa	AOD
Te Utuhina Manaakitanga Trust		Rotorua	PG & AOD
Tūwharetoa Health Services	Tūwharetoa Māori Trust Board	Taupō	AOD
Te Korowai Hauora o Hauraki Trust		Thames	AOD
Te Rangimārie Trust		Te Puke	AOD

Te Rūnanga o Ngāti Tahu Whaoa Hauora	Poutiri Trust	Reporoa	AOD
Te Ika Whenua Hauora	Poutiri Trust	Murapara	AOD
Te Roi o Heihei Alcohol and Drug Service	Poutiri Trust	Ōpōtiki	AOD
Ngāti Awa Health and Social Services	Ngāti Awa	Whakatane	AOD
Ngāti Porou Hauora	Ngāti Porou	East Coast	PG & AOD
Te Hauora o Turanganui-a-Kiwa	Te Rūnanga o Turanganui-a-Kiwa	Gisborne	AOD
Manaaki House		Wairoa	AOD
Kahungunu Executive	Kahungunu Executive ki Te Wairoa Charitable Trust	Wairoa	AOD
Te Rangihaeata Oranga		Hawkes Bay	PG
Ngā Punawai Aroha*	Hawkes Bay DHB	Hastings	AOD
Te Whatuiapiti Trust		Waipukurau, Ōtāne	AOD
Te Hauora Rūnanga o Wairarapa	Te Hauora Rūnanga o Wairarapa	Masterton	AOD
Te Whānau Manaaki o Manawatu		Palmerston Nth	Consumer
Best Care Whakapai Hauora	Tanenuiarangi Manawatu Inc	Palmerston Nth	PG & AOD
Mahia Mai a Whai Tara	Tui Ora Ltd	Waitara	AOD
Raumano Health Trust	Tui Ora Ltd	Pātea	AOD
Ngāti Ruanui a Tahua	Ngāti Ruanui	Hāwea	AOD
Toi Ora	Tui Ora Ltd	New Plymouth	AOD
Te Runanga o Raukawa Alcohol and Drug Support Service	Te Rūnanga o Raukawa	Levin	AOD
Rangataua Mauriora	Ngāti Toa	Takapuwāhia, Porirua	PG & AOD
Ngā Te Kau	Wellington Tenths Trust	Wellington	AOD
Te Rapuora o te Waiharakeke	Blenheim	PG & AOD	
Te Kahui Hauora o Ngāti Koata Trust	Te Kahui Hauora o Ngāti Koata Trust	Nelson	AOD
Te Makatea Hauora	Te Awhina Marae	Motueka	AOD
Te Rito Ārahi		Christchurch	AOD
He Waka Tapu	He Oranga Pounamu	Christchurch	PG & AOD
Ngā Kete Mātauranga Pounamu	Ngā Kete Mātauranga Pounamu Charitable Trust	Invercargill	PG & AOD

APPENDIX 6: Kaupapa Māori CIT Training 1991-1992

Participants in the three-month residential pilot training at Hanmer Springs in 1991 included:

- Akinihi Dawson (Men's Network, Kaitāia)
- Dick Wharerau (Men's Network, Kaitāia)
- Puti Lancaster (Te Ara o te Whakaaro Pai and Wairua Tahi Trust)
- Terri Cassidy (Waipareira Trust)
- Rahera Falwasser (Ngāti Awa Social Services)
- Maurice Kereopa (Ngāti Awa Social Services)
- Sonya (Kumeroa) Mathews (Te Rito Ārahi Māori Alcohol and Drug Treatment and Resource Centre)
- Adrian Te Patu (Te Rito Ārahi Māori Alcohol and Drug Treatment and Resource Centre)
- Stephen Te Moananui (Recovery Whānau, Tīmaru)

The first graduates of the Kaupapa Māori CIT A&D Certificate course in 1992 were:

Carrie Albrecht
Terri Cassidy
Wikii Daley
Lea Gage
Marilyn Gardiner
Ruihi Haira
Puti Lancaster
Arihia Te Hira
Rick Winiata
Mana Winikerei
Gayle ??
Kataraina ??
Lyn ??
Faith Winikerei

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