Māori and Addiction Treatment Services

A paper prepared for the National Committee for Addiction Treatment

AUGUST 2012
HE MIHI

He hōnore, he korōria ki te Atua. He tangi aroha ki ō tātou tini mate e hingahinga mai nā i ngā marae maha puta noa i te motu, mai i tēnā pito, ki tērā pito. E kore e taea ēnei ahuatanga te karo, nō te mea, ka pa ki tēnā, ki tēnā, ahakoa ko wai. Heoi te kōrero, e ngā mate haere, whakangaro atu ki tua o te ārai, haere atu ki ngā mātua tūpuna kei konā hei awhi i a koutou. Na reira, haere, haere, haere

Mō te kaupapa o te pepa nei, ka rere ngā mihi maioha ki ngā tangata tohutohu, ngā kaiwhakahaere, ngā kaimahi, ngā whare oranga, ngā tangata whaiora me ō koutou tūpuna. Kei runga rawa koutou, kei a koutou te mana, te ihi me te wehi o tēnei kaupapa taumaha. Nō reira, tēnā koutou, tēnā koutou, tēnā koutou katoa

Kāti
Introduction

This paper provides a summary of alcohol and other drug (AOD) treatment services available to Māori, principles and good practice approaches that support the wellbeing of tangata whaiora, and exemplar models of approaches taken by three Māori AOD service providers.

Funders and planners will be able to consider the different approaches, principles and good practice highlighted in this paper when making decisions on the volume and design of AOD treatment services for Māori.

Three non-government organisations were selected to showcase approaches to AOD service delivery that have allowed them to make some positive changes for tangata whaiora. These three providers do not cover the full spectrum of AOD treatment services available.

A sample of informants were interviewed for the development of this paper, including Māori AOD key workers, and both government and non-government administrators and managers working in AOD services. Ministry of Health officials (from the Addiction Treatment Services and Māori Health Improvement Teams) were also interviewed to find out what influences their funding allocation decisions.

Background

The context of this paper takes into account the following key facts:

- One in three Māori will experience a substance-use disorder at some time in their life
- Māori are more likely to use AOD treatment services than any other ethnicity
- More Māori access mainstream AOD services than services from Māori AOD or mental health providers
- In 2009/10 both the Māori male rate (4837.1) and the Māori female rate (3279.1) for clients seen in AOD treatment services were higher than the non-Māori male rate (2682.7) and the non-Māori female rate (2218.3, age-standardised, per 100,000 population). The Māori male rate was more than double the non-Māori female rate
- Māori had significantly higher rates than non-Māori for anxiety, conduct and substance abuse disorders
- Māori tamariki (children) and rangatahi (young people) are seen three times as often as non-Māori in AOD treatment services. Māori adults are seen two and a half times more often in AOD treatment services than Pacific adults or nearly three times the rate of non-Māori and non-Pacific.

---

3 Christchurch Health and Development Study: Mental Health of Young Adults (Otago University)
4 Source: DHB Service Profiles. Data for 2002/03 to 2009/10 extracted 7 June 2012, 2010/11 extracted 26 June 2012
Table 1: Vote Health Spend on Māori Mental Health and AOD 2009/10

<table>
<thead>
<tr>
<th>Mental Health and Addiction Service Category</th>
<th>2007/08 ($m)</th>
<th>2008/09 ($m)</th>
<th>2009/10 ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Youth (includes Child &amp; Youth alcohol and other drugs)</td>
<td>12.2</td>
<td>12.2</td>
<td>12.2</td>
</tr>
<tr>
<td>Alcohol and other Drugs (excludes Child &amp; Youth A&amp;D)</td>
<td>14.8</td>
<td>16.9</td>
<td>15.4</td>
</tr>
<tr>
<td>Workforce Development (includes Provider development)</td>
<td>6.6</td>
<td>7.5</td>
<td>4.3</td>
</tr>
<tr>
<td>Community/ Residential services for combined ages</td>
<td>48.6</td>
<td>52.3</td>
<td>48.0</td>
</tr>
<tr>
<td>Problem Gambling</td>
<td>3.6</td>
<td>3.3</td>
<td>2.5</td>
</tr>
<tr>
<td>Other Mental Health Services</td>
<td>2.8</td>
<td>1.5</td>
<td>2.3</td>
</tr>
<tr>
<td><strong>TOTAL MĀORI MENTAL HEALTH AND AOD FUNDING</strong></td>
<td><strong>104.6</strong></td>
<td><strong>111.2</strong></td>
<td><strong>102.0</strong></td>
</tr>
</tbody>
</table>

From 1 July 2007 to 30 June 2010, the total Māori mental health (and addiction) funding allocated to District Health Boards (DHBs) to purchase AOD treatment-related services decreased by $2 million (i.e. $104.6 million in 2007/08 compared to $102 million in 2009/10).

In 2008/09, there was a large increase in funds allocated to residential services, and a slight increase in adult community AOD services.

In 2009/10, funding for adult community AOD services, workforce development, residential services and problem gambling services was less than in the previous year.

**Definition of AOD Service Treatment Services**

Addiction treatment services are those that assist people and their families affected by a range of disorders, described in the DSM-IV\(^6\), including the substance use (abuse and disorder), pathological gambling as well as other impulse control disorders increasingly being referred to collectively as ‘behavioural addictions’\(^7\).

For the purposes of understanding AOD treatment, services comprise a variety of interventions for different populations with varying individualised goals. The table below provides the continuum available in the New Zealand health sector.

AOD interventions operate along a continuum of care, with early and brief interventions (relatively inexpensive) at one end of the spectrum\(^8\).

For those with substance abuse from mild to moderate AOD dependence, interventions can be provided by a range of practitioners in primary care settings, including general practitioners and other allied professionals (e.g. Corrections Department staff) at an early stage where substance use is first identified as hazardous or harmful.

---

\(^5\) Ministry of Health Data, 2012

\(^6\) DM-IV is the Diagnostic Manual of Mental Disorders, Fourth Edition. It is published by the American Psychiatric Association and covers all mental health disorders for children and adults. It also lists known causes of these disorders, relevant statistics and prognosis as well as optimal treatment options for consideration.

\(^7\) 2007 Matua Raki, pg. 3

\(^8\) National Committee for Addiction Treatment, 2008.Pg. 4.
Specialist and intensive AOD treatment interventions such as withdrawal management, specialist case management and counselling, opioid substitution, intensive day-programmes, residential programmes and therapeutic communities are also available. These intensive AOD treatment interventions (at the other end of the continuum of care spectrum) are tailored for those with moderate to severe AOD dependence. They are more costly and resource intensive.

The AOD treatment sector operates in both generic and ethno-culturally specific and in primary care (health and social services) and specialist settings.

<table>
<thead>
<tr>
<th>AOD Treatment Services</th>
<th>AOD Treatment Mix</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction AOD Community Support Service</td>
<td>Withdrawal management</td>
</tr>
<tr>
<td>Addiction AOD Consultation and Liaison</td>
<td>Comprehensive assessment</td>
</tr>
<tr>
<td>Addiction AOD Acute Package of Care</td>
<td>Psychosocial therapies and approaches</td>
</tr>
<tr>
<td>Addiction Day Treatment Programme</td>
<td>Kaupapa Māori addiction treatment</td>
</tr>
<tr>
<td>Addiction Managed Withdrawal Home Community Service</td>
<td>Residential and Therapeutic Communities</td>
</tr>
<tr>
<td>Addiction Managed Withdrawal Inpatient</td>
<td>Pharmacotherapy</td>
</tr>
<tr>
<td>Addiction Community Based AOD Service</td>
<td>Continuing care</td>
</tr>
<tr>
<td>Addiction Early Intervention AOD Service</td>
<td>Addiction Intensive AOD service with Accommodation</td>
</tr>
</tbody>
</table>

Based on the contextual information above, there is a continuing and very real need for Māori to have access to effective and appropriate alcohol and other drug treatment services.

Evidence\(^9\) suggests that the majority of Māori are accessing non-Māori (mainstream) services. However, Kaupapa Māori AOD treatment services have better retention rates of their Māori clients. The funding available does not cover the need or the demand for these services.

There is a lack of strong evidence of how effective AOD services are, especially for Māori. This is an area that could be better researched if funds were made available. Government, and non-government service providers are all constrained by funding, some more than others. The challenge with providers has been how sustainability is managed alongside service provision and meeting the various levels of AOD service need. Some grasp this challenge easier than others, while some safely struggle through it. Given the ongoing challenge, the approach to AOD service provision to Māori has adapted accordingly. What most providers have in common are their unique perception of their kaupapa (each to their own) and the principles that underpin their practice.

---

“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.”

Māori AOD Providers

In addition to DHB provider arm AOD services, there are up to 41 Māori providers funded by DHBs to provide AOD-related services, as follows:

<table>
<thead>
<tr>
<th>DHB</th>
<th>No. Of Providers</th>
<th>DHB</th>
<th>No. Of Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>2</td>
<td>Mid Central</td>
<td>4</td>
</tr>
<tr>
<td>Auckland</td>
<td>1</td>
<td>Whanganui</td>
<td>1</td>
</tr>
<tr>
<td>Waitematā</td>
<td>2</td>
<td>Wairarapa</td>
<td>1</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>1</td>
<td>Capital and Coast</td>
<td>2</td>
</tr>
<tr>
<td>Waikato</td>
<td>5</td>
<td>Nelson Marlborough</td>
<td>3</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>10</td>
<td>West Coast</td>
<td></td>
</tr>
<tr>
<td>Lakes</td>
<td>1</td>
<td>Canterbury</td>
<td>1</td>
</tr>
<tr>
<td>Tairāwhiti</td>
<td>2</td>
<td>South Canterbury</td>
<td></td>
</tr>
<tr>
<td>Taranaki</td>
<td>3</td>
<td>Southern</td>
<td>1</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Case Studies

The next part of this paper examines principles of good practice, and considers examples that have helped providers with:

- Innovative service approach
- Successfully securing funding
- Developing a culturally and clinically competent workforce
- Due diligence
- Clinical and cultural supervision
- Respecting tikanga and protocols that support the recovery journeys of whaiora and whānau.

International and local evidence suggests that an optimal addiction and mental health system is underpinned by principles that emphasise overall health, in which prevention works, treatment is effective and people recover.

While completing the three Māori AOD provider case studies, it was found that all had developed a vision and worked with guiding principles. These were grounded in Te Ao Tawhito, but all three service providers had breathed life into operationalising the vision and guiding principles, to respond to the contemporary realities of staff, whaiora and whānau they work with.

Provider selection was based on location, innovation, knowledge of the health sector, their approach and sustainability success.

---

These three providers are not intended to represent all Māori AOD providers, or any approaches each provider independently uses. They are merely individual providers which are successfully providing services to tangata whaiora in their service regions.

Showcasing some of their successes and experiences in this paper will give other AOD providers the opportunity to learn, and perhaps adopt, different practices when working with tangata whaiora.

Each tangata whaiora has a unique journey. Their experiences and learnings, including those given to them by Māori AOD service providers, contribute to their overall journey to wellness.

Case Study One: Pai Ake Solutions Limited, Waikato

Pai Ake Solutions Limited (PASL) is a Hamilton-based provider of community mental health and AOD treatment services to pakeke (adults) and rangatahi living in the Waikato region.

Most of their clients are Māori.

PASL was set up in 2002 with the goal of providing services responsive to whānau needs and preferences which addressed the realities of complex health, social and mental health and addiction problems.

With the support of key Māori health leaders, PASL set up an AOD Consumer Advocacy service with 2.2 FTE non-clinical positions. Within a very short time, an additional 2.8 FTE mental health positions were sourced.

After a closure of another local AOD service, PASL accumulated a further 2.5 FTE AOD positions. Following this, PASL secured a rangatahi AOD education programme.

Today, PASL has seven FTE positions and is supported by three FTE administrative staff.

It has 780 registered clients, with 249 active clients. Each key worker has between 16-20 clients, many of whom have complex needs.

Services that create positive changes

Staff believe it is crucial to have high-trust relationships with their clients. They make a real effort to build these relationships, to help keep client anxiety levels low, encourage their feelings of safety and path to wellness and recovery. For example, within safe boundaries, staff will visit clients at home, meet their whānau and have open counselling sessions at alternative locations such as parks or cafes.

The programmes have been successful for many clients, in particular the tāne (men) and wāhine (women) groups that support people who are affected by AOD and mental health illnesses. These groups run separately on a 15-week programme that focuses on leading healthy and meaningful lives. PASL encourages clients to attend with their whānau, so that whānau are part of the healing journey.

Since 2002, PASL has seen more than 1000 men through ‘Te Hikoi o Ngā Tāne’: the Walk of Men programme. More than 150 women have been through the ‘Te Ara Wāhine’: the Journey of Women. Following the Te Hikoi o Ngā Tāne programme, the men in continue a
support group of their own (with support from PASL), called ‘Te Ahi Kaa’. This programme is intended to encourage greater independence and confidence among the participants.

The growth of Pai Ake Solutions

PASL has always remained relatively small, and has never taken on more services than it can handle.

The organisation registered as a company with one director in 2002, but its governance style is integrated with operations, i.e. organisational decisions are made between key senior staff members.

Workers rate highly the organisation’s leadership style. According to one staff member, the leadership is supportive, relaxed and professional. Staff are encouraged to be creative in their delivery style, thinking outside the box to really ‘touch’ a person’s life.

PASL is rapidly building the expertise of its staff. There is a demonstrable effort from management to support a high level of professional competence among staff. It is mandatory for all workers to participate in higher learning, with one employee completing his PhD. External supervision is also mandatory for all staff, as a means of ‘getting ahead’ and increase the quality of service.

The practice coordinator leader also provides external supervision to other organisations’ clinicians, as well as group training (e.g. Community-based screening and Brief Interventions for Alcohol and Drug Problems) to providers. PASL does not charge for this training—it’s about relationships and upskilling the Māori workforce.

The challenges

Like most non-government organisations, the PASL pay scales are not aligned to market rates. However, these pay levels do not discourage people from working there. Some staff accepted a drop in salary when they joined the organisation because they were passionate about its kaupapa.

PASL is a close-knit whānau-orientated service that supports its employees in training and development, as well as their personal wellbeing paths. The kaupapa of PASL is ‘well whānau, well staff, well clients’.

While it is fair that wash-up or claw back clauses in contracts exist, as it creates efficiencies and accountabilities, these clauses also cause financial frustrations for employers. In the case of PASL’s contract, volume is important, and whilst some clients require more support (and therefore longer counselling sessions), PASL has to manage volumes and the classification of workers. In the latter case, some of the key workers are at level 6 with their training, but clinical FTE positions are associated with workers at level 7. This means key workers working with whānau cannot claim volumes of a clinical FTE.

According to staff, the service fits around the clients, their whānau and the employees. All three parties need to feel rewarded. PASL encourages open communication among staff.
The rewards

Through PASL’s experience and relationship with its clients, it has successfully secured six Corrections Department contracts to work with male inmates of Springhill Prison. More contracts have been offered by other government departments, but PASL wants to maintain a meaningful quality service.

PASL has close working relationships with key residential services throughout New Zealand such as Te Rūnanga o Kirikiriroa, the Hamilton Bridge Programme, Higher Ground and Nova Trust Board (Christchurch). Services commonly refer clients to them, while PASL also refers clients to other services, particularly residential services such as Te Utuhina Manaakitanga Trust, which offers a Kaupapa Māori service.

PASL in the future

PASL has recently engaged in strategic and business planning with the hope of expanding in the future. If PASL was to grow and offer a more comprehensive service, it would like to see the addition of a social worker and an occupational therapist to support the type of add-on services its clients need.

PASL wants to continue to offer a client-focused quality and professional service.

Case Study Two: Te Utuhina Manaakitanga Trust Services, Rotorua

Te Utuhina Manaakitanga Trust is the community alcohol and other drug service in Rotorua that offers treatment services to Māori and non-Māori.

The pakeke team services the Rotorua community and a mobile rangatahi team services the Lakes region, covering Rotorua to Turangi.

The trust also provides a 17-bed Kaupapa Māori residential service (Te Whare Oranga Ngākau) for the Midlands region, which covers the Lakes, Bay of Plenty, Waikato, Taranaki and Tairāwhiti DHB areas. The trust has a total of 42 staff members.

What has made Te Utuhina Manaakitanga Trust successful?

The trust has been operating for 24 years. Changes in governance and management five years ago led to it securing more health contracts relatively fast, in particular the rangatahi services with secondary schools and the development of Whare Oranga Ngākau.

Te Utuhina Manaakitanga Trust was awarded regional contracts within five years of establishing the AOD service.

According to general manager Donna Blair, success comes down to the passion, commitment and hard work from all workers involved in running the services.

Another significant factor is having good relationships with other providers, the funders and understanding their reporting requirements.

In addition, staff have worked hard to maintain and improve relationships with the community. It helps that approximately two-thirds of the trust staff are from Te Arawa, and
have strong links and support in the community. Te Arawa iwi endorses Te Utuhina Manaakitanga Trust, which also provides credibility and support for its services.

The general manager encourages an environment where the staff and organisation are seen as part of the community. This means participating in community activities, being part of the Te Arawa culture and weaving into the local networks. This has included supporting a local kapa haka group and fundraising with the Cancer Society and other charities.

People from a wide variety of cultures use Te Utuhina Manaakitanga services, including Asian, Pacific and Pakeha.

The Trust also provides AOD training and support for people in other sectors such as the forestry industry, and the local Police Adult Diversion Scheme, where AOD counselling services are offered (and mandatory) to those offenders on the scheme.

Ms Blair supports and encourages staff to actively participate in training and development. Some staff have been past service users, and with the right support and training have progressed to become trust employees. According to Ms Blair, it is important for the community to note lifestyle changes like these, particularly for those people who think AOD use is a common, daily occurrence.

*Residential Programme: Te Whare Oranga Ngākau*

The 24-hour residential programme has 15 AOD beds and two methamphetamine beds, with two clinical FTE and five non-clinical FTE positions.

Thirteen and a half (13.5) FTE staff work a 24-hour roster. There is a separate house for tāne (nine beds), and one for wāhine (eight beds), which offers the 12-week residential programme.

Some whaiora stay longer than 12 weeks, depending on the level and term of support required. A Kaupapa Māori environment forms the basis of the non-clinical and clinical services, with a set day programme based on tikanga, with clinical oversight.

The residential programme allows for both AOD treatment and tikanga activities e.g. AOD process groups, and one-to-one counselling to occur alongside kapa haka, mau rakau and other activities. The programme is therapy based.

Upon entering the residential programme, whaiora are welcomed into a whānau environment with a whaiora and staff-led whakatau. A kaihautu (Whānau Ora worker) works alongside the whaiora to engage their whānau. Whaiora get follow-up visits from the kaihautu once they have completed the programme. This depends on their whānau plan as well as monitoring tangata whaiora through the use of the ADOM (Alcohol and Drug Outcome Measurement) tool. Follow-up contact is also made up to 12 months on completion of the programme. This also supports a re-orientation back to AOD services, should someone have relapsed.

A challenge for the residential programme is maintaining “filled” beds. There are dips during the year, placing pressure on funding. In response to ebbs and flows of bed vacancies, staff often visit providers across the Midland region to encourage referrals and explain the referrals process.
Community AOD Services

The community AOD service covers the Lakes region, with staff located in Taupō, Turangi and Rotorua.

The community team has 17 AOD counsellors for the pakeke and rangatahi services. Part of their mahi involves staff visiting the Rotorua police cells each weekday morning to do assessments, or discuss support needs.

Programmes have been developed based on the needs of whaiora, including one-on-one, whānau and couple counselling and group sessions.

Where possible, the service attempts to accommodate the whaiora e.g. evening programmes such as ‘Ko Te Rito’ held on Tuesday evenings. Up to 30 people attend this eight-week programme, which is set up for those whaiora referred to mandatory counselling by the probation service.

The trust also runs the Ko Te Rito programme once a week during the day. The community service runs a number of groups: Waiata, Awhi Whānau (support) and Mā te Wā (pre and post treatment). Throughout the year, other groups – such as gender specific roopu – operate as required.

A high number of referrals come through the hospital, Police, the Corrections Department, the courts system, general practitioners and mental health services of both Māori and non-Māori.

The trust’s Māori staff are able to offer culturally safe, tikanga-based support to whānau. While voluntary, the Takarangi Competency Framework has given the trust an additional point of reference in its workforce development.

Case Study Three: Ngā Kete Mātauranga Pounamu Charitable Trust, Murihiku and Wakatipu

Ngā Kete Mātauranga Pounamu Charitable Trust (referred to as Ngā Kete Mātauranga) is based in Invercargill, and services the Murihiku and Wakatipu regions.

It provides a range of services, primarily to Māori, including public health (suicide prevention, substance prevention, disability information, smoking cessation, gambling prevention), community AOD, nursing support, rongoā Māori, student support and employment support services.

Ngā Kete Mātauranga has adult and youth community AOD services. The AOD contract requires it to meet an annual target of 2800 client contacts. For 2010/11, this target was exceeded, with 3258 contacts recorded.

On top of this, the organisation also works with groups. In 2010/11, the trust worked with 98 groups, with an average of 8-10 people per group. While Southern DHB has provisions for clawbacks if targets are not met, that provision has never been used.

For the past seven years, the organisation has received the same price for its AOD contract – this price has not considered the rise in the cost of living.
Workforce Development as a priority

Ngā Kete Mātauranga has the largest pool of AOD FTE positions (comprising 7.5 FTE positions) in the lower South Island region for all providers. Part of this includes 4.5 FTE adult AOD positions, one FTE rangatahi AOD position, one FTE problem gambling counsellor and an AOD intern trainee who is funded through the Te Rau Matatini scholarship (Hoe Tahi). Their caseloads are large, with an average of 26 cases per FTE position. If more funding was available, the team would engage an additional one FTE position in Murihiku, and 0.5 FTE in Wakatipu.

Workforce development is a key priority for Ngā Kete Mātauranga, and succession planning is important. All AOD staff belong to professional bodies, with the preference being members of Addiction Practitioners’ Association Aotearoa New Zealand (DAPAANZ). Other professional affiliations are with the New Zealand Association of Psychotherapists.

All AOD staff are encouraged to undertake further training, and external supervision is a mandatory part of each staff member's employment. According to management, working with similar professionals within the wider AOD sector is a means of lifting employee service knowledge and quality standards.

The trust says that while salaries may not be competitive, other non-financial benefits and rewards are provided to staff, such as supporting employees with their whānau commitments.

Referrals to residential care

The availability of AOD specialist services is restricted to the local DHB (provider arm). The Salvation Army (one FTE position) is the other local AOD treatment provider.

Ngā Kete Mātauranga can refer people to residential care in the South Island – the North Island is not generally funded.

The trust can also refer directly to the Mauri Ora programme that He Waka Tapu (Māori health provider) operates. This is a Māori AOD eight-week residential programme for pakeke based in Christchurch.

The trust’s Māori clients prefer Kaupapa Māori services. Non-Māori clients are recommended to the Salvation Army in Christchurch or Dunedin, or St Marks in Blenheim.

Moana House (Dunedin) or Odyssey House (Christchurch) are the preferred residential providers for referrals from the community probation service. In the first instance however, Ngā Kete Mātauranga would normally recommend the tangata whaiora directly to the probation officer if the tangata whaiora requires residential treatment.

For tangata whaiora with co-existing disorders, Ngā Kete Mātauranga makes dual diagnosis referrals to Odyssey House in Auckland. However, only two South Island dual diagnosis funded beds are available for South Island women, and there is always a large waiting list. The local DHB (through its assessment team, Drug and Alcohol Specialist Services) will undertake the assessment and approval process before referrals through to any residential service (except He Waka Tapu).
Culture of Continuous Improvement

There is a clear push to have a culture of continuous improvement and a pathway of ISO accreditation within Ngā Kete Mātauranga. In this regard, the trust will collaborate with like-minded organisations. The trust is also a Child, Youth and Family approved social service provider.

The trust’s quality assurance manager operates an internal audit programme across all services. The influence of ISO accreditation enables service managers to have good practices in place, and there are regular clinical reviews.

Different approaches to reach the community

Ngā Kete Mātauranga recognises that people requiring treatment are not always going to make self-referrals. So staff have considered different approaches – such as marketing – to introduce services to those who may need them.

While not funded by the justice sector, Ngā Kete Mātauranga runs a probation AOD information group. There are a high number of referrals from the community probation service. Tangata whaiora have one-on-one sessions before group sessions, for assessment and preferred clinical pathway directions. Eighty-five percent of these tangata whaiora proceed through to group treatment sessions (six hours spread over three weeks). This provides information – not therapy. Once they have completed this session, tangata whaiora can enter a therapy group, if they wish. The trust has at least one or two tangata whaiora per month requesting to continue with one-on-one AOD treatment. This, according to the trust, is a good outcome.

Te Rongopai is another programme that Ngā Kete Mātauranga operates. This is a support group for anyone in the community who may be affected by an AOD illness. The programme is open to adults and their whānau. This group has been recruiting a number of people, and soon the organisation will be starting a similar pilot support group for problem gamblers.

An AOD education and awareness group – He Wero – is available for young people. Following this support group, rangatahi are offered one-on-one sessions. Recently, Ngā Kete Mātauranga linked with one kura kaupapa to run an AOD education group with teachers. Whānau and growing the business

From the helm down, Ngā Kete Mātauranga works on very strong whānau values across its team of 50 staff members.

It encourages teamwork and whānaungatanga, and, according to its chief executive, the key to its success in growing its business comes down to staff communicating openly in the workplace. It’s about clearly identifying the needs of tangata whaiora, and how this can be achieved while maintaining the integrity of the organisation. As a result, staff take a strong measure of pride in their work.

Ngā Kete Mātauranga management take on board feedback from the community, particularly the kaumātua, who are considered wellbeing and service satisfaction indicators.
Learnings and recommendations from the three case studies

Elements of success according to the provider interviews include:

- Achieving positive outcomes
- Retaining and growing provider contracts
- Building and operating a viable and sustainable service
- Being well known and supported in the community.

The interviews and desktop review reiterated a number of the findings articulated in *He Tete Kura*, namely common denominators for providing Māori AOD treatment services such as:

1. Leadership
2. Workforce development (regulated or non-regulated)
3. Operating environments that support innovation and Māori communities having a choice of a Māori AOD service provider
4. Evaluation and research that informs service design, development and funding
5. Succession planning
6. Collaborative relationships and community support.

Leadership

There are a number of theories of leadership which include aspects of vision, transformation, management, aspiration and commitment. These case studies illustrate the different levels of organisational leadership necessary to be able to give Māori and the wider community quality and responsive services that minimise addiction-related harm. Many managers and leaders in this area have had little or no leadership training, but have developed their skills through their own personal endeavours.

If Māori AOD leaders were to design an AOD leadership course, what would that look like? Currently, there are no opportunities for Māori AOD managers to discuss how these skills can be developed. Opportunities such as the pre Cutting Edge Conference hui are insufficient. The opportunity to hold an extended marae discussion on how the Māori AOD workforce can be supported would enable robust discussion and a platform to plan for the management of future services.

Paraire Huata, Pai Ake Solutions Limited, Takurua Tawera and Terry Huriwai are examples of some in the sector who provide AOD specific workshops, time or resources to support individuals, teams and services in the sector with workforce and service development. This is a good example of Māori leaders spreading their knowledge and expertise. There are leadership forums; however the forums are not exclusively Māori. If an opportunity arose to develop a leadership programme specifically for the Māori AOD workforce, it would likely generate a huge wave of interest.

Workforce Development

The interviews showed that all three providers are conscious that Māori AOD personnel are a valued resource. Given that Māori make up about 18 percent of the 1400 AOD workforce, it is not surprising to see non-Māori working in Māori AOD treatment services.
Recruitment of suitably qualified staff is an ongoing problem for all services but particularly Māori. Many key workers enter the organisation without any AOD qualifications but have health backgrounds. Secondments and internships have proven useful ways to engage Māori into the sector, e.g. Ngā Kete Mātauranga utilised a local Kai Tahu AOD intern through the Hoe Tahi AOD scholarship – Two Birds One Stone: a funded Kai Tahu AOD worker learning on the job.

The addiction scholarships administered by Te Rau Matatini offer opportunities for Māori to work in AOD. However, further consideration needs to be given to incentives for working in AOD.

**Innovation and leading your own kaupapa in your service**

According to some Māori AOD key informants interviewed for this project, principles of good practice in a Kaupapa Māori space recognise that there are valid Māori models of good practice that contribute to meeting community and contractual obligations of minimising harm. These can be seen in the Takarangi Competency and Raukura frameworks, the Whare Tapa Wha or independent tribal frameworks that work for that tribe or provider, such as Te Aka. According to one Māori leader, it’s about having the ‘clear set of rituals’ or ‘kaupapa ake’, and being strong in leading that kaupapa, maintaining the integrity of that kaupapa in a contemporary context and being an integral part of ‘doing the business’.

Two providers mentioned the need to allow for service innovation. According to these providers, clinical practice and integrity can be realised through innovative approaches to service delivery. Each DHB has its own way of negotiating what AOD treatment services can be purchased across their respective regions. Additionally, each DHB has the discretion to allow for innovation – some more than others. Opportunities may arise through specific Ministry of Health funding to purchase additional services for specific government priority areas (e.g. targeting methamphetamine addiction). Is there an opportunity within the broad service specifications of the DHB and Ministry of Health contracts to allow for innovative and incentivised AOD treatment practices?

**More investment in Māori AOD Research**

Services are developed over time, through learnings (mistakes or otherwise). The interviews and desktop research indicates that there is insufficient information on what models of AOD treatment services are effective for Māori. Increasingly services are exploring programmes such as results based accountability (RBA), to articulate the ways their interventions make a difference in someone’s life. It is difficult to find any analysis of the Māori AOD service utilisation data, and any impact or changes the services have had on health outcomes. Better utilisation of tools such as ADOM (Alcohol and Drug Outcome Measure), RBA and Hua Oranga, and better reporting by providers could quickly provide the data to inform and refresh practice and service delivery, as well as enhance accountability.

---

Relationships a key to service development

Some interviewees agreed that iwi support helps in driving an agenda with some key players in the community.

All three providers agree that sustainability and funding are very much dependent on having strong relationships in the community. It is through these relationships that further opportunities arise, contracts are formed and services flourish.

Succession Planning

Just as important as building the AOD workforce, is the need to plan for staff departures. If some of the key leaders interviewed as part of this paper were not present, who would be leading the Māori AOD workforce? The strength of the AOD workforce is that there is a funded body fostering the capacity and capability of AOD workforce development. Given the number of the Māori AOD workforce with a recovery or service user background, recruitment and succession planning requires further consideration. A key priority in the near future is supporting AOD providers to plan and implement succession and recruitment strategies.

Recommendations

One of the key characteristics of good practice is ensuring that this occurs. There is evidence of good practice in some Māori providers, but this is ad hoc. Māori have been proactive within the AOD sector, given their funding constraints. It is worth noting that they are not driven by money -- but by outcomes for whānau, and principles of good practice.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Evidence</th>
<th>Indicative Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Developing a Māori AOD leadership course which includes mentoring and supervision to support up and coming Māori AOD workforce and developments in the sector</td>
<td>• Interviewees and desktop research confirmed that there are mainstream specific leadership forums, but none that are Māori AOD specific that supports current and future leadership</td>
<td>Medium Term (12 to 24 months)</td>
</tr>
<tr>
<td>• Review the incentives for recruitment of Māori into the AOD Workforce (regulated or non-regulated). As part of this work, look at the succession planning opportunities for current and future Māori AOD leaders</td>
<td>• Māori comprise about 18 percent of the approximate 1400 AOD workforce in New Zealand</td>
<td>Medium term</td>
</tr>
<tr>
<td>• Create opportunities within the broad contract service specifications of the DHB and Ministry of Health to allow for innovative and incentivised AOD treatment practices</td>
<td>• There is no specific evidence that limits providers to not be innovative within the current service specifications, however the specifications are based on outputs and not outcomes. Outcomes allow for more service creativity and innovation.</td>
<td>Medium term</td>
</tr>
<tr>
<td>• Create a Māori AOD research agenda as a basis of service design and development</td>
<td>• There is limited research available on Māori AOD services, providers and workforce</td>
<td>Short term (within 12 months)</td>
</tr>
<tr>
<td>• The opportunity to hold an extended marae discussion on how the Māori AOD workforce can be supported would enable robust discussion and a platform to plan for the management of future services</td>
<td>• There are minimal opportunities for the Māori AOD workforce to discuss and share information to plan for development of future AOD services to Māori</td>
<td>Medium term</td>
</tr>
</tbody>
</table>
Appendix One: Ministry of Health Data

Table 2: Number of Alcohol and Drug Clients Seen as percentage of each population

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Ethnicity</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child &amp; Youth</td>
<td>Māori</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.5%</td>
<td>0.9%</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>0.1%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.3%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Adult</td>
<td>Māori</td>
<td>1.6%</td>
<td>1.6%</td>
<td>2.1%</td>
<td>2.9%</td>
</tr>
<tr>
<td></td>
<td>Pacific</td>
<td>0.6%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>1.3%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>0.8%</td>
<td>0.9%</td>
<td>1.0%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>