

# **Collaboration with and for Rural Māori with Substance use and Related Problems**

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## **Abstract**

Collaboration is argued to be a necessary process in the effective treatment of people experiencing substance use and related problems. The process of collaboration is proposed to guide practitioners within services to better work together to meet the needs of service users, and to coordinate and integrate other services in response to related health and social problems that may contribute to a range of further compounding complications. There is evidence that despite these related problems being identified on entry to substance use problem treatment centres, these problems are rarely addressed, and that the problems of poor comprehensive care for people experiencing substance use and related problems are more pronounced for ethnic minorities and people living in rural communities. The lack of collaboration within and across addictions and mental health services, health and social services for Māori, the indigenous population in New Zealand, is of particular concern as Māori are disproportionately affected by substance use and related problems, particularly the social determinants of health.

Collaboration is often poorly defined in the literature, and studies primarily take a narrow view of collaboration, that is, viewing collaboration from one perspective, such as between organisations, or between practitioners from different professions. There are very few studies that explore multi-perspective descriptions of what the collaborative process is or practices that support this, or studies that describe experiences of how people address substance use and related problems in their own whānau (family) and communities, or the role of culture in collaboration, such as when Māori and non-Māori organisations or practitioners are seeking to work together.

This study utilises Kaupapa Māori Methodology within a case study design to explore collaboration in the context of a rural community for Māori with experiences of substance use and related problems. This includes a qualitative inductive data analysis approach. Three different stakeholder groups were selected in order to contribute to a multi-perspective view of collaboration to explore the different challenges and strategies utilised within and between these stakeholders. Individual interviews were conducted with key community members (KCM; n=10). These participants were involved in the initial forming of services in the area, who also provided an understanding of collaboration across time; Individual and group interviews were conducted with service users and their whānau (SU; n = 20). This involved service users with a self-identified substance use problem and engaging with two or more other health and social services and self-nominated whānau members. This incorporated a

discussion of their experiences of addressing substance use and related problems as a whānau collective, and also engaging with a range of health and social service practitioners. The final participant group involved three focus groups with health and social service practitioners (PFG; n= 21). These groups incorporated practitioners from a range of iwi, non-government community groups and statutory services discussing their experiences of collaborating with service users and their whānau, and other practitioners.

The study findings provide support for a contextual view of collaboration, where collaboration occurs within and between stakeholders operating at different levels of health and social care. Within a professional practice system, this occurs between government organisations in designing health and social contracts (policy level), between service managers regarding joint projects (organisational level), and between practitioners within and across different organisations and professions when working with the same service user and/or whānau (practitioner level). The study findings also identify a whānau collaborative system that is argued to interact with the professional practice system. The whānau collaborative system incorporates collaboration between community members and organisations to address local needs (community level), whānau members addressing the needs of whānau and the whānau members (whānau/whānui level), and individuals mobilising resources to address their own needs (whānau level). Each collaborative system is argued to have a range of strategies for enabling collaboration and reducing barriers to collaboration. These two systems are incorporated in an overarching model, the '*Contextual model of whānau centred collaborative practice*'. Unique challenges related to substance use and rurality are recognized. One of the unique outcomes of this study is the identification of intergenerational Māori experiences related to colonisation that permeated every level of collaboration across and between both collaborative systems. Based on this, the concept of whakapapa is used to encase the two collaborative systems within the model to represent the cultural values, experiences and practices that are proposed to enhance collaboration, address barriers to collaboration that have continued to repeat across time, and provide traditional pathways to wellbeing.

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Kia whakarongo aku au

Ki te tangi a te manu nei

A te matui

Tui-i tui-i tuituia

Tuia i runga

Tuia i raro

Tuia i waho

Tuia i roto

Tuia i te heretangata

Ka rongo to pō

Ka rongo te ao

Tuia i te muka tangata

I takea mai i Hawaiki nui

I Hawaiki roa

I Hawaiki pāmamao

Te huno i wairua

Ki te whai ao

Ki to ao mārama

Tihei mauri ora

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Haere, haere, haere.

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E tika ana te korero i o tatou tūpuna

I au ano nga whakāro o aku matua

I te whakāro mo te riri

I te whakāro mo te pai

I te whakāro mo te toro whenua

Ā, i te whakāro whakatupu mo te iwi

Ko nga whakaaro hoki tena ūku matua i mau i ahau

Apiti hono, tatai hono

Te hunga mate ki te hunga mate

Apiti hono, tatai hono

Te hunga ora ki te hunga ora

No reira

Tena koutou tena koutou tena koutou katoa

Hui e

Taiki e!

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## **Tiri i te mohiotanga**

Te umu tirama nuku

Te umu tirama rangi

Ko koe kei wetekia noatia e koe

Whiwhia ūu ngakau, ūu mahara

Kia puta ki te whai ao, ki te ao marama

Tēnā te umu ka eke

Te umu kei a koe

Nā te umu o ēnei kōrero

Ka mā nga koromatua

Ka mā hoki tēnei tangata

This karakia was gifted to me by a kaumatau (tribal elder) from Ngati Apa to use in this research. This karakia facilitates invoking the ahi within the mind of the readers to ignite and begin to enlighten the reader as they proceed. Versions of this karakia can be found in Mitchell (1972).

# **1      Introduction**

As a term, collaboration is a rallying call and catchphrase used to encourage funded services in the health and social sectors to work together to produce synergistic outcomes. It is assumed that collaboration leads to better use of resources in a fiscally restrained environment, and to better address complex, compounding and intergenerational health and social problems (Taskforce on Whānau-Centred Initiatives, 2010; O’Leary, 2014; Butterfoss, 2007). Despite the prominence of this term in government documents, there is very little literature that defines what collaboration is, how it should be done, and the roles, practices and systems that are required to develop and embed collaboration within health and social services in New Zealand (O’Leary, 2014). There is also a dearth of information and evidence that considers the implications of cross-cultural collaboration between Māori and non-Māori practitioners or organisations.

Due to the ongoing impacts of colonisation, Māori, the indigenous population in New Zealand, are over-represented in negative health, education and social statistics, including imprisonment, substance use and substance use disorders, psychiatric disorders, and poor health outcomes (Department of Corrections, 2015; Mental Health Commission, 2012; Ministry of Health, 2014). These health inequities are further compounded in rural communities, where Māori are often either seeking to maintain links to traditional lands, or moving into new rural areas in order to access cheaper accommodation (Marrone, 2007; McLachlan, Hungerford, Schroder & Adamson, 2012). But living in rural areas also often equates with lack of employment opportunities, disconnection from whānau, and a lack of health and social service options (Fraser, 2006; Rameka, 2006; Jansen, Bacal & Crengle, 2008; McLachlan et al., 2012; Mauriora Ki Te Ao - Living Universe Limited, 2010).

One of the government health policy changes in the last decade, which has promoted both collaborative and culturally congruent models of health and practice is Whānau ora. This is a national health initiative guiding policy and practice towards more comprehensive and collaborative care for whānau (families) (Taskforce on Whānau-Centred Initiatives, 2010). It proposes that collaboration between government departments, organizations, practitioners, and whānau is key to making both philosophical and practical changes to health care in order to address the health and social inequities for Māori.

A number of studies have focused on collaboration within the social service sector in New Zealand (Craig & Courtney, 2004; Trotman, 2005; and Hazel & Hawkeswood, 2016),

however there has been little attention given to collaboration between addiction and mental health services and their interactions with primary health and the social service sector in relation to addressing complex co-existing problems, such as addictions, mental health and related social problems.

McLachlan, Levy, and McClintock et al. (2015) conducted a literature review focussed on Māori and parental substance use in New Zealand. It identified the importance of practitioners having cultural competencies, and the knowledge and skills to facilitate access for Māori to appropriate health and social services. The authors advocate embedding a Whānau Ora philosophy and whānau-centred best practice within addiction treatment.

McLachlan, Hungerford, Schroder, and Adamson (2012) gathered practitioners' experiences of collaboration, working with and for rural Māori with substance use problems. This study was a pilot for the present research. The study utilized a focus group format, including health and social service practitioners, addiction and mental health practitioners, and service managers. The results indicated a range of cultural factors particular to the local context (rurality and tribal history) that influenced both barriers and enablers to collaboration. The study also identified that a long history of competition between health and social service providers also contributed to significant barriers to collaboration. This identified the importance of understanding the local history, peoples and place; and the interactions between these; before attempting to understand or facilitate present collaborative relationships and practices. The study also highlighted the interactive nature of collaboration between organisations, practitioners and service users and their whānau. This highlighted the importance of taking a multi-level view of collaboration in order to understand the systemic and personal influences on collaborative practice.

Taylor, Bessarab, Hunter and Thompson (2013) conducted a study in Australia exploring the challenges and enablers of a collaborative service arrangement for Aboriginal clients with substance use issues. The study interviewed practitioners from mainstream and Aboriginal addiction services to explore collaborative relationships and practices between these groups. The results identified specific historic cultural preferences and practices that, while relevant to Aboriginal practitioners, were not clearly understood or valued by mainstream practitioners. Funding arrangements and issues of power were also identified as barriers to collaboration between these services.

None of the above studies effectively explored the foundational context for collaboration, that is, the history, peoples and place that collaboration occurs within, in order to understand the

development and maintenance of collaboration. Nor did they identify the impact of these factors on each other and the people accessing these services. These studies also did not engage with service users to identify their experiences of engaging in collaboration with services, or how whānau themselves work collaboratively as a collective to address substance use and related problems.

This study addresses a priority area in Māori health, substance use and related problems. The present study utilises a qualitative case study method, guided by Kaupapa Māori Methodology. Substance use often occurs along with a range of other health and social problems, which worsen the course of the substance use and can, act as barriers to effective treatment outcomes (Savic, Grynevych & Best et al., 2014; Alexander, Pollack & Nahra et al., 2007). However research shows that while the co-existing psychosocial problems are often identified at entry to substance use treatment, those needs frequently remain unmet. This neglect of the psychosocial aspect of substance use disorders is even worse for ethnic minorities (Pringle, Emptage, & Hubbard, 2006; Ducharme et al., 2007; Marsh, Cao, Guerrero, & Shin, 2009). The same can be said for those involved in the criminal justice system (Paino, Aletraris & Roman, 2016) and for those in rural communities “deprivation accentuates the impacts of rurality, and together they can result in poorer health outcomes” (National Health Committee, 2010. p 64). Substance use and related problems provide the context in this study by which collaboration can be explored. The study also focused on a region which has established exemplars of effective Māori health services collaborative practice. This was completed in order to identify and further understand several important interrelated factors: appropriate culturally responsive service provision for Māori service users and their whānau; collaborative practice with Māori service users and their whānau, and also collaborative practice between Māori and non-Māori practitioners and organisations who work with these Māori service users and their whānau.

This case study focuses on the geographical area covered by the researcher’s own iwi, Ngāti Apa. This area is the Southern Rangitīkei. Whanganui is the main urban area, which is approximately 60 kilometres from the furthest point of Ngāti Apa territory. The area contains a mix of independent and satellite urban communities, rural areas with low urban influence, and highly rural/remote areas (towards Rata and Parewanui). Based on the 2006 census data, the WDHB had a population of 63,980. The proportion of Māori in the WDHB area is higher than that of all other DHB regions in New Zealand. The Whanganui Health Needs Assessment (MidCentral District Health Board & Whanganui District Health Board, 2015)

also noted that the Whanganui region contains high deprivation communities, and Māori were over-represented in these communities.

The few studies that have been conducted to understand the social needs of residents of the Rangitīkei area, have primarily been qualitative and completed under the auspices of the iwi (Te Rūnanga o Ngāti Apa) and the Rangitīkei Regional Council. These studies have reported that substance use is one of the key challenges and needs within the area, along with violence, mental health, and social isolation (Rangitīkei District Council, 2010; Ash, 2012; Smith, 2007). Issues related to substance use included the increase in methamphetamine use, drug dealing, the normalisation of a drinking culture and drink driving, and the impact of substance use on children, education and employment (Smith, 2007; Gilling, 1997; Rangitīkei District Council, 2010; Ash, 2012;). Two interrelated issues were identified as primary barriers to accessing health and social services. These were distance and transportation difficulties (Ash, 2012; Smith, 2007; Rangitīkei District Council, 2012).

Te Kotuku Hauora Limited (TKHL), the Ngāti Apa health service, is the main iwi health and social service provider delivering services within this area. TKHL has been identified as an exemplar of Māori health service collaborative practice. TKHL was identified as receiving one of the first integrated health and social service contracts in the region, and received two Te Puni Kōkiri (New Zealand Ministry of Māori Affairs) Whānau Ora awards for service delivery in 2004 and 2006 (during the short period that these awards were available). TKHL was also noted to have maintained established governance and service level agreements with other Māori health providers within the region. These included Te Oranganui, a large Māori Health provider in Whanganui; Hauora-a-Iwi, a Māori service governance group that represents the collective interests of Māori at the Whanganui District Health Board; and the Māori Health Outcomes Group that also advises the Whanganui District Health Board.

Collaboration was focused on complex problems occurring within areas with limited service options (Hazel & Hawkeswood, 2016; Mauriora Ki Te Ao - Living Universe Limited, 2010). There is strong literature support for rurality presenting a context with limited service options, and unique barriers for existing services to access this population, and barriers for this population accessing specialist services (Gibsin, Lisy, & Davy et al., 2015; Fraser, 2006; Marrone, 2007; McLachlan et al., 2012). This particular rural area was chosen as it has a primarily Māori population (23.5% compared to the national average of 14.1%) (MidCentral District Health Board & Whanganui District Health Board, 2015) and a long history of established innovative collaborative health service development and delivery. This provided

the opportunity to identify unique Māori health service practice enablers of collaboration. A focus on the experiences of substance use and related problems of Māori service users and their whānau allowed for the identification of unique collective cultural experiences, strengths and strategies for addressing substance use within collaboration. Finally, a focus on substance use and related problems provided the platform (rationale/central focus) for exploring collaboration within and between whānau, communities, health and social services for this population.

The purpose of this research is to explore collaboration in the context of a rural community with regards to Māori with experience of substance use and related problems. This study takes a systemic view of collaboration (from service design to delivery). The study attempts to first develop an understanding of the context in which collaboration takes place. This includes understanding the history, peoples and place in which collaboration with and for people with substance use and related problems takes place. This was also to allow access to learning about the history of collective action by local Māori in response to the health and social needs of Māori.

The study then describes the relationship between this early service development and ongoing collaborative relationships between health and social service practitioners, both within and across professions and organisations. Building upon the early service development in the area and the impact of ongoing collaborative relationships, the study also documents and discusses the values, practices and preferences of Māori and mainstream practitioners that enhance or reduce barriers to collaboration.

Significantly, the study also adds the experience of service users with substance use and related problems and their whānau. The inclusion of the views of service users and their whānau provides the opportunity to explore the values, preferences and practices that act as barriers to collective whānau efforts to engage with health and social services.

The study documents and describes a comprehensive, culturally congruent view of collaboration, and presents a framework that can guide service users, whānau, service planners, funders, managers and practitioners in understanding and discussing the complex and interrelated nature of collaboration with and for Māori across different levels of collaboration irrespective of the objectives of the collaborative relationship.

This thesis is organised into eight chapters.

**Chapter One** introduces the reader to the rationale for the present study. This chapter briefly discusses the importance of collaboration, and the lack of information or knowledge about systemic collaboration within New Zealand. This chapter also briefly introduces the reader to the different factors of focus in the present study, including the role of collaboration in improving outcomes for Māori, the importance of cultural practice in collaborating with Māori, the rural area under study, and the need for collaboration when addressing substance use and related problems within rural communities.

**Chapter Two** reviews literature that informs the exploration and understanding of a systemic, culturally congruent and contextual model of collaboration with and for rural Māori with substance use and related problems. A literature review focused on the vast potential combinations of concerns within the study does not fit well with the systematic quantitative style literature review. A range of topics require exploration, including Māori and collaboration, rurality and collaboration, rurality, substance use, Māori and collaboration and the occurrence of these at different levels, i.e., organisational, practitioner and service user and their whānau. Therefore, an adapted narrative literature review was conducted, which was framed within a structured multi-level collaborative framework identified within literature on contextual models of collaboration

**Chapter Three** comprises the methodology and methods for this study. It describes the Kaupapa Māori Methodology used to guide the qualitative case study design and the data analysis processes utilised in this study.

Chapters four through to seven present the results.

**Chapter Four** presents key community informant (KCI) participant experiences and recollections of the initial development of health and social services in southern Rangitīkei and the impact of cultural and historical factors on the ongoing relationships between health and social services within the area.

**Chapter Five** reports the experience of service users and their whānau in addressing their own needs, explores the impact of rurality and substance use and related problems on wellbeing, and identifies their engagement in collaborative relationships with practitioners from these rural health and social services.

**Chapter Six** presents practitioner experiences of working with rural Māori with substance use and related problems and also of engaging within and across services and professional disciplines within and across different health and social sectors.

**Chapter Seven** identifies the key implications of the results of this study for future collaborative practice. It provides a culturally congruent systemic model of collaborative practice, which provides an overview of the different levels and systems impacting on and interacting with collaborative practice and whānau collective action. The model discusses the role of Māori values, beliefs and practices on each level of collaboration. This model includes findings, which reflect practices that enhance collaborative practice within each level of collaboration. This section discusses the application of whakapapa (in this context the term is used to represent intergenerational issues and relationships) and tikanga Māori (Māori practices) to collaborative practice and the application of the contextual model of whānau centred collaborative practice. Finally, it reports potential limitations of the study and provides recommendations for future research.

## **2 Literature Review**

### **2.1 Introduction**

This literature review utilises a narrative review methodology. This methodology allows for a comprehensive analysis of a broad range of relevant literature, inclusive of peer reviewed academic literature and ‘grey literature’. This allows for all information in the public forum to be collated in order to identify consistencies and inconsistencies in the current knowledge economy (Pautasso, 2013). Adams, Smart and Huff (2017) report that grey literature can incorporate literature in areas where “scholarship lags” (Adams et al., 2017), and explore novel fields of enquiry and further support previous academic findings. The authors provide a summary of common sources of grey literature relevant to literature reviews. These include:

- commissioned reports
- community engagement toolkits
- conference proceedings
- government department reports
- non-government organisation (NGO) reports
- policy documents, and
- working papers.

An integrative method allows the synthesis of information in order to find “common ideas and concepts from the reviewed material” (Pautasso, 2013, p. 2). Using a narrative approach that is inclusive of integrative methods “results in a comprehensive portrayal of complex concepts, theories or health care problems...” (Whittemore & Knafl, 2005, p. 548). This was particularly important given the vast number of potential topics and relationship between topics in the present study.

### **2.2 Review method**

#### **2.2.1 Literature search**

An electronic database search was conducted utilising Ovid and Proquest between 5 May 2006 and December 10 2016. Search terms included collaboration and collaborative practice. A range of key search terms were used independently, and in connection with each other. These included rural, rurality; Māori, whānau, indigenous; social problems, socio-economic,

deprivation; substance use, substance abuse, substance dependence, addiction; mental health, mental illness, psychiatric; collaboration, integration, collaborative; organisation, organisational, organization, organizational, strategic, planning, funding, interprofessional; family, whānau, client, patient, service user. Accessing New Zealand workforce development sites and government department websites sourced grey literature. Ancestry searching (accessing referenced articles from key literature) and hand searching of relevant journals was also used to identify outlying relevant information that was either not available on electronic databases or would have been missed by the chosen search terms.

### **2.2.2 Data evaluation**

Data was evaluated and further reduced according to authenticity, methodological quality, informational value, and relevance to the focus of the study (Whittemore & Knafl, 2005). Authenticity referred to the role of participants' perspectives in the results, methodological quality relates to the appropriateness of the methods used, rigour, and credibility. Informational value, and relevance to the focus of the study related to the ability of the data to contribute to the field of study. This formed the basis of exclusion and inclusion criteria. The primary inclusion criteria was informational value, particularly those articles which provided the intersection and interaction of different levels of collaboration and/or different topics within the study and collaboration such as Māori, substance use and collaboration. Studies were excluded if they had a sole focus on one level of collaboration or were focused on collaborative research or education initiatives.

### **2.2.3 Data analysis**

The data produced in the literature review is presented in three sections (discussed below). The first section analyses the concepts of collaboration and related concepts, and the second section explores Māori concepts related to collaboration. From these sections, a basic construct of contextual collaboration is used as a framework to present information that enhance or reduce barriers to collaboration. These were: Strategic, Organisational, Practitioner, and Whānau Collaboration. Data was placed within one of the four levels of collaboration, and then a constant comparison method was utilised, in which each interpretation of the literature was compared with other literature as it emerged to identify commonalities from which patterns, themes, variation, and relationships could be presented and discussed (Patton 2002; and Whittemore & Knafl, 2005). The data analysis took place in three stages, similar to that outlined by Thomas and Harden, (2008), coding enablers and barriers, organising these codes into descriptive themes, and then producing analytic themes

that captured both the enabler and barrier as a common concept. This led to the production of themes within each of the four levels of collaboration.

#### **2.2.4 Presentation**

This literature review is presented in three separate sections:

- Collaboration: Concepts, context and levels
- Collaboration from a Māori worldview, and
- Barriers and Enablers to Collaboration.

The first section provides definitions and descriptions of the different aspects of collaboration and different examples of collaborative models in practice. The literature will then look at comparative and unique Māori definitions, descriptions and models that reflect collaboration in practice in the second section.

The third section will then review the literature regarding Barriers and Enablers of collaboration as applied to the different areas of focus of the present study, including:

- Health and social service practice
- Māori
- Substance use and related problems, and
- Rurality.

### **2.3 Collaboration: Concepts, context and levels.**

The term collaboration is often not well defined (Harmsworth, Awatere & Robb, 2016). A recent study identified that the term ‘collaboration’ was defined less than one percent of the time in a wide range of New Zealand Government documents (located on the State Services Commission website) (O’Leary, 2014).

Eppel, Gill, Lips and Ryan (2008) produced a discussion document regarding collaboration in New Zealand, which built upon an extensive literature review and individual and group interviews with key stakeholders from identified exemplars of successful collaboration across public sector initiatives. The authors identified the difficulties inherent in producing a set of collaborative steps or best practice guidelines for collaboration, identifying that “any attempt to lay out the ‘steps to success’ would be bound to fail” (Eppel et al., 2008, p 11) and

“attempts to plan and structure them would have been the death of the initiative” (Eppel et al., 2008, p. 12). The authors provide a framework that describes collaboration as a series of phases, with considerations made ‘before starting’, ‘getting together’, ‘working together’ and ‘sustaining’ (Eppel et al., 2008, p. 12). Two important areas are highlighted on each side of the framework: learning and supporting. The model also acknowledges the different contexts impacting upon collaboration. However, despite being a New Zealand research paper, none of these phases refer to the value, role or recommendations in relation to collaboration for or with Māori.

Due to the ongoing controversy in relation to the term collaboration, Ball and Thornley (2015) in their review of community development proposed that the development of descriptions and examples would better guide an understanding of contested terminology. A recent study of collaboration in New Zealand reported that despite a lack of a unified or commonly agreed upon definition of collaboration, three key themes are evident in literature on collaboration (Hazel & Hawkeswood, 2016). Those themes were:

- collaboration is about working together to achieve outcomes not possible independently,
- there is an assumption that collaboration leads to efficiency and efficacy, and
- collaboration occurs along an integration continuum from low-level networking to higher-level mergers.

Collaboration is described as occurring within a defined, time limited period, such as working on a project to address a specific issue like a community development or public health initiative (Ball & Thornley, 2015; Widmer, 2011). It is described in other circumstances as an ongoing process, as in health service delivery between professionals, or between service users and practitioners. The term interprofessional collaborative practice is most commonly used when discussing collaboration between different professionals within or across professions or organisations (Dougherty, 2013; Penny, 2013).

Martin-Rodriguez, L., Beaulieu, M., D'Amour, D., & Ferrada-Videla et al. (2005) provided an overview of the important mechanisms within collaboration arguably contributing to its success. These mechanisms were presented within three groups of determinants: interactional, organisational, and systemic. The authors identified that cultural values “may also have an impact on the development of collaboration between professionals” and that “some cultures may harbour deep cultural values that run counter to the spirit of collaboration” (Martin-

Rodriguez et al., 2005, p. 134). Despite culture being identified as one of the key systemic determinants of successful collaboration, culture was not incorporated within interactional or organisational elements. This highlighted a lack of importance given to the issue and/or a lack of literature available exploring cultural elements across different determinants of successful collaboration.

Hazel and Hawkeswood (2016) proposed a set of common collaborative elements through which to explore enablers and barriers to collaboration. These elements included vision, people, resources, processes and culture. The authors identify that culture could be considered to cover three different areas, organisational, ethnic, and project. They argue that, “while the existence of differing ethnic cultures is at least on most people’s radar (even if not always handled well), the intersection between organisational and project cultures is less visible.” (Hazel & Hawkeswood, 2016, p. 37). They also state that there “was little acknowledgement of organisational or project culture amongst this study’s participants” (Hazel & Hawkeswood, 2016, p. 37), and they do not further describe ethnic culture as applied to collaboration.

As stated, collaboration can occur at a practice level or at a community level. But it has been argued that collaboration must be considered in a broader context, considering the different systems that influence and impact upon collaboration between practitioner and with service users and their whānau (Whānau ora task force report, 2009). A range of different levels of collaboration have been identified, and these are reflected within four broad areas (Taskforce on Whānau-centred Initiatives, 2010; LaFond, Brown and Macintyre, 2000; Jansen, Bacal, & Crengle, 2008; McLachlan, 2015):

- funding strategy and policy
- structural and system-level, organisational
- practice, practitioner, human resource and systems of care, and
- service user, whānau and community level.

Kodner and Spreeuwenberg (2002) argue that integration occurs across these sectors with the goal of creating “connectivity, alignment and collaboration within and between the cure and care sectors” (Kodner & Spreeuwenberg, 2002, p. 3). Collaboration can therefore be viewed from a ‘bottom-up’ perspective incorporating the experiences of the service user and their whānau, or from a ‘top-down’ perspective considering the relationships and actions between those who prioritise, fund and design the services. Despite the growing literature related to

‘top-down’ forms of collaborative relationships, “less is known... about what collaboration should look like and which strategies are most effective at the point of direct service delivery to improve access and client outcomes” (Addiction and Mental Health Collaborative Project Steering Committee, 2014, p. 7). The Whānau Ora model has therefore argued for a paradigm shift from a top-down approach to family and whānau priorities and self-determination (bottom up approach).

Rose and Norwich (2014) provided a framework of collaboration that incorporated the different levels of collaboration, and discussed the interaction between these levels (Figure 1). The framework includes four contexts in which collaboration occurs, policy context, local context, group functioning and individual factors. These contexts and the factors within these contexts are argued to interact and influence each other through various feedback loops.

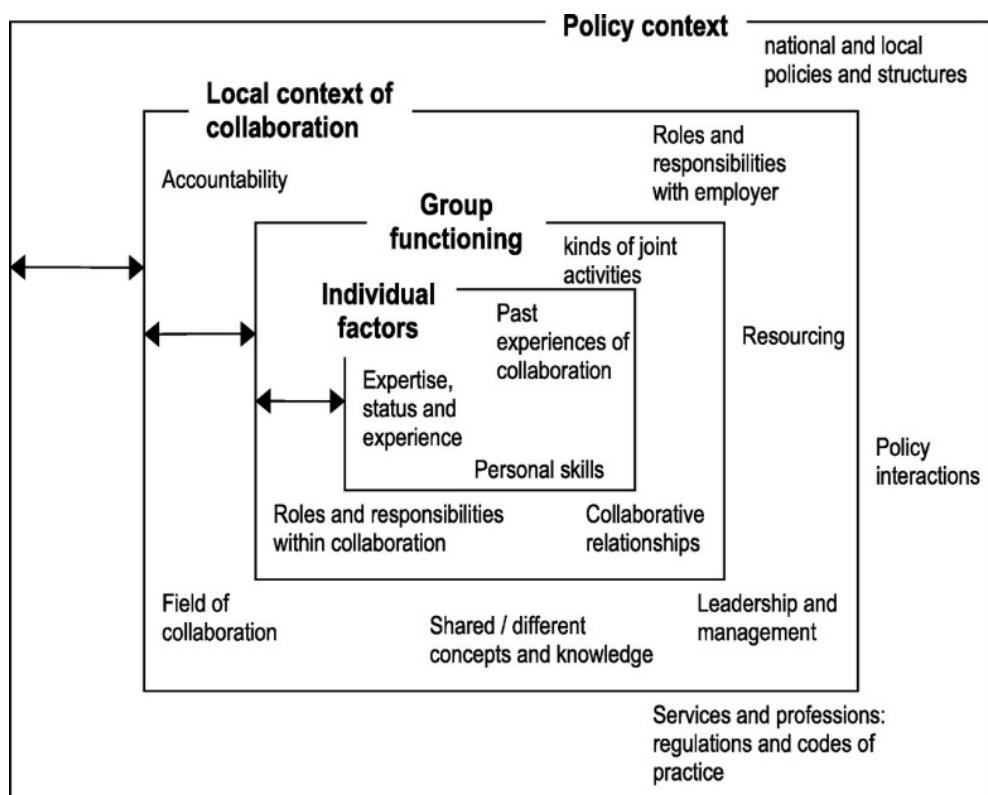


Figure 1 - A contextual framework of collaboration (Rose & Norwich, 2014, p. 64).

The key factors within the policy context were identified as:

- national and local government policies and structures
- the interactions and tensions between different policies, and
- the regulations and codes of practice of different services and professions.

The authors argue that the work within the policy context established the general frameworks and approaches that are applied in the local context. The key factors within the local context included:

- the purpose of collaborative action
- roles and responsibilities of specific professions
- leadership and management structures
- lines of accountability
- resources, and
- shared/differing concepts and knowledge.

Within the local context were both group functioning and individual factors. The key factors within group functioning included:

- roles and responsibilities within collaborative groups and teams
- kinds of joint activities, and
- history, duration, continuity and kinds of collaborative relationships.

Key factors within individual factors included:

- individual professional expertise
- perceived status and professional experiences
- past experiences of collaboration, and
- personal skills.

## **2.4 Collaboration from a Māori worldview**

Literature has identified Te Tiriti o Waitangi (The Treaty of Waitangi) as a key document that has been applied directly to initial and ongoing relationships between Māori and the Crown in a range of settings, including health, education and environmental contexts (Robb, Harmsworth & Awatere, 2015; Kingi, 2007). Due to the disagreements between Treaty texts, a range of principles have been derived from these texts and applied to legal proceedings. The Royal Commission on Social Policy (1988) presented the intent of the Treaty of Waitangi as principles, those being defined as partnership, participation, and protection.

Despite differences in interpretation, the Treaty has continued to be viewed as a vehicle for Māori and non-Māori organisations in ensuring equity in health, social and economic development for Māori (Buetow, 2004; King, 2006; Waa, Holibar & Spinola, 1998). The Crown has been recorded to view the Treaty as a historical curiosity with a lack of relevance to legal issues (Durie, 1998; Kingi, 2006), and by non-Māori health and social providers with general apathy (Local Partnerships and Governance Research Group, 2005). Knox (2004) developed a framework for identifying the level of Treaty involvement in collaborative relationships between Māori and the Crown. This included Treaty-based partnerships, Treaty-influenced partnerships and Treaty-referenced partnerships. The varying levels reflect the incorporation of legislation and the operationalization of this in practice.

Exploring and articulating the concepts related to and underpinning collaboration has been identified as an important first step, as “Māori perceptions of partnership are wholly different to those of non-Māori” (Local Partnerships and Governance Research Group, 2005. P.6). In a pilot study for the present thesis, McLachlan, Hungerford, Schroder and Adamson (2012) reviewed Māori concepts and terms most closely aligned with a basic definition of collaboration of ‘working together’ and integration. These included mahi tahi (working together), and definitions of integration were hononga (joining), and whakakotahi (to unify, integrate) and rāranga tahi (to integrate). This language used to explain collaboration is correlated to relational behaviour – working together. The Māori values that underpin relational behaviour include:

- whakapapa (genealogy) and whanaunagatanga (relationships, kin and non-kin) (Ritchie, 1992; McLachlan et al., 2012; Ministry of Education, 2009; O’Leary, 2014)
- manaakitanga (hospitality) (Local Partnerships and Governance Research Group, 2005; Knox 2004; Ministry of Education, 2009; McLachlan et al., 2012; O’Leary, 2014)
- wairuatanga (spirituality) and rangatiratanga (status) (Knox 2004; McLachlan, 2010; O’Leary, 2014), and
- kotahitanga (unity) (O’Leary, 2014; McLachlan, 2010).

Within the study by McLachlan et al., (2012), rural health and social service practitioners who were participants identified that the term ‘collaboration’ for Māori also could be linked to negative connotations. One example of this was the use of the term kūpapa (traitor), which

was used to highlight the perception that some behaviour by iwi or Māori within health and social services was seen to reflect support for ongoing colonial structures.

When considering the different Māori terms used to represent collaboration, and the potential connection between the concepts of collaboration and colonisation, it becomes clear that further exploration of terms is needed. Consideration should be given to terms that can encapsulate the concept, while also encompassing its intent, values and practices. Several authors have affirmed the importance of appropriate tikanga (correct practice) in initial engagements with and between Māori. These authors have applied a pōwhiri (traditional formal welcome onto a marae) process, or the less formal whakatau (to settle; a welcome with less ritual involved, which can also be conducted in locations other than a marae), or a hui (meeting) (Berryman & Bateman; 2008). This is particularly useful in defining what Durie (2003) identified as important in encounters on the marae, the concepts of engagement, boundaries and time.

Paraire Huata (Huata, 1997) applied a pōwhiri framework to a therapeutic context in Te Pōwhiri Poutama. These steps included:

- karakia (to acknowledge the sacred)
- mihi (to greet, pay tribute, thank)
- whakapuaki (to express, reveal)
- whakatangitangi (to release, grieve)
- whakaratarata (clarify), and
- wakaotinga (to close).

Lacey, Huria, and Beckert et al., (2011) also applied the stages of a hui to doctor - patient relationships, including:

- mihi (initial greeting and engagement)
- whakawhanaungatanga (making a connection)
- kaupapa (attending to the main purpose of the encounter), and
- poroporoaki (concluding the encounter).

In identifying the different steps of the pōwhiri, it is important to identify that at each stage, there are different concepts and values underpinning actions and intent (tikanga). Ritchie (1992) reports that the Māori concepts and practices that underpin tikanga (correct practice) are difficult to portray in analytic or simple terms, and goes on to state that whanaungatanga (relationships) were “the basic cement that holds things Māori together” (Ritchie, 1992, p. 67).

Whanaungatanga was also identified as integral within research into working with Māori in substance abuse treatment (Huriwai, Armstrong, Huata, Kingi & Robertson, 2001). Mead (2003) also identified the concepts of tika (right/correct) and pono (honest/true) as concepts as important in evaluating behaviour, and concepts such as take (issue/concern, not the English word “take”), utu (cost/response), and ea (satisfaction/resolution) as important for addressing transgression and resolution within relationships.

The importance of both the application of Te Tiriti o Waitangi and tikanga Māori (especially concepts captured in te reo Māori) can be seen reflected in culturally adapted models of collaboration including Coproduction (McKenzie, Whiu and Matahaere-Atariki et al., 2008 and Kōwhai Consulting Ltd, 2008), an eight-step tikanga process to achieve desired freshwater planning and management outcomes for Māori (Robb, Harmsworth & Awatere, 2015); and a conceptual model for bicultural partnering (Knox, 2004).

## **2.5 Barriers and enablers to collaboration**

Internationally and in New Zealand, researchers have examined enablers and barriers to health care access and collaboration between health and social service providers (Jansen, Bacal, & Crengle, 2008; Gibsin, Lisy, & Davy et al., 2015). Enablers of collaboration have also been termed ‘facilitators’ or ‘best practice elements’ and their presence or absence are argued to reflect “opposite sides of the same coin” (Hazel & Hawkeswood, 2016, p. 24), that is, an absence of these elements can in itself be a barrier. Focusing on barriers and enablers to collaboration has allowed for a better understanding of the application of collaboration in practice, and also supported the identification and dissemination of results to promote best practice (enablers). It also provided recommendations for addressing barriers (McLachlan, 2015; Addiction and Mental Health Collaborative Project Steering Committee, 2014).

In this section, literature that explores enablers and barriers to collaboration in health and social services will be reviewed, along with literature that has a specific focus on issues relevant to this study, including Māori service access and experiences, rurality, and substance

use and related problems. The author will use a systematic approach to presenting the occurrences of barriers and enablers in health and social care, such as those described by McLachlan (2015) and LaFond et al, (2002) and reflected in work by Jansen, Bacal and Crengle (2008) and Gibsin, Lisy, and Davy et al., (2015). The following headings will be used: strategic collaboration, organisational collaboration, practitioner collaboration, and whānau collaboration.

### **2.5.1 Strategic collaboration**

In line with the description by McLachlan (2015), strategic-level collaboration is considered to involve collaboration across government ministries, departments and between organisations at a governance level. The literature on enablers and collaboration as outlined above are presented in four themes, including:

- government priorities
- engaging service users, their whānau and communities in service design and development
- government funding models
- formal agreements.

#### **2.5.1.1 Government priorities**

Policy and political environments have been identified as important factors in the implementation and sustainability of collaborative initiatives (Gibsin, Lisy, & Davy et al., 2015). The Ministry of Social Development (MSD, 2003) reported that government agencies have focused on contract outputs related to the delivery of their core business at the expense of whole-of-government or integrated approaches to service delivery. New Zealand research has noted that ongoing changes in policy priorities, along with organisational restructuring and different regional boundaries for different government departments are barriers to collaboration between public health organisations (Widmer, 2011). Kowhai consulting (2008) concluded government priorities and processes constricted and worked against a collaborative process. Despite early work on the development of shared goals and processes, actual actions were to be driven by government timeframes and priorities, which led to insufficient time and attention to relationships or joint negotiation within the goal of coproduction.

As part of a review of a government-initiated service partnership between an Aboriginal community-controlled alcohol and drug service (Aboriginal Alcohol and Drugs Service,

AADS) and three mainstream alcohol rehabilitation and support services, Taylor, Bessarab, Hunter & Thompson (2013) identified that structural and historical barriers to collaboration had occurred at a strategic level, and had a flow on effect through the different levels of collaboration between these organisations. The authors identified that funder induced contractual changes, including the transferral of funding from Aboriginal services to Mainstream services, and Aboriginal services being required to engage in collaboration with these mainstream providers had led to “unequal power relations between the funding agency and the non-Aboriginal partners on the one hand and AADS on the other” (Gray, Wilson, & Allsop et al, 2014, p. 486). This was noted to contribute to an atmosphere of distrust. The aboriginal health services identified that this type of coercive behaviour was reflective of intergenerational colonial practice “although mainstream partners were not directly responsible for the redirection of funding, by receiving it they were complicit in replicating a colonial practice that (once again) undermined Aboriginal self-control”. (Taylor, Bessarab, Hunter & Thompson, 2013, p. 3).

Distrust has also been noted as an issue that requires addressing across the full continuum of collaboration in New Zealand, including relationships between the Crown and iwi (Taylor & Thompson, 2011; Mauriora Ki Te Ao - Living Universe Limited, 2010). The Whānau Ora Taskforce Report identified that “relationships between the Crown, iwi, providers and whānau should be equal, and based on trust, respect and belief in the worth of the individuals and each other” (Mauriora Ki Te Ao - Living Universe Limited, 2010, p. 19). This reflected the importance of values between the individuals and groups, and the importance of collective guiding values (McLachlan, 2015).

### **2.5.1.2 Engaging service users, their whānau and communities in service design and development**

The New Zealand National Health Committee (NHC) identified the importance of designing services that were more in tune with the needs of service users, whānau and community, with a greater focus on interconnected physical, mental and social health and wellbeing (National Health Committee, 2010). In order to address these priorities, it has been identified that there needs to be active and effective collaboration and integration across The Ministry of Health, DHBs, and Primary Health Organisations (National Health Committee, 2010). International research on collaborating with indigenous service users has identified the importance of having strategies in place for partnering with local communities (Gibsin, Lisy, & Davy et al., 2015). Recommendations for engaging local communities included involving community members in service design and planning, employing local indigenous health workers, and

training local community members to participate in health service delivery (Gibsin, Lisy, & Davy et al., 2015).

Taylor, Bessarab, Hunter and Thompson (2013) reported that indigenous ways of working were not understood, acknowledged or appreciated by government funders. In relation to service design and contracting, literature has identified that the cultural needs and preferences of the service user, their whānau and the community is often not sought or incorporated. Literature discussing service design for Māori identifies that almost all clinical mental health services in New Zealand are delivered by mainstream services, and these services tend to focus on addressing symptoms as opposed to causes. This reflects a significant difference in health philosophies and priorities between Māori and non-Māori health service providers (Ihimaera, 2007).

When considering the design of services, the literature also identified a deficit in capturing the perspective of service users and their families in decision-making and evaluation in New Zealand (Ihimaera, 2007; Mauriora Ki Te Ao - Living Universe Limited, 2010). This reflected a lack of “bottom up” development, therefore services were less likely to be aligned with the cultural and service needs and preferences of service users and their whānau.

### **2.5.1.3 Government funding models**

Funding models and approaches to planning and contracting have been identified as levers to bring about change in relation to service delivery and practitioner level integration (Smith & Ovenden, 2007). Literature focussed within the addictions and mental health fields has identified that there is a lack of incentives for change, and in fact there are active disincentives to change practice (Addiction and Mental Health Collaborative Project Steering Committee, 2014). The Whānau ora taskforce report identified that policy direction; design and delivery should be aligned with practitioners working with whānau. An example given to illustrate this concept involved ensuring contracting allowed the necessary time for ongoing relationship building and consistent engagement with whānau (Mauriora Ki Te Ao - Living Universe Limited, 2010). The task force reported that collaboration is not an end result of service design and contracting, but must start from the top. “Providers and agencies collaborate with and complement each other in policy design, delivery and funding” (Mauriora Ki Te Ao - Living Universe Limited, 2010, p. 20). This is supported by Ihimaera (2007) who notes that best practice occurs when decision-making is made at a local level between funders and providers.

A wide range of literature recommended simplified contracting and alignment and integration of existing contracts towards a more collaborative and comprehensive health and social service delivery focus (Widmer, 2011; Mauriora Ki Te Ao - Living Universe Limited, 2010; Ministry of Health, 2010). However, Kania & Kramer (2013) identified collaborations as often seeking the wrong type of outcome, or not identifying or acknowledging unintended positive outcomes. The authors argued that predetermined solutions rarely work, particularly when addressing complex social problems. When evaluating and measuring collaboration, contracts were recommended to focus on outputs as well as outcomes, along with the added value of collaboration. Other funding mechanisms to support collaboration included contracts that supported provider growth, the development of interagency databases, shared frameworks for outcome monitoring and reporting, and access to shared management and governance services (Ministry of Health, 2010).

#### **2.5.1.4 Formal agreements**

Various authors promoted the importance of developing formal mechanisms to encourage and support collaboration and collective action (e.g., Addiction and Mental Health Collaborative Project Steering Committee, 2014). This includes mechanisms to ensure values, shared objectives and emerging solutions are sought, developed, applied, measured and communicated (Easterling, 2013; Kania & Kramer, 2013; Ihimaera, 2007). An example of this was the development of a management or project steering group represented by key stakeholders (Edinburgh Alcohol and Drug Partnership, 2013; McLachlan, 2015). Another was the development of formal collaborative terms of reference or memorandums of understanding (Edinburgh Alcohol and Drug Partnership, 2013; McLachlan, 2015).

Formal agreements were also identified as important in an exploration of barriers and enablers of collaboration between Aboriginal and mainstream alcohol and drug services. Taylor, Bessarab, Hunter and Thompson (2013) identified that clear agreements were helpful for addressing challenges in collaboration including practical aspects of case management, cultural and clinical roles, and decision making. The authors identified that when agreements did not articulate the role of cultural and clinical practices and the associated roles, relationships were left vulnerable to misunderstandings. Despite agreements in place between indigenous and mainstream services, indigenous practitioners still identified having little control in collaborative relationships with mainstream providers. They experienced mainstream providers having ultimate decision-making power in client placement decisions, and that this reflected long-standing colonialist behaviour (Taylor, Bessarab, Hunter & Thompson, 2013).

Knox (2004) explored issues related to partnership within the Māori community of Waitakere City, identifying areas of improvement and associated recommendations. This study was part of a larger three-year project of ‘headline’ partnerships by Local Partnerships and Governance Research Group (Trotman, 2005). The study incorporated literature reviews, national and regional hui/forums, and partnership case studies involving central government, local authorities, and non-governmental organisations including iwi and Māori groups. Knox (2004) reported that partnership agreements were the basis for defining goals, principles of relationships and associated processes. The author reported that partnership agreements with Māori are ideally based on and guided by The Treaty of Waitangi, as this allows for a discussion of meaning for both parties and how this can be negotiated and applied to ensure a balancing of power. Other aspects of collaboration noted by Knox (2004) that could enable a better understanding of forming partnerships with Māori, included the concepts that:

- partnership is viewed as a long-term commitment by Māori. Investment of time and resources are required at the outset of collaboration to ensure capacity for collaboration, and this relationship should be maintained as an ongoing relationship
- the incorporation of Māori concepts, terms, outcomes and measures requires careful consideration and negotiation
- Māori have holistic views, often requiring broader integrated multi-sectorial collaboration.

### **2.5.2 Organisational collaboration**

In line with the description by McLachlan (2015), organisational level collaboration is considered to involve collaboration between different organisations, and aspects related to the provision of services. The literature on enablers and collaboration as outlined above are presented in six themes, including:

- Poor relationships between organisations
- Collaboration fatigue, tokenism and power dynamics in collaborative relationships
- Service level agreements
- Leadership
- Awareness and application of diverse cultural realities, values and practices
- The impact of rurality and isolation.

### **2.5.2.1 Poor relationships between organisations**

Both a history of competition and mistrust between providers have been identified as barriers to collaboration (Kania & Kramer, 2013). Research on inter-agency collaboration with and for rural Māori with substance use and related problems identifies a history of competitive contracting that has contributed to ongoing tension that reduces the likelihood that organisations would work together on an equal basis to address common goals (i.e. collaborate). “Power – Some agencies think they have more power, they’re not willing to work in partnership” (McLachlan, 2011, p. 21).

McLachlan et al. (2012) reported that historical conflict between previous managers of different health and social service organisations created an ongoing cycle of mistrust and poor relationships. Participants in this study identified a history of competitive contracting had contributed to this conflict.

Enablers of successful collaboration with indigenous Australian organisations are argued to involve engaging with organisations with existing and, at times, long term relationships in place; strong community control, ownership and management of the project; and consultation with staff on implementation of the intervention (Gray, Wilson, & Allsop et al, 2014). Ongoing meetings and workshops are also identified as important to address challenges and progress partnerships (Taylor, Bessarab, Hunter & Thompson, 2013).

### **2.5.2.2 Collaboration fatigue, tokenism and power dynamics in collaborative relationships**

‘Māori collaboration fatigue syndrome’ (O’Leary, 2014), ‘over collaboration’ (Knox, 2004) or ‘consultation and collaboration fatigue’ (Local Partnerships and Governance Research Group, 2005) are terms that have been coined to reflect increased demand for Māori representation within collaborative relationships. Despite the increased demand and participation of Māori, studies have indicated that participants conclude that this has not fostered true partnership, due to them experiencing cynicism that their mainstream partners are less sincere and committed in their efforts (O’Leary, 2014). Māori participants have reported experiencing their participation as often tokenistic, just ‘ticking the box’ of government departments. Māori participants have reported the experience of giving the same feedback for many years with little productive response (O’Leary, 2014; Local Partnerships and Governance Research Group, [Trotman, 2005]).

In a large study of ‘headline’ partnerships involving central government, local authorities, non-governmental organisations including iwi and Māori groups, Local Partnerships and

Governance Research Group (Trotman, 2005) undertook literature reviews, national and regional hui/forums, and case studies. The summary of findings included a list of ‘key issues’ for collaborating with iwi and other Māori groups. These recommendations highlighted the tokenistic attitude towards Māori representation citing an attitude of “any Māori will do” (Trotman, 2005, p. 33).

Trotman (2005) further reported that the processes in determining appropriate Māori representatives within collaboration agreements was less than ideal, stating “Māori are regularly being asked to do things above or below their mana” (Trotman, 2005, p. 33). In the multisite formative evaluation of co-production between Te Puni Kōkiri (Ministry of Māori Development) and six iwi groups (Kōwhai Consulting Ltd, 2008), participants involved in the project identified that representation was not equal across groups, with Māori participants identifying that their leadership (CEOs) were expected to attend events (workshops) that were more appropriate for management level staff, and Crown partnership representation was not always of equal status or consistent in representation. This may reflect both tokenism and devaluing of the Māori collaborative partner’s role, and also reflect a cultural difference in that Māori culture is more finely attuned to mana, with associated expectations that collaboration is based on an equal level, calibrated by the mana of those involved.

Kōwhai Consulting (2008) noted that engagement with appropriate Māori leadership requires an acknowledgment of the diversity amongst Māori (including iwi, whānau, hapū and organisations). The authors noted that perceptions of engagement with Māori often assume uniformity between the roles of iwi and other Māori organisations. But participants in this study identified iwi authorities as the most appropriate group for partnering with the Crown in collaborative initiatives, and stated that iwi authorities may also be in different stages of development (pre or post treaty settlement) and therefore may or may not have the capability or priority to engage at different levels. In the study of Māori perceptions of collaboration in Waitakere (Knox, 2004), the author identified that there were an array of different Māori organisational and social structures, and each may require a different engagement process. The Local Partnerships and Governance Research Group study (Trotman, 2005) identified appropriate and planned engagement is an important aspect of engagement of Māori organisations in collaboration. “It is important that the right people approach Māori, at appropriate levels of seniority. The Māori ‘rule of thumb’ for engagement is ‘kanohi ki te kanohi, rangatira ki te rangatira’ – face to face, chief to chief” (Trotman, 2005, p. 33). Knox (2004) reports that to address over consultation:

- Ensure non-Māori seek to understand and incorporate Māori priority issues.
- Māori organisations and iwi representatives determine their level of engagement and scale of consultation.
- The mana of those Māori individuals involved is acknowledged, no matter what their level is within an organisation.
- Mandate appropriate representation of Māori spokespersons at meetings, and
- The development of participation and decision-making is incorporated within partnership agreements to ensure value for Māori involved in the consultation process.

The issue of power sharing in collaboration with Māori has been raised as an issue in other fields including resource management. Wevers (2011) proposed a spectrum of power sharing in co-management. It incorporated a continuum, with higher level of power retained by government at one end, such as rights of Māori being no greater than the general public; to a higher level of power shared with Māori at the other end of the continuum, such as co-management between government and Māori and Māori veto powers. Therefore a key enabler of collaboration for and with Māori, in response to tokenism, power imbalance and a desire for tino-rangatiratanga has been active participation across the full spectrum of design, decision making and implementation within a collaborative relationship (Local Partnerships and Governance Research Group, 2005; Kōwhai Consulting Ltd, 2008).

#### **2.5.2.3 Leadership**

Commitment of senior leadership to collaborative efforts has been identified as important (Widmer, 2011), and whether within management or on the ground floor, a collaborative champion is important for maintaining focus on vision and objectives (Easterling, 2013). Poor leadership and strong personalities at governance and management level have been identified as contributing to poor engagement between indigenous and mainstream alcohol and drug services (Taylor, Bessarab, Hunter & Thompson, 2013). Effective leadership is argued to have the ability to bring together diverse peoples, and there also needs to be a willingness from an organisation to move beyond their own mission or objectives (Easterling, 2013).

#### **2.5.2.4 Awareness and application of diverse cultural realities, values and practices**

The cultural histories of collaborative partners have impacted on how each partner views the other and on how services were delivered to service users. Taylor, Bessarab, Hunter and Thompson (2013) cited the colonial-footprint and associated historically linked issues, which

had impacted on clinical practice between indigenous and mainstream practitioners. In a review of Māori experiences of access to health services, Jansen, Bacal and Crengle (2009) identified the lack of culturally appropriate and responsive services was a barrier to Māori service user access to health services. Participants in this study identified a lack of the use of te reo Māori (Māori language), lack of culturally appropriate education and promotional material and information, and a lack of Māori staff as substantial barriers to access quality health services.

Research on barriers and enablers of collaboration in substance use and related problems treatment in Australia noted that mainstream treatment programmes cannot simply be transplanted into an indigenous community, and that these indigenous services are not simply mainstream oriented services managed by indigenous communities. They are guided by indigenous beliefs, practices and priorities (Gray, Wilson, & Allsop et al, 2014). Taylor, Bessarab, Hunter & Thompson (2013) identified that indigenous organisations have multiple responsibilities that are often not identified or acknowledged by partnering mainstream services and/or funding providers. Indigenous organisations have accountabilities to their own peoples and community priorities whilst simultaneously having accountabilities to funders and partner organisations. For partnership to be successful between indigenous and non-indigenous organisations, these dual accountabilities need to be acknowledged and valued (Taylor, Bessarab, Hunter & Thompson, 2013).

In a review of Māori experiences of access to health services, Jansen, Bacal and Crengle (2009) identified the universal western approach to health care as an organisational barrier to Māori accessing health services. The authors identified that a mainstream ‘one size fits all approach’ does not respond to the diverse needs and preferences of Māori. Issues identified within systems of care included inflexible appointment systems; the timing and availability of services; lack of options; and unclear continuity of care such as maintenance in treatment and follow-up (Jansen, Bacal & Crengle, 2009).

#### **2.5.2.5 Staff recruitment and retention in rural areas**

In a review of Māori experiences of access to health services, Jansen, Bacal and Crengle (2009) identified the under-representation of Māori in the health professions as an organisational barrier to Māori accessing health services. Wong and Nixon (2016) identified that despite Māori making up 14% of the national population, and making up a higher proportion of peoples living in highly rural and remote areas, Māori General Practitioners (GP) make up less than 4% of both the urban and rural generalist workforce.

Marrone (2007) also identified isolation and rurality as significant barriers to the delivery of health services for indigenous populations, including Māori. The author identified that many traditional tribal areas are located in rural and remote areas, and health services in these areas tend to be understaffed and find it difficult to recruit staff. Difficulty in attracting staff is further compounded by the identification staff turnover as a barrier to the continuity of collaborative relationships. McLachlan et al., (2012) also identified staff recruitment, low numbers of staff and lack of qualified staff as barriers to delivering substance use services to rural whānau experiencing substance use and related problems.

#### **2.5.2.6 Resourcing the development of capacity and systems to support the application of collaboration and integration**

Poor resourcing and support has been argued to contribute to both reluctance and resistance to engaging in collaboration. (Dougherty, 2013; Eppel, 2013). Reluctance was related to the likelihood of more time and effort required by practitioners in establishing and maintaining collaboration.

Collaboration across organisations, within or across professions has been cited as a time consuming and frustrating endeavour (Kania & Kramer, 2011). Organisations tend to expend time and energy on establishing shared goals, agendas and interests, with very little time actually engaging in collective action (Easterling, 2013). The application of collaborative practice relies on a range of factors, including the capacity and capabilities of the organisation to collaborate (Ihimaera, 2007). The literature also reports that the adoption of new collaborative practices spread very gradually if at all (Kania & Kramer, 2013).

Additional resourcing of administrative support and time, in order for practitioners to engage in interpersonal collaboration, has been identified as an enabler of collaboration (Easterling, 2013; Mauriora Ki Te Ao - Living Universe Limited, 2010). Taylor, Bessarab, Hunter & Thompson (2013) identified that additional financial resourcing is required when a partnership is in early phases and involves agencies with a history of very little engagement with each other. Research exploring collaboration between mainstream and Aboriginal alcohol and drug services in Australia, identified that an increase in funding had a direct relationship with enhanced interagency and community collaboration, and a range of other service delivery issues such as the development of consistent tools, increased client contact and general capacity to deliver services (Gray, Wilson, & Allsop et al, 2014). A range of other systems have been identified as important to effectively resource the establishment of a collaborative initiative between organisations:

- Consistent system and treatment pathway tools (Taylor, Bessarab, Hunter & Thompson, 2013).
- Evaluation loops, where relationships, shared objectives and emerging solutions are sought, measured and communicated (Kania & Kramer, 2013).
- Mechanisms and measures that addressed issues; relational factors such as communication and vision; operational factors such as referral pathways and meetings; and client outcomes (Easterling, 2013; Taylor, Bessarab, Hunter & Thompson, 2013).
- Sharing information between services is challenging at both a practice level, and in relation to shared knowledge of privacy and confidentiality (Addiction and Mental Health Collaborative Project Steering Committee, 2014). It has been argued that information and communication technologies (ICT) support case management and communication across organisations (Mays, 2013; McKinlay, Gray and Pullon, 2013; Smith & Ovenden, 2007).
- Training in collaborative practices, such as knowledge of privacy and confidentiality and the development and strengthening of awareness of each other's practices, preferences and culture has been identified as an enabler of collaboration (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Edinburgh Alcohol and Drug Partnership, 2013).

#### **2.5.2.7 Awareness of collaborative partners**

Barriers to collaboration between organisations have included a lack of knowledge of other organisations' services, philosophies, culture or preferences (McKinlay et al., 2013; Fredheim, Danbolt, Haaver, Kjonsberg & Lien, 2011; Kodner & Spreeuwenberg, 2002). Lack of knowledge of roles in partnerships, and also the different skills, ways of working, and strengths of partners have been identified as impairing the development of collaborative ventures between indigenous and mainstream alcohol and drug services. An example of this was a perception that lack of knowledge of each other's services led to a lack of referrals to that service (Taylor, Bessarab, Hunter & Thompson, 2013).

Several recommendations have been made regarding increasing the awareness of collaborative partners and enhancing the communication between partners. This includes leadership, technology and training (McKinlay et al., 2013; Fredheim, Danbolt & Haaver et al., 2011; Kodner & Spreeuwenberg, 2002). Culturally specific enablers have been identified regarding training. Joint training and workshops facilitated by culturally competent facilitators

have been identified as a method of enhancing interpersonal relationships and increasing project problem solving between mainstream and indigenous practitioners who are attempting to work collaboratively in the alcohol and drug sector (Gray, Wilson, & Allsop et al, 2014; Taylor, Bessarab, Hunter & Thompson, 2013).

#### **2.5.2.8 The impact of rurality and isolation**

Features of rural New Zealand have been identified as making the delivery of health services in rural communities particularly challenging. This has included the large distances between communities and the physical terrain. Communities that are physically isolated can also contribute to diseconomies of scale when needing to plan and fund services. There are high levels of deprivation in some rural communities, high concentration of Māori in some regions requiring more culturally attuned services, and seasonal fluctuations in populations that make planning and delivering appropriate health services hard to manage (Fraser, 2006).

Research into access of mental health services in rural communities identified that rural communities have very little in the way of options or choices for service users, and those that are available may be at some great distance for the service user (McLachlan et al., 2012; Fraser, 2006, Rameka, 2006). Jackson, Judd and Komiti et al., (2007) reported that due to a lack of clinical specialists in rural areas, service users were more likely to be reliant on GPs for specialist services. However due to the high workload of GPs in rural areas, it wasn't always possible for GPs to allocate sufficient time to address these complex issues.

Telehealth services were identified as a potential enabler of effective health care for rural and remote communities, providing opportunities for GPs to consult with clinical colleagues and access continuing education, and for patients to access advice and information (Fraser, 2006).

#### **2.5.3 Practitioner collaboration**

Practitioner-level collaboration is considered to involve collaboration between practitioners within or across professions. This takes into consideration issues such as interprofessional collaboration practice, multi-disciplinary teamwork. It also includes the processes that support practice and the attitudes and behaviour of the practitioner within collaboration. The literature on enablers and collaboration are presented in six themes, including:

- Siloing and turf protection
- Conflicts of interest for indigenous practitioners in rural communities
- In tune with the history, needs, resources and culture of the community

- Flexible and responsive comprehensive care
- Indigenous health workers
- Indigenous practitioner knowledge, skills and preferences

### **2.5.3.1 Siloing and turf protection**

Negative attitudes between professionals within the addictions and mental health fields in New Zealand have been identified as a significant barrier to collaboration. These negative attitudes have been identified as a consequence of a range of factors, including: “differing philosophies, treatment approaches, funding sources, training and qualifications, and staffing” (Ministry of Health, 2010, p. 23). McKinlay et al., (2013) identified the role of ‘turf protection’ and reinforced the negative impact of attitudes and scopes of practice. “Entrenched attitudes about scopes of practice, professional “turf” and historical power structures can sabotage the essence of what good teamwork is” (McKinlay et al., 2013, p. 147).

Within cross cultural collaborative practice, lack of knowledge about the preferences, abilities, practices and values of the practitioner from a different culture has been identified as a barrier to effective collaboration (Gray, Wilson, & Allsop et al, 2014). Taylor, Bessarab, Hunter and Thompson (2013) reported that mainstream western practitioners did not understand the preference of Aboriginal Australian practitioners wanting to welcome and be involved at first contact with Aboriginal clients who may be referred in from different services, or who may be of a different language group, whereas Aboriginal Australian practitioners viewed this contact as traditional protocol and part of the healing process.

Trust has been argued to be an important element of collaboration, which is established through the development of solid interpersonal relationships (Widmer, 2011). When trust is reduced, relationships fail due to competition and mistrust (Kania & Kramer, 2013). In a New Zealand study on collaboration across primary health and mental health providers in urban and rural communities (Holdaway, 2003), Māori community support/health workers reported that mainstream practitioners did not recognize or respect their knowledge and skills. These practitioners also reported that there was a lack of information across sectors that have negative impacts on service users, and a general lack of commitment to integrated care across the sectors.

A willingness to acknowledge and respect the perspectives of other professions and practitioners has been identified as an enabler of collaboration (Dougherty, 2013). In

collaborating with other practitioners, it has been argued that mutual knowledge, incorporating the defining of roles, competence, systems, possibilities and restrictions is also an enabler of developing interprofessional collaborative practice (Fredheim, Danbolt & Haaver et al., 2011; Widmer, 2011)

### **2.5.3.2 Conflicts of interest for indigenous practitioners in rural communities**

In a study on the challenges of collaboration with and for rural Māori with substance use and related problems (McLachlan, 2010), rural health and social service practitioners reported the significant challenges they faced living and working in the same rural area. These included having multiple roles in the whānau such as an uncle or auntie, or community, such as on the marae, or sports club. These dual roles (practitioner and or whānau/community member) often place them in an uncomfortable position of knowing or having a connection with a service user and/or their whānau. Some practitioners in this study report that whanaungatanga (relationship) can be a positive thing, as it makes engagement easier, however others reported a state of taukumekume (tension) reflected in the cultural concept of kūpapa (traitor), where different groups are unsure whether you are there to help or use your inside knowledge of them to cause harm to the service user, and benefit the organisation.

Aboriginal Australian alcohol and drug practitioners also report that they have both clinical responsibilities to their organisation and practice along with cultural responsibilities to their communities that mainstream western practitioners did not understand or acknowledge. This led them to report that mainstream staff did not acknowledge the value they added to the service contributing both clinical and cultural competencies (Taylor, Bessarab, Hunter & Thompson, 2013).

### **2.5.3.3 In tune with the history, needs, resources and culture of the community**

Knowledge of the local communities' resources, needs and culture has been argued to enhance the responsivity of services (McLachlan, 2015). Howard (2003) finds that alcohol and drug services with increased cultural competencies provide better access to health and social services, and in-turn clients attain better psychosocial outcomes. In a series of focus groups with rural addictions, health and social service practitioners working with Māori with substance use and related problems (McLachlan et al., 2012). Participants identified the importance of practitioners understanding the cultural and geographical history of the area. Participants reported that this knowledge can be imbued within culturally informed practice, can enable whanaungatanga with Māori service users and other organisations, and can assist in establishing whakapapa between Māori moving into the region from different iwi as

culturally appropriate methods of welcome and integration into a new area. This was reinforced by Taylor, Bessarab, Hunter and Thompson (2013) who reported that Aboriginal Australian practitioners, prefer to conduct all welcome processes for Aboriginal service users coming from outside of the area to support the engagement and transition.

#### **2.5.3.4 Flexible and responsive comprehensive care**

The type of service delivered was also identified as important for engaging service users and their whānau. A preference was observable for services that are responsive and flexible including:

- Time and place of delivery (Smith & Ovenden, 2007).
- Ability to respond to a range of health and social problems through an integrated approach with a single point of contact (Smith & Ovenden, 2007; Ministry of Health, 2010).
- Multidisciplinary teams with a mix of clinical and non-clinical experience and expertise to be able to respond to complex whānau presentations (Ministry of Health, 2010).

#### **2.5.3.5 Indigenous health workers**

Māori service users and other indigenous service users have reported that both access to indigenous workers, and access in either indigenous or culturally safe spaces was an important enabler (Gibsin, Lisy, & Davy et al., 2015; Jansen, Bacal & Crengle, 2009). One term for an indigenous health worker in New Zealand is a kaiāwhina, or community health worker. The National Health Committee (2010) noted that kaiāwhina were becoming more prominent in primary health care in rural communities, encompassing various roles, including supporter, navigator, information broker, locator, educator, interpreter, coach/mentor, facilitator, co-ordinator, friend, spiritual provider/intervener, and pastoral care. These workers were noted to bridge the gap between mainstream clinical staff and Māori patients and their whānau through active outreach in whānau homes (National Health Committee, 2010).

#### **2.5.3.6 Indigenous practitioner knowledge, skills and preferences; and practitioner cultural competencies**

Cultural competence is both a skill and an attitude required by practitioners. Practitioners are argued to need the “knowledge, skills, and dispositions necessary to adapt the consultation or collaboration process to the cultural context in which these services are provided” (Dougherty, 2013. p. 63). Marrone (2007) notes that western health systems and practitioners

need to take into account indigenous spirituality views on health and healing. The different views between indigenous practitioners and western practitioners about contributing factors to alcohol and drug problems is a source of tension. Taylor, Bessarab, Hunter and Thompson (2013) reported that western practitioners consider that Aboriginal Australian practitioners used the impact of Australian colonial history as justifying client behaviour and the need for different treatment approaches. These practitioners also report that Aboriginal Australian practitioners used the non-Aboriginality of western practitioners against them, in that they did not understand the client's situation. Historical and intergenerational trauma has also been acknowledged by other research into health access by indigenous populations to contribute to substance use and other issues such as depression and suicide (Marrone, 2007).

Taylor, Bessarab, Hunter and Thompson (2013) reported different relational preferences for indigenous health practitioners working with mainstream alcohol and drug services. The authors noted that Aboriginal Australian alcohol and drug practitioners preferred face-to-face contact with partnering practitioners from mainstream services, whereas mainstream western practitioners relied on emails and telephone contact. This tension between the indigenous and western practitioners was noted by the authors to feed mistrust and polarise the partnership. Gray, Wilson, and Allsop et al, (2014) identified the importance of culturally fluent practice, as opposed to an add-on of cultural practices “going beyond rhetoric and ensuring the operationalization of culture in psychotherapeutic practice” (Gray, Wilson & Allsop et al, 2014, p. 486).

Cultural training and support for western practitioners was identified as an enabler for enhancing the ability of western practitioners to engage with indigenous practitioners and service users (Gibsin, Lisy, & Davy et al., 2015), and culturally competent facilitators were identified as important to enable “courageous conversations about the often unspoken difficult issues; the ‘elephants in the room’” (Taylor, Bessarab, Hunter & Thompson, 2013, p. 7).

#### **2.5.4 Service users and whānau collaboration**

Organisational level collaboration is considered to involve collaboration between different organisations, and aspects related to the provision of services. The literature on enablers and collaboration are presented in five themes, including:

- Tino rangatiratanga – whānau self-determination
- Rural isolation and compounding poverty reducing access to services and other necessary services and opportunities

- Whānau attitudes towards help seeking and service utilisation
- Racism and discrimination
- Normalisation of substance use.

#### **2.5.4.1 Tino-rangatiratanga – Whānau self determination**

Both academic and New Zealand government literature informed by a Whānau ora approach, encourage practice to enhance the abilities of service users and their whānau to address their own issues and those of their whānau members, garner their own strengths and make decisions about what is important for them (Mental Health Commission, 2000; Ramage et al., 2005; Ihimaera, 2007; Mays, 2013; Ministry of Health, 2010; Mauriora Ki Te Ao - Living Universe Limited, 2010).

Literature that has addressed the preferences and needs of indigenous populations to access health services, have consistently acknowledged the need to enable empowerment of the service user, in order to share responsibility for their health and health care. It was concluded that this required access to culturally relevant information, and active participation and decision-making in all areas of their care (Gibsin, Lisy, & Davy et al., 2015; Ministry of Health, 2010).

Literature also identified the importance of recognising the influences that whānau and peers have on service user's attitudes and behaviours (Jansen, Bacal & Crengle, 2009; Gibsin, Lisy, & Davy et al., 2015) and that this influence can either enable or inhibit access to care (Gibsin, Lisy & Davy et al., 2015).

#### **2.5.4.2 Rural isolation and compounding poverty reducing access to services and other necessary services and opportunities**

In a study of health access experiences of rural Māori women, Rameka (2006) identifies issues of social marginalisation, poverty and distance from important services as significant barriers for Māori. The author notes that poverty was a specific issue for Māori in these rural areas, which contrasted sharply with the wealthy non-Māori farmers. As an example, Māori typically experienced a lack of fulltime employment, generally labouring or farming work, or needed to leave their families for periods to access seasonal work (Fraser, 2006). McLachlan et al., (2012) identified that whānau often moved into the rural areas due to unemployment and the need for cheaper accommodation, and that these individuals then had fewer opportunities for employment in the rural area, and their problems, such as substance use, were often compounded due to being disconnected from traditional whānau support systems.

Research into indigenous peoples accessing health services has identified socio-economic status as a barrier to accessing health care (Marrone, 2007; Jansen, Bacal & Crengle, 2009). Barriers are noted to include direct costs of consultation and prescriptions, and indirect costs such as travel, childcare and time off work (Jansen, Bacal & Crengle, 2009). Māori accessing health care noted doubts as to the value for money of consultations (Jansen, Bacal & Crengle, 2009). These barriers were even more pronounced for rural populations, with recommendations made for provision of transport and accommodation for patients from rural and remote regions (Gibsin, Lisy & Davy et al., 2015). Other practical issues that were important to address included the costs on whānau for accessing services such as transport and time off work (Ramage et al., 2005; Ihimaera, 2007). Social isolation for rural people was compounded by having no landline or cell phone coverage (National Health Committee, 2010).

#### **2.5.4.3 Whānau attitudes towards help seeking and service utilisation**

Goffin (2014) reviewed literature to inform responses to the high rates of mental health problems and suicides among farmers in New Zealand. The literature review did not specify the ethnicity of participants within the studies reviewed, and did not report any culture specific factors that acted as either barriers or enablers of care. From the literature they reviewed, the authors identified a range of attitudinal barriers to both help seeking and service utilisation, lack of knowledge about mental health concerns, and concerns about health services that reduced service utilisation. Attitudinal barriers included stoicism towards ill health or injury, a tendency to underestimate problems, an unwillingness to discuss emotions, fatalism, and a focus on practical problem solving. These attitudes are cited alongside values such as pride, independence and self-efficacy in rural communities. Jansen, Bacal and Crengle (2009) identify Māori relational attitudes and health beliefs as cultural fit barriers to accessing services, including shyness, a reticence to challenge authority, and a ‘wait and see’ attitude to illness.

It was noted that the attitudes towards accessing health are based on cultural relational preferences of the service users, and the past experiences of accessing health services of the service user, and at times the past experiences of their whānau and those close to them (Jansen, Bacal & Crengle, 2009). This was reinforced in the study by McLachlan et al. (2012), in which the previous experience of the service user and their whānau can influence the choice of future service access. This is a significant barrier to care in small rural communities, where there may not be other options. Openly exploring and addressing the

service access history and experiences of the service user and their whānau at service entry is reported to be an enabler of collaboration in this context.

Stigma has been identified as a factor that influences service users' attitudes to accessing mental health service in rural communities, and that this outweighed other variables such as gender, education or income, mental health symptoms or disability levels (Jackson, Judd & Komiti et al., 2007). This has been argued to be worse in small rural communities due to concerns by patients about lack of privacy in close-knit communities (Jackson, Judd & Komiti et al., 2007). McLachlan et al., (2012) also identified shame and embarrassment (whakamā) as barriers to whānau seeking help or accessing services for substance use problems.

Research into access to mental health services in rural communities identified that rural populations were less likely to access psychological or psychiatric services than urban populations, and that psychological variables and knowledge about mental health problems and their treatment impact upon help-seeking and service utilisation for this population. (Jackson, Judd & Komiti et al., 2007). A lack of knowledge of mental health problems or how these may be expressed was also identified as reducing service utilisation in rural communities (Goffin, 2014). Concerns about service utilisation include confidentiality, lack of knowledge about what services do, a lack of confidence in services, concerns about confidentiality and concerns about service users being hospitalised against their will (Goffin, 2014). Confidentiality is also identified in a study of barriers and enablers of collaboration with and for Māori with substance use and related problems (McLachlan et al, 2012).

Despite negative interaction with some health services, Māori have reported favourable experiences of working with practitioners who are able to address multiple needs, and with practitioners who they have developed a trusting relationship with over many years (Jansen, Bacal & Crengle, 2009; Fraser, 2006). Enablers for rural farmers accessing mental health services from their GPs also include having an established relationship with their GP, a belief that the GP can help, provide support, and a perception that there is less stigma involved with consulting with their GP (Jackson, Judd & Komiti et al., 2007).

Literature also identifies that clear communication and information could address several barriers to service users' engagement with services. These included addressing the fears of service users that their information would be shared indiscriminately (Kodner & Spreeuwenberg, 2002; Ministry of Health, 2010) and the need for clear consent processes and forms that explain clearly what information is being collected and shared, for what purpose, and with whom (Ministry of Health, 2010).

#### **2.5.4.4 Racism and discrimination**

A qualitative study examining Māori experiences of health care, by Jansen, Bacal and Crengle (2009) identified that racism and past experiences of being patronised, impacted on the willingness of Māori to engage with health services. Rameka (2006) also reported rural Māori women's experiences of discrimination within health care. Addressing racism was noted to be an important aspect of addressing barriers to access and also the contributing factors for poor health outcomes including mental health and substance use problems. "Longitudinal studies suggest that self-reported racism precedes negative health outcomes. The strongest associations were observed for mental health outcomes and health related behaviours including substance abuse, alcohol abuse and smoking" (Marrone, 2007).

#### **2.5.4.5 Normalisation of substance use**

McLachlan et al (2012) identified service user and whānau attitudes towards substance use as a barrier for service users accessing and engaging in substance use treatment. Rural practitioners in the study reported that substance use was often normalised in whānau, and that it was either not seen as a problem, or that service users had a lack of ability or desire to change.

### **2.6 Summary**

The literature reviewed identifies that collaboration as a concept is widely used but lacks definition. It is also a complex term with potentially challenging connotations for Māori, due to the connection between a collaborateur (French term used for people who worked for or with the German army during world war two) and kūpapa (traitor). It is evident that collaboration incorporates both system based and relational practices, and from a Māori perspective, Te Tiriti o Waitangi (The Treaty of Waitangi) is the basis for the start of formal collaborative relationships. The treaty principles of partnership, protection and participation along with Māori values and practices are widely considered key to guiding the process of collaboration, from engagement to maintenance of relationships and collective aspirations

Rose and Norwich (2014) provide a model of collaboration that incorporates several important levels of collaboration, including policy, organisational, group functioning and practitioner beliefs and practices. However, this model does not sufficiently account for the involvement of history, particularly the colonial footprint and its impact on each of the different levels of collaboration. This model also does not incorporate the role of service users

in collaborating within the whānau to address their issues, or the collaboration between the service user and their whānau with practitioners.

Barriers and enablers of collaboration clearly occur across strategic, organisation, practitioner and service user and whānau levels. These enablers and barriers incorporate values, beliefs and practices. The lack of shared understanding of different values, beliefs and experiences contribute to tension across different levels of collaboration. And this is magnified when there are cultural differences between collaborating partners. There is a lack of literature of the experiences of indigenous practitioners engaging in interprofessional collaborative practice with mainstream practitioners and the impact on the collective aspirations of both groups. For service users and their whānau, the level of understanding of health, illness, and past experiences with health and social service impact on their willingness to help-seek or access health and social services. Socio-economic factors are further compounded by rurality in influencing collaboration.

In order to understand and sufficiently define collaboration for rural Māori with substance use and related problems, research is required that captures the experiences of Māori, across the different structural, organisational, practitioner and service user/whānau levels of collaboration. Published literature to date in these areas has identified a wide array of factors that can limit and facilitate successful collaboration. As discussed earlier, the enablers of collaboration are often opposite side of the same coin, in that their absence can be a barrier to collaboration.

There were a range of common barriers to collaboration that were found to impact across all four levels of collaboration (policy, organisational, practitioner and whānau). These included mistrust, rural isolation, and the impact of colonisation. Barriers to collaboration at a strategic level included: funder induced contractual changes, unequal power relationships, distrust, and the ongoing impact of colonisation. The enablers of collaboration were noted to include a co-development approach to collaboration. This incorporated taking a long-term view of collaboration and actively engaging service users, their whānau and communities in service design and development. It also integrated acknowledging, understanding and incorporating indigenous ways of working. Formal processes were also identified as enablers of collaboration. This included funding models and approaches to planning and contracting that plan for, expect and enable collaboration, and formal agreements outlining values, objectives and collaborative practices.

Organisational barriers to collaboration included: a history of competition and mistrust between providers, Māori experiencing collaboration fatigue and tokenism in collaboration with non-Māori, and staff recruitment and retention in rural communities. Enablers of collaboration were noted to include mechanisms and activities that brought practitioners together, such as formal and informal contact between services, inter-agency and inter professional training, the use of technology by practitioners in accessing advice and support, and resourcing practitioners to engage in collaboration. This encompassed considering allocation of time, administrative support, and also case management tools that support collaborative practice. Collaboration also required the right people to be present for collaboration to progress. This comprised ensuring the right people (decision makers) are at the table consistently; that when engaging with Māori, it is with iwi representatives, not just ‘anyone Māori’. It also involved ensuring there were strong leadership who would champion collaboration. It was also noted to be important that organisations took a broad contextual view of collaboration. This incorporated organisations looking beyond siloed organisational objectives – showing flexibility in engaging in collective objectives, understanding, acknowledging and addressing historical cultural experiences between groups (the colonial footprint), and having awareness of the strengths, references and practices of your own and partner services

Barriers to collaboration at a practitioner level included: different philosophies of illness, wellbeing and change; professional ‘patch protection’; living and working in rural communities, particularly with cultural and/or genealogical relationships; and indigenous workers having both clinical responsibilities to the organisation and cultural responsibilities to their communities. Practitioner level enablers of collaboration included attitudinal factors, such as a willingness of practitioners to acknowledge and respect the perspectives of other professions; competency issues, such as cultural competencies, and related to this, cultural training and support for non-Māori practitioners. Flexible and responsive comprehensive care was identified as an enabler of collaboration, and knowledge of the local communities’ resources, needs and culture was identified as helpful in working in this way.

Whānau level barriers to collaboration were noted to include: rural isolation and poverty, negative attitudes and stigma related to help-seeking and service access, practitioner racism and discrimination against Māori service users, and normalisation within families of substance use. Enablers of collaboration at a whānau level were reported to include, the availability of indigenous health workers; the approach taken by practitioners, including strengthening and enabling whānau to address their own issues; whānau having long-term

relationship with health providers; and clear communication and information regarding service process, confidentiality and privacy

Contributing new insights to this literature within the author's local context will require a focus on the history of the local iwi group and the development of health and social services through relationships with the Crown. Research will also require attention to Māori practitioners' experiences of interprofessional collaborative practitioners. Finally, a lack of literature on indigenous substance users and their whānau collectively addressing their own issues or engaging in collaboration with different practitioners and organisations demands addressing.

Therefore the purpose of the current study was to build on existing knowledge and to further explore collaboration in the context of a rural community for Māori with experiences of substance use and related problems. This involved a focus on a complex series of interpersonal relationships and systems occurring with a rural Māori community. The next section will discuss the methods utilised in the current study, including Kaupapa Māori Methodology, which is argued to strengthen the ability of the researcher to engage with the present topic and participants, and ensure the objective and approach taken aligns with Māori values, beliefs, preference and aspirations. A case study approach is described which provides a framework for analysing a complex set of relationships within a bound system.

### **3 Methodology and methods**

*Ki te whei ao, ki te ao marama*  
*(into the world of light and understanding)*

#### **3.1 Introduction**

This chapter will detail Kaupapa Māori research (KMR) and how it was used to privilege indigenous epistemology and indigenous voices. It will then detail the methods employed within the research to explore Māori participant beliefs, perspectives and experiences.

KMR forms the philosophical basis and framework behind this research, and has informed which methods were therefore employed for this study. KMR was selected as the most appropriate methodology due to its ability to position itself within Māori worldviews of establishing and maintaining relationships, developing shared understandings, and responding to challenges. This is particularly important when considering both the participants and researcher. Māori are the predominant participant group and recipients of the implications for actions produced from the research, and the primary researcher is also Māori, of the Ngāti Apa iwi of the Rangitīkei region.

#### **3.2 Methodology: Kaupapa Māori research**

This section discusses KMR as follows:

1. What is Kaupapa Māori Methodology – how is it defined by its authors – why is it the best fit for this research?
2. How it is a response to colonisation – and an active method of decolonisation.
3. How KMR works in terms of its application to research.
4. What are the benefits of using this methodology (inclusive of current critiques) and why therefore is it appropriate for this research?

KMR has been described as a philosophical, theoretical, and conceptual framework and a set of methodological principles and processes (Smith, 1997; Smith, 1999). It has been widely applied in social science research, often being described and valued as more than just a research methodology (Moewaka-Barnes, 2000; Bishop, 1996; Gibbs, 2001; Smith, 1999; Walker, Eketone, & Gibbs, 2006). Smith (1999) highlighted the importance of KMR as a theory, by describing some of the potential outcomes of KMR, including convincing Māori of the value of research, and the research community of the need for greater Māori involvement

in research, and to develop new research strategies and approaches (Jones, Crengle, & McCreanor, 2006). Cram (2001) reinforced the importance of KMR for Māori, by proposing the Waitangi Tribunal claims process as one of the taumata (platforms) for Kaupapa Māori, from which there has been a significant growth in Māori research capacity, models, and information collected that is relevant to Māori.

Smith (1999) also proposed that KMR holds two significant strands, which are divergent and complimentary. The first strand relates to the time before the colonisation of Aotearoa (New Zealand) by the British. For the purposes of this research this first strand will be referred to as the ‘tūturu strand’ – in that it reclaims, retains and holds true to original teachings and guiding principles that were in existence in pre-European times. This strand is evident within Graham Hingangaroa Smith’s statement that KMR is “the philosophy and practice of being Māori” (1992, p.1), what Bishop (1999) describes as the taken for granted social, political, historical, intellectual and cultural legitimacy of Māori.

The second strand as identified by Smith (1999) is the language of critique, a post-colonial discourse in which KMR seeks to search for understanding within a Māori worldview, and to challenge accepted western norms and assumptions about knowledge and the way it is constructed (Bishop, 1996; Moewaka-Barnes, 2000; Jones et al., 2006). For the purposes of this research the second strand will be referred to as the ‘tino rangatiratanga strand’ – in that it stands as a tool to decolonise, advancing the self-determination of Māori.

The usefulness, purpose and outcome of research is a paramount concern of Māori and KMR (Jones et al., 2006), that is, “Kaupapa Māori research involves a concept of the possibility and desirability of change” (Moewaka-Barnes, 2000 P.5). Moewaka-Barnes (2000) points out that methods utilised within KMR are likely to be subordinate to the issues of utility, that is, the way the data is collected is less important than the positive benefits of the research - the desirability of positive change for Māori.

### **3.2.1 Strand 1: Tūturu**

#### **3.2.1.1 Values and practices that evolved for our wellbeing and interconnection with all things**

In order to understand the two strands of KMR and how they apply as the methodology behind this research, they must be examined in greater detail. First, the tūturu strand. It has been argued that KMR is not solely based on a response to colonialism and restoring tino rangatiratanga (Mahuika, 2008), nor is it western theories disguised in Māori vocabulary (Mahuika, 2008). KMR is proposed to have underlying principles and philosophies based on

a Māori world view (Jones et al., 2006), dating back to the beginning of time and the creation of the universe (Nepe, 1991). Linda Tuhiwai Smith (1999) referred to this position within KMR as the time before colonisation, a time in which Māori were ‘intact’ and had absolute authority over their lives.

This strand then, refers to original teachings and guiding principles that one could assert have always existed in te ao Māori with the purpose of maintaining our wellbeing and interconnection with all things. It acknowledges or remains tūturu to those things with the express purpose of retaining them. It recognises that they have been handed down through the generations – ngā taonga tuku iho – for a purpose, and have evolved with us as a society. Within the application of KMR then, the actions of the researcher must exemplify these, and they will be examined further here. The literature discussed will highlight the integrated nature of traditional practices and worldviews, within the evolving nature of social, health and research realities. It also highlights the source of this knowledge within legend, art, and rituals, and the unifying thread of wairuatanga (spirituality) and the practices of tapu (restricted) and noa (unrestricted) utilised to maintain the balance between the worlds of nature and wairua (spirit) – traditional practices which are as important and valid today as they were before colonisation.

Ritchie (1992), a pākehā academic, who learnt to speak to reo Māori (Māori language) early in his career and who was noted to have developed close ties with local Waikato iwi provided his view of Māori values and practices. He argued that it is difficult to portray Māori values in simple or analytic terms. This reflects the interrelated and symbiotic nature of Māori indigenous beliefs. These values both transcend the material world (Ritchie, 1992) and provide the central tenet for maintaining the socially mediated model of health. Māori values relevant to relationships include whakapapa (genealogy), whanaungatanga (relationships, kin and non-kin), manaakitanga (hospitality), wairuatanga (spirituality), rangatiratanga (status) and kotahitanga (unity). Each of these values and concepts also include and relate to other values and concepts. As an example, Mead (2003) identified that the terms tika (right/correct) and pono (honest/true) were important concepts that underpinned values, and were important evaluative principles for behaviour. Whanaungatanga has been cited as the “the basic cement that holds things Māori together” (Ritchie, 1992, p. 67).

As discussed by Marsden (2003), despite social change, and the significant negative impact of colonisation on Māori, these first principles, core beliefs and values systems remain, providing the foundation that can evolve over time to encapsulate new discoveries, and meet

current realities. The symbiotic relationship between the individual, the collective (whānau, hapū and iwi), the environment, and te ao wairua (the spiritual world) can be seen within contemporary Māori models of health and wellbeing, such as Te Whare Tapa Whā (Durie, 1994), Te Wheke (Pere, 1984), and Ngā Pou Mana (Henare, 1998; Huriwai, 2002).

### **3.2.1.2 How Māori values and practices are articulated, promoted, and perpetuated**

These foundational values – first principles, practices, and views of reality are proposed to be held, and transmitted through tikanga (cultural practices), including but not limited to, te reo Māori (Māori language), whakapapa, karakia (incantations), inoi (prayer), whakairo (carving), ta moko (tattoo), tukutuku (panel weaved patterns), waiata (song), haka (war dance), oriori (laments), pōwhiri (formal engagement process) and tangi (funeral) rituals. Tikanga Māori (Māori cultural practices) are proposed to be accepted as reliable and appropriate for achieving certain goals, and have been handed down through the generations. These have continued due to the successful outcomes of the behaviour, such as engagement rituals that establish safe and effective relationships, and have been handed down through infusion in stories, and the arts and language listed above.

Pohatu (2005) spoke of waiata mōteatea (genealogical/geographical specific sung poetry) as kaipuripuri (holders and distributors) of ancestral voices that reflect ‘powerful messages’ that were created and are applied for wellbeing and advancement, relevant for current and future generations. Marsden (2003) was purposeful in arguing that ‘myth’ and ‘legend’ were not mere fables or representation or ‘primitive faith in the supernatural’, but that they were purposeful constructs meant for condensing their “view of the world, of ultimate reality and the relationship between the Creator, the universe and man” (Marsden, 2003. p.56).

The world view of Māori can also be seen in Māori social structures and relationships, and the practices inherent within these, that is, the collectivist goals and ownership of knowledge (Bishop, 1999; Walker et al., 2006). Marsden (2003) described the social groupings of Māori, that is, whānau (family), hapū (sub-tribe) and iwi (tribe) as an ‘organism’ rather than organisation. This does not mean that there were not specific organising practices and roles, but that these groups focused on the needs of the group, and these groups were connected by whakapapa.

Whānau have been identified as both a concept and a building block of traditional Māori society, with its own values and practices of individual and collective responsibility (Smith, 1997; Mahuika, 2008). Whānau has also been argued to provide an organising principle for conducting research, where besides the practical aspect of undertaking research, that is, the

support of your family, the term kaupapa whānau has been proposed to reflect the way Māori researchers, kaumātua (elders) and the academic community can provide a family that in essence provides support to the researcher and the research project (Cunningham, Stevenson & Tassell, 2005; Smith, 1999).

### **3.2.1.3 Cosmology and ontology**

Guba and Lincoln (1989) propose three fundamental areas of exploration that can assist in clarifying the basic beliefs or worldview that define inquiry paradigms. These are ontology, epistemology and methodology. Ontology relates to the form and nature of reality, in essence the philosophy of reality - what is there that can be known. Epistemology relates to the relationship between what can be known (reality) and the inquirer – in essence what counts as knowledge and how we come to know this.

Walker et al., (2006) warned that Māori epistemologies, that is, what is seen as important and who can access this, has been seen as highly specialised and valued, with culturally based restrictions around its use. Rev. Māori Marsden has been identified as a tohunga, scholar, writer, healer and philosopher (Marsden, 2003). He was selected by his elders to enter the whare wānanga, that is, the tribal centre of higher and esoteric learning. Therefore, his views and recall of ngā mea Māori (those things Māori) hold mana (prestige).

Marsden (2003) is clear that Māori thoughts and beliefs about reality are based on an integrated view of the connection between cosmology (the nature of the universe and its creation), spirituality, the environment and tangata (people). He described spirituality as the ‘unifying thread’, which had been removed from ‘science’ in western thinking by early scientists. A Māori worldview avoids this ‘compartmentalisation’, something which is essential to western science, in order to test hypothesis, and measure control and outcomes.

### **3.2.1.4 Wairuatanga: Tapu and noa**

The unifying thread of spirituality can be seen as the critically important states of tapu and noa. Tapu has several definitions, including sacred, set aside, and unclean; whereas noa is described as safe and permissible (Marsden, 2003). Any breach of tapu is proposed to bring serious physical and spiritual consequences, therefore karakia or inoi and specific practices such as consumption of cooked food and cleansing with water are used to bring about a state of noa, or uphold tapu. The practices established to maintain tapu, and create noa can be seen within a wide range of traditional practices, including pōwhiri, preparation of kai, hangaia (building), whakairo and preparation and practices associated with rongoā (medicine). Bishop

(1999) discusses how processes associated with the states of tapu and noa guide the research process “such as the multiplicity of rituals within the hui and within the central processes of whanaungatanga” (Bishop p. 5).

### **3.2.1.5 Defining kaupapa and tikanga**

‘Kaupapa’ is a term that has been used in various social and political contexts over time, growing organically from within Māori communities and discourse (G. Smith, 1997). Marsden (2003) describes the meaning of the term kaupapa, by separating it into two words – kau and papa – kau denoting ‘to appear for the first time, come into view, to disclose’ and papa as ‘ground’ or ‘foundation’. He said kaupapa can refer to ground rules, first principles or general principles.

Another term is ‘tikanga’ which, when broken down, can be explained as tika referring to ‘right’ or ‘correct’ and ‘ngā’ being the plural preface. Marsden referred to this term as meaning method, plan, or custom, the right way of doing things (Marsden, 2003). Marsden (2003) identified that despite the ‘cultural erosion and genocide’ imposed by colonial forces, beliefs about reality and life provide a thread of reality, which holds together the social fabric of Māori culture.

### **3.2.1.6 Tikanga in research practice**

Cram (2001) reinforced the role of tikanga in legitimising KMR by proposing that tikanga are to be followed throughout the research process, from inception to the dissemination of results. She also mentioned the importance of tikanga in the ongoing relationships formed between the researcher and research participants. The organising and relational principles and practices within whānau have also been cited as an effective means of organising and supervising research (L. Smith, 1999; Mahuika, 2008). Bishop (1999) took the importance of tikanga in research practice further by proposing an ‘epistemological version of validity’ in which authority and legitimacy are located within tikanga, defining what is and what is not acceptable research, text and processes for Māori. This highlights the importance of understanding, drawing upon and measuring research practice based on a Māori worldview, Māori preferences, and Māori practices – tikanga.

### **3.2.1.7 An evolution of Kaupapa Māori research and tikanga in practice**

Pipi, Cram, Hawke, Hawke and Huriwai et al., (2004).proposed that first principles and tikanga can also be operationalised within research, and that critically reflecting on these

practices helps researchers make the unconscious become conscious. This proposal can be seen within the early academic writing in the field of KMR.

One of the first published guidelines for working with Māori came from Ngahuia Te Awekotuku (1991). In her article she proposed a set of nine principles of ethical conduct for researchers in the Māori community. This included responsibilities to the iwi studied and the government.

Linda Tuhiwai Smith (1999) further extended upon these early principles by proposing a set of seven cultural values and guidelines for researching with and for Māori, guidelines seen as a ‘community-up’ approach, that is, an approach that is guided by the needs, preferences and choices of participants, in this case Māori. These principles were further interpreted and discussed by Cram (2001), and are seen as the benchmark or standard of much of the work conducted in KMR since its publication. Kennedy and Cram (2010) built upon these cultural values in proposing an ethical framework for working with whānau, the ‘Community-up approach to researching with whānau’.

Another example of values and tikanga being operationalised comes from Taina Whakaatere Pohatu (2005). He focuses on the specific Māori term āta, the principles behind this, and how it relates with other specific Māori principles. Despite not being proposed as an ethical model for research, it was proposed by the author as having the potential as a “transformative approach to advance ethical social service practice in Aotearoa today” (Pohatu, 2005, p. 2), arguing that āta has the potential to address tensions between practitioners and social service users who have been “marginalised and dis-empowered in a range of their relationships” (Pohatu, 2005, p. 2).

### **3.2.2 Strand 2: Tino rangatiratanga**

The second strand of KMR speaks of tino rangatiratanga; it is aspirational. It is a theoretical framework that acts as a decolonising tool; it takes an anticolonial stance and draws on the knowledge and practices of Māori in a post-colonial world. The function of KMR in the tino rangatiratanga strand can be defined as the absolute questioning of commonly held beliefs and the way knowledge has come about. It challenges western - non-Māori paradigms, and uncovers the taken for granted assumptions underlying these western ‘norms’ (Cram, 2001; Jones et al., 2006; Pihamo, Cram & Walker, 2002). Spoonley (1995) argued that the term post-colonialism can be used to position ourselves in order to critically engage with and challenge colonialism, whereas other academics and researchers have preferred terms such as

anti-colonising and decolonising to represent the resistance and proactive aspects of KMR (Mahuika, 2008; Smith, 2000).

### **3.2.2.1 Kaupapa Māori research legitimises Māori worldviews, which are protected by Te Tiriti o Waitangi**

As discussed above, KMR is founded and predicated upon Māori worldviews (ontologies) and views of knowledge (epistemologies), including processes and practices for accessing, defining and protecting knowledge that existed before European arrival in New Zealand. Bishop (1999) argued that these pre-existing practices and processes are protected by the Te Tiriti o Waitangi, and despite being marginalised through predominantly western research practices, are today legitimised within KMR discourse. In discussing Te Tiriti o Waitangi, Cram (2001) referenced Moana Jackson (1987/1988) who stated that Te Tiriti o Waitangi affirmed ‘our’ right to conduct research by Māori for Māori.

### **3.2.2.2 Kaupapa Māori research, Te Titiri, and tino rangatiratanga/self-determination**

Article One of Te Tiriti o Waitangi relates to good governance; Article Two to tino rangatiratanga (self-determination); and Article Three to equality and equity between Māori and non-Māori. The principle of tino rangatiratanga is proposed by Bishop (1999) to be one of the ‘significant dimensions’ in KMR that sets it apart from traditional western research, as tino rangatiratanga is the operationalization of self-determination by Māori. He argued that this self-determination challenges issues of power and control of the different aspects of the research process including initiation, benefits, representation, legitimisation and accountability.

These components highlight a move from Māori as recipients of research, to self-determining what and how research is conducted. Graham Hingangaroa Smith (1997) called this transformation ‘conscientisation’, that is, a change in mindset from waiting for things to happen to them or reacting, to a proactive direction toward change. From this conscientisation, comes resistance, “a conscious ‘collective will’ to make change of existing circumstances” (G. Smith, 1997, p. 484). From conscientisation also comes praxis, that is, the action from the conscientisation and resistance, a lived and dynamic experience. This transformative praxis can be seen within the Māori cultural revitalisation of the 1970’s and 1980’s, such as the Kohanga Reo movement, Kura Kaupapa and Te Reo Māori (Bishop, 1999).

### **3.2.2.3 Colonising effects of research**

Many authors have described the process of western research and practices as a ‘social pathologising’ theory and practice, which has positioned Māori, and Māori culture as unable to cope with human problems, positioning western culture and knowledge as superior (Bishop, 1999; L. Smith, 1999). Therefore, colonisation has provided a platform for western researchers to normalise and legitimise western frameworks of knowledge, knowledge acquisition, and areas such as health and social development (Pihama et al., 2002; Jones et al., 2006). Much of the dissatisfaction and, in fact, harms resulting from Māori participation or subjectification in research has been under a predominantly western positivistic paradigm.

Positivism views reality as an external object, which exists, and is under control of natural laws and mechanisms, such as mechanistic cause-and-effect (Krauss, 2005). Therefore, research is proposed to be able to identify the ‘true’ nature of reality. The relationship between the positivistic inquirer and this reality is separate. The inquirer is argued to be objective, and to not influence or be influenced by the object being studied. The knowledge that is deemed worthy of study, is in turn those things that can be measured, verified, controlled and predicted (Guba & Lincoln, 1989). Positivistic methodology follows empirical scientific approaches, such as defining (operationalizing) the key components, observation, experimentation, and controlling confounding conditions (threats to validity and replications), with an aim to replicate and generalize. The more this is obtained the “truer” or more reliable/valid the results (Guba & Lincoln, 1989; Ryan, 2006). This is in essence a reductionist approach. Because of the nature of facts being measurable, and the researcher being an independent observer and then the inquirer, the information gathered and the reporting of this interaction is value-less (Ryan, 2006). Reporting this information is done in a manner that describes causal relationships, in a similar fashion to other sciences, reporting only those facts that could be defined, controlled and replicated (Ryan, 2006).

The positivistic paradigm has been widely criticized in social sciences, particularly from qualitative research paradigms. Indigenous groups, which are often studied and the recipients of findings, are another group particularly critical of this paradigm. This is particularly because indigenous peoples see events and phenomena as a whole and inter-connected (Ryan, 2006). Guba and Lincoln (1989) provided a thorough critique of the positivistic paradigm. One of the important features of this critique was the term ‘context stripping’, in which information is continually ‘stripped’ to those elements that are most common, able to be controlled and manipulated. This means that important information, relevant to certain contexts, events or situations may be rejected due to not meeting strict scientific assumptions.

This brings into question the relevance of data, as the world in essence is an evolving world, rather than static and refined ‘event’ or ‘object’.

Linda Tuhiwai Smith (1999) strengthened this argument by proposing that a key aspect of KMR is critically analysing the ongoing impact of colonisation on Māori, including the process of research itself. Despite the positioning of KMR as a distinct paradigm (that is, more than, and less than a paradigm), similarities have been drawn between KMR and a wide range of qualitative research paradigms. Smith (1999) proposed KMR has similarities to critical theory, which she termed localised critical theory, due to its role in critiquing dominant western paradigms, and addressing power imbalances, yet she and others criticised its lack of ability to bring about ‘concrete’ benefits to Māori, and contribute to Māori communities research capacities (Walker et al., 2006).

Walker et al. (2006) drew parallels to service-user led and participatory action research due to the self-determination goals of KMR. They also made an important point that KMR is its own philosophy and strategy, and that it is likely to be acceptable to Māori, more so than the wider academic community. In reading examples of KMR, it is also possible to see aspects of Social constructionist paradigms. As an example, Walker et al. (2006) noted that in a KMR research project “...it was the participants and the researcher together who decided what constituted an adequate depiction of their social reality concerning the Matua Whangai Programme...” (p. 339).

### **3.2.2.4 Being aspirational, benefiting Māori**

In order to create space for KMR to take a strong critical position on what Graham Smith called “the politics of Pākehā dominance in New Zealand” (1995, p. 22), KMR is required to identify and differentiate these western assumptions, paradigms and worldviews as merely one of many cultural perspectives. This strong critical stance allows us to promote our own perspectives and unique approaches, ways of knowing, and ways of being (Cram, 2001; Mahuika, 2008). In response to the negative impact of colonization, G. Smith (1997) proposes that KMR has to have as implicit components:

- I. The ability to make ‘space’ for itself to exist within the context of dominant Pākehā relations
- II. The ability to sustain the validity and legitimacy of the theory in the face of challenge from traditional intellectuals
- III. The ability to be ‘owned’ and accepted by Māori communities
- IV. The ability to provide the potential to transform, for the better, Māori existence
- V. The ability to be reflective and reflexive

In the experience of the researcher this has generally been a matter of asking: What's the benefit for us? And are we in control of how this comes about? This will be discussed further in regards to the methods for this research, selected as informed by the KMR methodology.

### **3.2.3 Critique of Kaupapa Māori research**

Despite the strong foundations of KMR within tikanga and Kaupapa Māori, there are challenges to the application of traditional Māori concepts and practices with Māori in a contemporary reality, questions as to the legitimacy of KMR as an academic theory as opposed to a movement of action and transformation, and the challenges of Māori academics meeting the expectations of both Māori and western academia.

The first of these is that there is no single 'Māori worldview'. Māori are not the homogeneous group portrayed in both western and some Māori discourses. "Not all Māori have been raised or live in a 'customary' context and the relevance of 'traditional' values is not the same for all" (Huriwai et al., 2001, p. 1035). Therefore, the way that tikanga is understood, interpreted and practiced in particular circumstances varies from iwi to iwi and hapū to hapū (Bishop, 1999; Cram, 2001; Marsden, 2003). Mahuika (2008) refers to this and points out a lack of self-critical positioning that contributes to the dichotomization between Māori and Pākehā, and insider and outsider. Moewaka-Barnes (2000) points out that defining KMR in relation to or compared with dominant western paradigms "subverts our right to be Māori – ordinary" (p. 4).

There are also arguments that KMR has moved away from both its kaupapa roots and the contemporary context that Māori live. Anaru Eketone (2008) argues that the KMR developed and promoted by academics, including Māori academics is 'somewhat removed' from KMR practices found within community based programmes and organisations. The discussion of concepts of western and indigenous ontologies (worldviews) and epistemologies (theories of knowledge), of itself, has been identified as a task of the colonised, that is, the necessity of grappling with introduced language and ideas (Mika, 2010).

The exercise of defining KMR in itself has drawn criticism, as it reflects the view of Māori approaches as the 'other' within 'our' own country, in essence a reminder of the power of colonisation (Moewaka-Barnes, 2000). Smith (1997) highlights the evolution of KMR from being aware and critical of the 'other', to the need to adequately reflect on the 'self' in

describing the importance of engaging in a genuine self-critique for the opportunities produced for greater progress and transformation. The task of walking in two worlds, that is, the world of te ao Māori (being Māori and being in Māori institutions and roles), and te ao Pākehā (interacting in western institutions, including academia) is seen as a reality and challenge.

Linda Tuhiwai Smith (1999) (p. 14) describes these difficulties as “the way we relate inside and outside our own communities, inside and outside the academy, and between all those different worlds”.

It is the position of this researcher that an awareness of these critiques stands as the basis on which the identified potential pitfalls can be avoided. In regards to insider outsider positioning, Walker et al., (2006) argue that Māori researchers are more likely to have ability to effectively engage in processes of whakawhanaungatanga. This allows a researcher to become an ‘insider’, a position where more in-depth knowledge may be shared, and a deeper more comprehensive understanding can be formed. This is based on the depth of information shared, and the ability of an insider to understand the subtleties and nuances of what takes place in interactions (Walker et al., 2006). This will be discussed further now.

### **3.2.4 How Kaupapa Māori research informed the selected methods**

#### **3.2.4.1 The role of the researcher in Kaupapa Māori research – Insider/outsider positioning**

So after the discussion on KMR, its purpose, foundations, and application as well as its tūturu and tino rangatiratanga strands, what does this mean for this research? Put simply: the actions of the researcher have to exemplify te ao Māori values and practices – and this must be done in a way that is both tūturu and aspiring at all times for tino rangatiratanga.

In many ways, the researcher can be seen as an outsider when it comes to te ao Māori. Being white-skinned with Celtic names therefore makes one a recipient of the privileges that come with being viewed as white in New Zealand (or, being privileged to avoid the kinds of discrimination that can come with being recognised as other than the dominant culture). In the tradition of internalised racism, it is easy (for both the researcher and other Māori) to question whether one can be considered Māori when not living on the land of one’s Māori ancestors, or with the hapū/iwi.

The researcher’s ability to function successfully in KMR requires several key things, including being able to provide tangible outcomes from research for one’s own people and

having the support of a research whānau from within the hapū and iwi. This whānau supports and holds the researcher accountable for the practice and for establishing open and accountable relationships with hapū and iwi. Together these guide the establishment of relationships, shared purpose, shared expectations, and levels of accountability for ensuring the safety of participants, researcher and broader iwi interests.

Ultimately, when all of this is taken into account, the researcher's approach (the methods as resulting from the KMR methodology) can be described very succinctly in relation to the broader concepts relating to the kupu (word) 'whānau'; specifically, the value *whanaungatanga* and the practice *whakawhanaungatanga*. These will now be explained.

### **3.2.5 The guiding values and practices for this research**

The concept of whānau, in both a specific and a broader sense, has widely been acknowledged as a core value for Māori (Ritchie, 1992; Bishop, 1999). In the simple and rich syntax of te reo Māori, the addition of the suffix -tanga (comparable to the English suffixes -ness and -ship) and the causative prefix whaka- (to bring about) transform the foundational concept of whānau into a value and a practice which can be enacted and woven throughout one's life, work, and research practice.

For the researcher then, whanaungatanga (relationship) is the overarching value that drives research approaches – both philosophical and practical. Inherent within this value are the guiding principles of *tika*, *pono* and *aroha*.

This chapter was opened with a positioning statement that relates to transparency; as a researcher, as a process, and for results. Transparency can be described as being *tika* and *pono*; two foundational Māori values that Hudson et al. (2010) referred to in their Ara Tika framework. They asserted that *tika* (what is right or correct) contextualised research with Māori and reflects the validity of the research. They go on to say that *whakapono* (to make honest, and by extension for the researcher, *pono* being truth and honesty) introduced within best practice reflects a relationship of transparency, good faith, fairness and truthfulness.

Hudson et al. (2010) introduced *aroha* as a protective element, a caution to consider the risks and responses to these in the process of research. Linda Tuhiwai Smith (1999) referred to 'aroha ki te tangata,' a term within KMR which Jones, Crengle and McCreanor (2006) presented as an overarching principle, considering participant welfare and expressing genuine care, and which Cram (2001) described as 'a respect for people,' allowing people to define their own space and meet on their own terms.

For the researcher, the principles of tika, pono, and aroha are inherent in whanaungatanga. Together these then inform the practice of whakawhanaungatanga – the act(s) of establishing and maintaining relationships. While this can be achieved in myriad ways, it exhibits in practice as manaaki, koha, and kanohi kitea.

The term ‘manaaki’ has several traditional meanings, generally revolving around reciprocal relationships ensuring that the mana of all parties is maintained. Jones et al. (2006) described the principle and process of ‘manaakitanga’ as incorporating several other practices with the intent to care for participants, uphold their mana and contribute to trusting relationships. Hudson et al. (2010) likewise referred to manaakitanga as being about cultural and social responsibility and respect for persons. Cram (2001) explained it simply as “sharing, hosting, [and] being generous.”

Closely connected to (and arguably inseparable from) the principle of manaaki is the concept of koha. This reflects the desire of the researcher to ensure (or give) aspirational outcomes as defined by the participants. In return, the researcher receives the generous koha of participants’ time, stories, even their vulnerability – for the very act of telling one’s story makes the teller vulnerable. The reciprocal nature of giving and receiving builds trust between researcher and participants, and upon trust is built confidence. This confidence then, gives value and validity to the research outcomes. This increases the likelihood that the participants will draw on the research and apply it in their contexts.

Kanohi kitea (or he kanohi i kitea – the seen face) refers to the importance of meeting people face-to-face, and to also be a face that is known to and seen within a community (Cram 2001). It was also acknowledged by Jones et al. (2006) in their work with Māori men as the importance of creating opportunities for researchers and participants to develop a high level of trust.

Wrapped around and through all of these values and practices are the tikanga required to bring about and maintain the quality of the relationship. Tikanga are the practices that balance safe/unsafe, tapu/noa, and, while most observable in traditional rituals of encounter such as the pōwhiri, are also played out in the subtleties of everyday encounters, even in contemporary settings.

For this research, it is within whanaungatanga and whakawhanaungatanga that the two strands of KMR are satisfied. Within this value and practice the tūturu can be claimed and retained while tino rangatiratanga is advanced.

Details of the practices which result from these values (in particular whanaungatanga and kanohi kitea) are outlined in 3.32 – Consultation: the kumara vine, and 3.3.2.1 – Whānau tautoko group.

### **3.3 Methods: Case study**

This section discusses the case study methods as follows:

1. Case study design - Why case study design was chosen as the method and the framework used.
2. Initial consultation - An explanation of the development of the case study through consultation appropriate to KMR and participants.
3. Population and sample - An explanation of how and why participants were selected
4. Data collection - How data was gathered
5. Data analysis - How data was then analysed
6. Ongoing consultation - How data was fed back to participants and the wider research group

For the researcher, once all the philosophical theory has been mused upon, analysed, synthesised and conscientised, the question of methods is a simple one to answer. KMR as a methodology has the flexibility to incorporate a wide range of methods. Smith (2000) argued for being “open to using any theory and practice with emancipatory relevance to our indigenous struggle” (p. 214), and Mahuika (2008) argues for exploring western theory and practice in order to select those components or aspects that can augment and supplement KMR.

Qualitative research methods were selected. This was due to the emphasis on relationships in the literature reviewed on collaborative practice, and the strength of qualitative research in exploring and reflecting the ‘lived experiences’ of participants, at a deeper and more context specific way than positivistic quantitative methodology. Qualitative research methods have been identified by a range of Māori researchers as meeting the preferences of Māori, allowing the acknowledgement of multiple realities and negotiation of power (Moewaka-Barnes, 2000).

#### **3.3.1 Case study design**

This research follows a case study strategy, and incorporates both case study design principles and an inductive analysis approach. A case study strategy provides a conceptualisation of the area under study, and incorporates different case study design elements. A ‘case’ has been

referred to as a ‘bound entity’, usually in the form of a person, organization, behavioural condition, or other social phenomena (Yin, 2012). An integral aspect of a case study design, which in some way differentiates it from other qualitative and quantitative research methods, is its focus on developing an in-depth understanding of a broad range of contextual and complex interrelated phenomena within its real-life context, particularly when the lines between phenomena and context are blurred (Yin, 2012). This is in contrast with methods that seek to measure (surveys) or manipulate variables (quasi-experimental design). In order to develop an in-depth understanding, case studies seek multiple sources of data, such as those found in direct observations, interviews, archival records, documents, participant observations, and physical artefacts. This allows for multiple facets of a phenomena and its interaction with its context to be explored and understood (Baxter & Jack, 2008; Yin 2012).

Several different approaches have been described for developing a case study design. In general the common elements include:

- defining the unit of analysis
- the binding of the case
- the development of a case study design, and
- the development of propositions.

Defining the case can be a difficult task, as the case could be the participants, a behaviour or specific perspective of the participants, the organisations, the location or a collection of the above. The task of defining the case therefore involves clarifying the key issue under investigation, termed the ‘unit of analysis’, and the contextual variables that interact with the unit of analysis. The task of defining the case has been termed ‘binding’ the case – in essence providing boundaries to the case – and can include consideration of time and place, time and activity, and/or by definition and context (Baxter & Jack, 2008).

May (2010) differentiates types of case study as instrumental or intrinsic. Instrumental involves larger numbers of case studies and an outcome of theory building and generalisability, whereas intrinsic seeks depth of understanding rather than breadth. It is argued that the intrinsic case study approach lends itself to inductive and participative research method techniques (Vanderstoep & Johnston, 2008).

Vanderstoep and Johnston (2008) specify that families, organisations and social groups can be the focus of case studies. Due to the social nature of case studies and the situatedness of a case, it is important that the context of the case is described, which can include “social, economic, cultural, geographical, or historical settings” (Vanderstoep & Johnston, 2008, p.

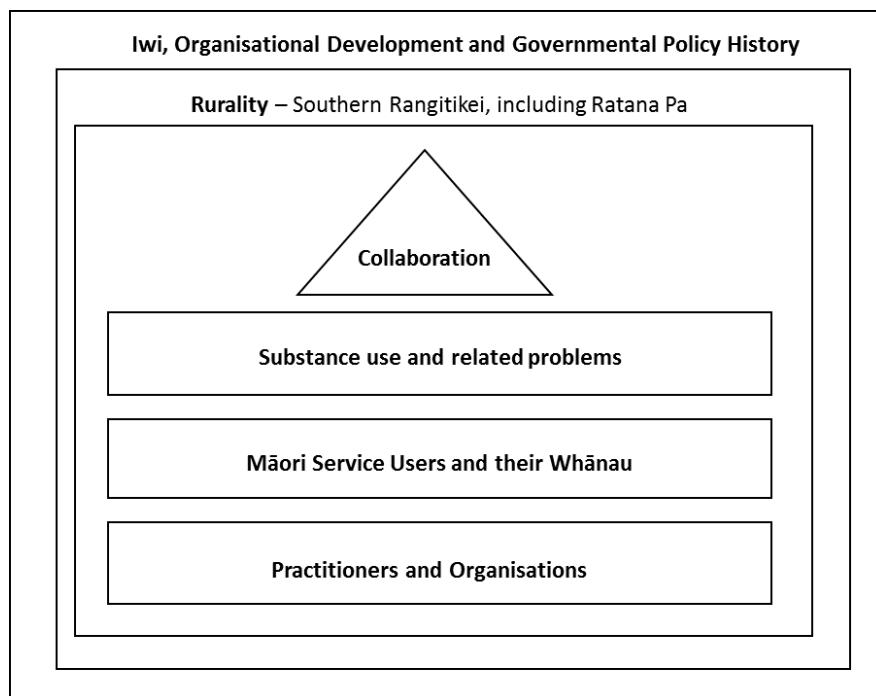
2010?). This then moves to the interpretation of events and relationships, which can include both on site data collection and review of historical documents (Vanderstoep & Johnston, 2008), providing a “method through which to describe and understand the rich, complex sets of interrelationships between different social interests” (May, 2010, p. 221), and to “present a rich portrayal of a single setting to inform practice, establish the value of the case and/or add to knowledge of a specific topic” (Simons, 2009, p. 24).

### **3.3.2 A conceptual framework for this case study**

Miles and Huberman (1994) and Baxter and Jack (2008) provide specific examples of the conceptual frameworks of case studies. Within these, both the ‘binding of a case’ and the establishment of ‘propositions’ can be observed. For the purposes of this research, the unit of analysis is collaboration, and the embedded units of analysis that are proposed to impact on collaboration are:

- Iwi, organisational development and governmental policy histories
- Māori service users and their whānau
- Practitioners and organisations
- Rurality and substance use and related problems.

These can be seen in the conceptual framework in Figure 2 below.



*Figure 2 - Case study framework*

A conceptual framework reflects the factors identified within literature reviews, previous fieldwork and the clinical experience of the researcher to impact upon the primary unit of analysis (Baxter & Jack, 2008). However, this model does not stipulate the relationships amongst the variables. These factors can be formed into propositions. The developments of propositions provide further boundaries to ensure the research remains within feasible limits (Baxter & Jack, 2008).

It is important to note that a conceptual framework can reduce the ability to be inductive. It is also acknowledged that key assumptions are made when the research question and case itself are defined (Yin, 2012). Baxter and Jack (2008) recommend that researchers monitor their research to ensure it is not becoming deductive through journaling and discussing with other researchers. Within a doctoral research, this could be reflected in the supervisory relationship.

The propositions for this research include:

1. The history of the iwi, government policy changes, and the health and social service organisations contribute barriers to existing relationships between service users, their whānau, practitioners and organisations.
2. Rurality contributes barriers related to travel (to access services) and limited service options available in rural communities.
3. Substance use and related problems contribute to personal barriers for service users and their whānau in both addressing their own issues and engaging with practitioners and services. Substance use and related problems also impact on practitioners' attitudes towards service users and their whānau.

### **3.3.2.1 Case study data analysis**

Yin (2012) argued that data analysis within case study design begins with the systematic organisation of the data into relationships. This will be examined in more depth in 3.12 – Data analysis. May (2010) asserts that two important factors should be taken into account: the use of multiple methods, and a strong emphasis on iteration between data and analysis. Multiple methods allow for a form of triangulation where confirming and non-confirming data can be identified and alternative explanations can be considered. Triangulation can include direct observation in the field, interviewing participants in the case and analysis of written documents (Woodside, 2010). Wolf (1990) notes the importance of both historical documents and the accounts of participants with different (and longer) perspectives of the context. “Rich as I believe these (respondent) interviews are, they are frozen in time, individual statements only vaguely anchored in the social and historical context that created them” (Wolf, 1990, p. 351). Yin (2012) asserts that three (or more) independent sources of data supporting the same

set of events, facts or interpretations are desirable when providing a robust convergence of evidence within triangulation, and this method has been applied in this research.

### **3.3.3 Limitations and considerations within case study**

There is criticism (from both proponents and opponents of case study strategy) about the generalizability of findings to other cases. This criticism questions whether research of a specific issue or context is able to legitimately benefit other contexts (May, 2010). Some aspects of this research will be generalizable, for example the interrelationship between collaboration, rurality and substance use. But generalizability is not a main aim for this research. The outcomes are sought to benefit the specific participants and their whānau, hapū, iwi and the region's service providers.

## **3.4 Initial consultation: The kumara vine**

As a research project facilitated within the rohe (geographical boundaries) of Ngāti Apa and guided by KMR, consultation was the starting point. At the onset this was conducted through the process of whanaungatanga, developing genealogical whānau connections with:

- key stakeholders at Te Rūnanga o Ngāti Apa
- Ngāti Kauae (the researcher's hapū), and
- the iwi health and social service provider Te Kōtuku Hauora o Rangitīkei.

This allowed discussion of all aspects of the research: the applicability of the research question to the peoples of the southern Rangitīkei, research design, recruitment, and data gathering techniques, data analysis, and reporting findings.

Substance use and related problems were identified through this informal consultation process as a key issue for the local communities. This included direction to review the Rangitīkei Community Profile (Rangitīkei District Council, 2011), which identified substance use as a significant problem for the area, particularly related to school dropouts, suspensions, and offending. The chairperson of the Ngāti Kauae hapū at the time introduced another iwi member who was a senior researcher at Te Atawhai o te Ao Independent Māori Research Centre in order to discuss issues of methodology and methods, and processes for member checking and reporting findings. From this consultation, it was decided to form a local advisory group, called a whānau tautoko group.

### **3.4.1 Whānau tautoko group**

The whānau tautoko group was formed to represent local Māori researchers, iwi representatives and representatives from Māori health and social service providers that could provide guidance on locally relevant processes for research, to support the research process with activities such as debrief and problem solving. It was agreed that contact would be made first informally as needed, and second (when doing fieldwork) the rōpū (group) would meet at least annually. It was also agreed that bi-monthly advisory board update pānui (pamphlet) would be sent out, discussing progress and issues related to the research project.

In these initial discussions agreements were made that KMR was the most appropriate methodology, and that qualitative case study design would be the most applicable method for the research topic. One of the advisory board members, Cherryl Smith, mentioned ‘the Kumara Vine method’, (slowly working around and meeting people as the project progressed, and generally through introductions), proposing that a formal approach and presentation was more likely to scare people, and that they first needed to know the researcher personally. This was in complete alignment with the already conscious philosophical positioning within the value of whanaungatanga and the practices of whakawhanaungatanga. This led to a range of introductions to local and urban health and social services to seek support for the project and access to recruitment of participants for the research.

### **3.4.2 Community and statutory social service providers**

After these introductions were made, presentations and discussions were carried out:

- DHB Clinical governance team (letter of support provided – see Appendix A)
- Te Kōtuku Hauora o Rangitīkei Iwi service staff team (screening and intervention training provided on request – see evaluations in Appendix B)
- Regional Māori Health Outcomes Group (MHOG).

## **3.5 Population and sample**

### **3.5.1 Location**

This research is focusing on those service users that live and access services in the southern Rangitīkei area, as this is the location of DHB services and wider social, health and education service options. This area was chosen for two overarching reasons:

- a) The researcher’s own whakapapa, giving a very tangible (and therefore recognisable by participants) legitimacy to the undertakings.

- b) This rural region is reflective of some of the common aspects and challenges associated with rural service delivery.

Rangitīkei District is one of the largest districts by area in the North Island, and one of a group with a population of less than 20,000. According to the New Zealand Statistics urban/rural profile classification, the Rangitīkei area includes the ‘independent rural’ community of Marton, and a spread of both ‘rural area with low urban influence’ and ‘highly rural/remote’ areas. This area has experienced change including a decline in population over the last 18 years. Statistical projections suggest that the 15,100 residents could be as low as 11,200 by 2021 (Thomas & Cowie, 2004). The Rangitīkei is less culturally diverse than the rest of the country with 16% Māori and 84% European (Thomas & Cowie, 2004).

Within the Rangitīkei district approximately 400 people live in the settlement of Rātana, predominantly Māori representing iwi from all over New Zealand. This is due to its place as the spiritual base of the Rātana faith, a movement with spiritual and political significance for Māori (Thomas & Cowie, 2004).

### **3.5.2 Participants**

As discussed, the unit of analysis for this case study design is collaboration, and this collaboration happens within and between both:

- service users and their whānau
- practitioners, service users and their whānau.

This led to the development of two participant populations:

- a) service users and their whānau (a total of 20)
- b) health and social service practitioners (21)

As a pilot study (McLachlan et al., 2012) identified both the history of the cultural and geographical area, and the development of health and social services as critical to understanding current collaborative relationships, a third participant population was developed:

- c) key informants of health and social service developments in the area (10).

### **3.5.3 Inclusion criteria**

Following are the criteria for inclusion in each participant group.

## Community key informants

- a) Community members
- b) 18 years and older, and
- c) Identified by whānau tautoko group members as involved in the development of services for Māori by Māori in the Rangitīkei area.

## Service users and their whānau

- a) Primary participants self-identified as
  - Māori
  - at least 18 years of age
  - currently involved with two or more health or social service agencies, and
  - a substance use problem.
- b) Primary participant was invited to bring whānau members along to their interview.
- c) Whānau members were required to also be at least 18 years of age.
- d) There were no gender, ethnic, or specific relationship criteria for whānau participants.

## Practitioners

- a) Work as paid or volunteer staff members of health or social services, and
- b) Work directly with adults 18 years and older living in the Southern Rangitīkei area.

### **3.5.4 Sampling and recruitment**

Sampling was purposeful for each group, and also allowed for snowball sampling, where participants identified other participants who may share relevant information. All participants received an information sheet (see Appendix C) and consent form (see Appendix D). Engagement with participants was conducted through what has been termed gatekeepers or insiders, or for this research and researcher, both literal and figurative “aunties”.

Gatekeepers and insiders have been identified as important conduits for accessing participants (King and Horrocks, 2010; Marshall & Rossman, 2011). Tolich and Davidson (1999) defined a gatekeeper as “any person who can facilitate an outsider’s entry into a ‘restricted’ location” (p. 94). These gatekeepers can be both formal (such as the head of the organisation) and informal (anyone in a position to connect the researcher to others in this ‘restricted’ area). King and Horrocks (2010) pointed out that these insiders might select participants that hold or do not hold certain views, and may also apply undue pressure to participants to participate. The authors suggested being careful in selecting these insiders, and making sure they understand the research process and objectives. They also recommended that these insiders

receive guidance and have regular contact with the researcher. It was also noted that once participants have shown an interest in the project that the researcher make direct contact with the participant to discuss the research process and ensure informed consent is achieved.

Three team meetings were attended to discuss the research objectives, participants sought, recruitment process and the importance of accessing participants with a wide range of experiences with services. Direct contact was also made with participants when they identified an interest to participate. The contact involved further discussion of the research objectives, research process and issues of consent and privacy.

In reality, each participant group in this research can be seen as ‘restricted’ groups, with distinct definitions of who is and can be an insider. Despite the term ‘gatekeeper’ usually having a negative connotation, it can also be seen as those trusted by the groups, and as having the best interest of the group. Being a predominantly rural community, different staff and advisory group members met during the consultation phase presented as gatekeepers to several groups.

#### Community key informants

These participants were identified by advisory board members as key people with an understanding and involvement in the area, and/or involved in the development of services in the area. Participants were then sent an information letter and followed up with a phone call. An insider, often an advisory group member, introduced those participants who had not previously met the researcher. A snowballing sampling process was also used in the recruitment process.

#### Service users and their whānau

First, criterion sampling was used to ensure participants represented the area of focus (substance use, multiple agency use, and rurality). Maximum variation and typical case sampling was then applied to ensure participants reflected the diverse realities of Māori (traditional and contemporary structure) and different combinations of service engagement, such as different common health conditions and social service engagement.

Two strategies were employed to recruit participants:

- a) Advertising fliers (Appendix E) seeking participants were posted in agencies that work with individuals and whānau with substance use problems, and

- b) Staff delivering services in the Rangitīkei were trained in the recruitment criteria and provided these fliers to the clients of their services who met selection criteria.

Service users and their whānau also prompted other whānau members and peers to make contact with the researcher, providing a snowballing sampling process.

### Practitioners

The local iwi social services identified those staff members from within their own services, and others that deliver within the Southern Rangitīkei. Initial contact was made, and the service manager or team leader nominated practitioners to attend. This provided both Snowball and criterion based sampling, identifying staff that represent the diverse range of services in the community who currently engage with individuals (and their whānau) with substance use and related health and social problems.

Practitioners from the following organisations participated:

- Te Kōtuku Hauora o Rangitīkei
- Whanganui District Health Board
- Te Oranganui
- Staff from statutory and non-statutory health and social services delivering services within the Rangitīkei area.

## **3.6 Data collection**

### **3.6.1 Individual interviews**

Individual interviewing techniques and approaches have particular considerations, and are a data collection method where the practices of whakawhanaungatanga are vital. King & Horrocks (2010) describe the importance of practical issues associated with individual interviews such as conducting interviews in an environment that is confidential, has limited interruptions, and allows the participant to feel comfortable, and the researcher to likewise feel safe. Building rapport has also been cited as a vital consideration that can either make or break an interview, that is, whether a participant will share openly or not (King & Horrocks, 2010).

Other important aspects of an interview as discussed by King and Horrocks (2010) are:

- the application of open ended questions
- avoiding the use of closed or leading questions
- interviewer self-awareness of their own body language

- not providing judgemental responses to participant comments
- probes, or follow-up questions intended to provide further information, which can come in the form of elaboration, clarification or completion probes.

The role of the interviewer was to manage the interview process, being cognisant of opening and closing the interview in a way that maintains the wellbeing of the participant (see 3.11.2 and 3.11.6 for specific approaches used). It was also important to maintain a stance of active listening and encouragement, and of the interview progress and direction (King & Horrocks, 2010). In line with KMR and the researcher's own research philosophies, generous amounts of kai were provided at all interviews (individual, whānau, and focus groups). This meets the requirements of manaaki and koha, and assists in whakawhanaungatanga. Prayer was also used to open and close all interviews. Specifically, inoi (Christian prayers) were used, as opposed to karakia (traditional Māori prayers) as recommended by the advisory group because of the predominantly Christian faith in the area including Rātana. This was done to uphold the mana (mana-aki, or promote the mana) of participants, and to facilitate spiritual safety within the process.

The use of individual interviews has both strengths and limitations. Interviews provide the opportunity to create a comfortable place and pace for data collection, which can itself, with good interviewer skills, access information at more depth than a simple survey or electronic interview, (e.g. questions delivered via email). They also allow for accessing the personal meaning individuals and groups attach to everyday life-experiences (Edwards & Holland, 2013).

Qualitative interviews have been critiqued as being too subjective, due to the transparency of the value-laden characteristics of this method. This is seen as having an impact on the interviewer-interviewee power dynamics and influence over the analysis including possible bias, difficulty in replication of the method and the inability to generalise the findings beyond the case study (Edwards & Holland, 2013). There are also practical limitations to conducting individual face-to-face interviews. These interviews are time consuming in both organising and conducting, with the distinct possibility of non-attendance by participants. The potential for meaning from data (language) being misinterpreted is also possible, which can lead to the researcher skewing data to match their own bias. It is argued that quantitative research has the same limitations is less transparent on its value-laden characteristics (Leavy, 2011).

Due to the explorative nature of the research question, qualitative interviews were seen as an appropriate method for this study. A semi-structured interview guide was developed to

increase likelihood of encouraging participants to describe and discuss their experiences as a stakeholder group in this study. A qualitative interview guide provides a list of question areas and prompts that guide the interviewer to explore concepts and constructs alongside the participant. This allows the interaction between the interviewer and interviewee to collectively guide the process (King & Horrocks, 2010).

### **3.6.1.1 Key informant interviews**

Ten key informant interviews took approximately one hour to complete. Each interview was preceded by an initial phone call to discuss the research objectives, process and issues of consent and confidentiality. Each interview was opened and closed with a Christian inoi to whakawātea (clear the space) and end formalities. Kai was provided and a taonga was provided to each participant as a koha and gesture of reciprocity - an acknowledgement of their contribution of time, memories and mātauranga (knowledge).

Interviewees were provided in advance with; a description of the research, the ethics and consent process, and the general topics that would be discussed. This was again reviewed in the introduction meeting prior to the interview. The semi-structured interview guide for key informant interviews was used (see Appendix F) and included questioning in the following areas:

- How did Māori health services develop in Rangitīkei?
- As a rural area, what are the specific incidents or challenges that have drawn all community services together?

Participants were informed verbally and in writing, both before and during the interview, of their right to withdraw from the research at any time. All participants were asked to sign a consent form (see Appendix D), and complete a demographic form (Appendix G). The demographic form had questions related to: iwi and hapū affiliations; age band; years lived within the Rangitīkei; years delivering services within the Rangitīkei; past roles within the Rangitīkei (within services and the community); and past roles regionally and/or nationally in relation to services for Māori by Māori:

### **3.6.1.2 Focus groups**

As an additional data collection method, focus groups were used. This was specifically done because of the method's relevance given:

- the context of the research which is examining collaboration, relationships and practices
- considerations of the KMR methodology, and
- the researcher's overarching value of whanaungatanga

King and Horrocks (2010) described a wide range of benefits to group interviews, including the 'naturalistic' nature of groups in encouraging recall of information and elaboration of ideas, the ability to uncover the social context of people's understandings and beliefs, and the provision of different levels of information (group as opposed to individual) to form part of a triangulation of analysis.

The strength of groups is the creation of a socially-oriented atmosphere that encourages the sharing of participants' beliefs, attitudes and feelings (Marshall & Rossman, 2011; Freeman, 2006), gaining a sense of agreement on issues and checking tentative conclusions (Simons, 2009), the flexibility to respond to unanticipated issues as they arise and providing an opportunity for naturalistic observation (Marshall & Rossman, 2011). The socially oriented nature of group interviews has been argued to encourage the positioning of Māori participants as experts in the research process, and reflect Māori processes of participatory decision making (Dyall, Bridgman & Bidois, 1999).

According to Bishop (1999) the process of hui (a meeting conducted under tikanga) provides guidance in the process of research, by incorporating rituals of encounter that connect people (whakawhanaungatanga), lay down the take (issues), and provide the taumata (platform) for participants to discuss, shape and collaboratively construct a deeply meaningful narrative. Under the guidance of kaumātua, following local tikanga, the hui and the processes within it can uphold the mana of participants and the tapu (sacredness) of the take (Bishop, 1999).

Despite strong evidence for the benefits of group interviews, there are challenges both practical and ethical. There is the potential for participants to dominate discussion or not openly participate – this identifies the issue of power dynamics (Marshall & Rossman, 2011). In this research there were:

- managers and their staff in the sample population
- professionals seen as more qualified or influential
- staff from agencies in which there was a competitive context (funding).

It was therefore important to clarify the importance but limited nature of confidentiality in this setting. Steps were taken to reduce the likelihood that agency management and staff were in the same focus groups.

### **3.6.1.3 Practitioner focus groups**

Three focus groups were formed with 21 participants in total. These participants were placed in each group to ensure there was a broad mix of professions and agencies present to ensure the reduction in ‘siloing’ of ideas, and to reflect the realistic nature of relatively independent collaboration between practitioners and agencies in rural communities.

Following tikanga, the researcher (being from the host iwi) facilitated both the interview and tikanga aspects of the session. This process was termed a whakatau (settling), and included practices at the opening and closing of each session, such as acknowledging the important spiritual and cultural features and people of the area (whaikōrero), greeting the participants and researchers (mihimihi), prayer (inoi), and shared kai.

A semi-structured interview format was utilized to guide discussions (see Appendix E). Three overarching questions were developed, along with 11 prompts (sub-questions), in response to the literature reviewed and the researcher’s 20-year history of working in community development and clinical settings in the capacity of a youth worker, alcohol and drug clinician and clinical psychologist. Group discussion was audio recorded and transcribed verbatim.

All participants were asked to sign a consent form (see Appendix D), and complete a demographic form (Appendix G). The demographic form had questions related to: iwi and hapū affiliations; age band; gender; profession; workplace; service; role; length of time working in the region;

### **3.6.1.4 Service user (and their whānau) interviews**

Once an individual was recruited into the study, they were then able to nominate and invite other individuals that they considered part of their whānau. Contact was made with the participant via telephone by the researcher. The researcher discussed the process and objectives of the study, arranged a suitable appointment time and location and provided the opportunity for the participant to nominate and invite whānau members. The definition of who could be classified as whānau was up to the participant, and could be anyone involved on their journey towards hauora (wellbeing). The importance of allowing participants to self-identify whānau has become more evident in the literature. “While distinction between different types of whānau may be useful in some circumstances, in reality these distinctions

often become blurry and irrelevant" (Cram & Kennedy, 2010, p. 5). Whānau has been described as complex and fluid (Cram & Kennedy, 2010), in which whānau could be either whakapapa based (shared ancestry) or kaupapa based (shared function or goal) (Cunningham, Stevenson & Tassell, 2005). It is also possible that different whānau members may be more or less involved in certain topics or whānau functions, therefore this should be a consideration in what constitutes whānau in terms of a pathway to hauora (wellbeing). "Whānau is dynamic in terms of its membership and able to expand and contract in response to a research question. So sometimes the household might be the 'whānau', and other times the 'whānau' will be those across several households; depending upon the topic of enquiry" (Cram & Kennedy, 2010, p. 8).

Cram and Kennedy (2010) described several ethical considerations when research involved whānau collectives, including that the research itself should ensure the protection of Māori concepts and the integrity of whānau. In relation to selection, the authors identified the importance of considering who may potentially be left out from selection as whānau, who may be coerced to participate, and the complex issue of confidentiality.

In this research participants selected those they identified as whānau in their hauora journey, and confidentiality, consent, and the right to withdraw were all again discussed at the beginning of each focus group. As with the practitioner focus groups, whānau service users were reminded that there was limited confidentiality in a group. All participants were asked to sign a consent form (see Appendix D), and complete a demographic form (Appendix G).

The interview was conducted for approximately one hour. A semi-structured interview format was utilized to guide discussions (see Appendix E). Questions were developed in response to the literature reviewed and the experience of the primary researcher. The general line of questioning included:

- Whānau strategies for managing difficult times
- Whānau experiences of working with multiple agencies now and in the past
- Whānau strategies for managing relationships with multiple agencies
- The impacts of substance use on the support you receive from whānau and from agencies
- The impacts of living in a rural community on the support you receive from your whānau and from agencies.

All participants were asked to sign a consent form (see Appendix D), and complete a demographic form (Appendix G). The demographic form had questions related to: iwi and

hapū affiliations; age band; years lived within the Rangitīkei; number of whānau living with them; current source(s) of income; current agencies they are working with; other agencies they have been involved with within the last 2 years; issues they were experiencing; other challenges; issues that they were not receiving agency support for.

Each participant was given a koha of a \$30 supermarket voucher at the interview, for their participation. This is in line with guidelines for koha provided by the Health Research Council of New Zealand.

### **3.7 Data analysis**

There is a ‘chasm’ of analysis that lies between data collection and reporting, in which themes or concepts are obscured, reframed or left invisible by the constraints of the imposed methodologies (Thomas, 2003; Tolich & Davidson, 1999). This has been referred to as a ‘magical’ transformation of information (Marshall & Rossman, 2011), and would be in conflict with the KMR methodology and the researcher’s own principles of tika, pono and aroha. Such a ‘magical’ transformation potentially reduces the likelihood that research findings and recommendations will be owned, supported and applied by key stakeholders – an outcome which again, is in conflict with the purposes of this research.

Therefore, a clear description of the process used in organising, analysing and reporting findings will now be provided. A clear description is important in order to allow information auditing, a process by which a theme can be traced back to a participant’s documented comment (King & Horrocks, 2010). In essence, this ensures that there is no ‘magical’ transformative process between data collection and publications of findings.

#### **3.7.1 Thematic analysis**

There are several qualitative approach which could be used to guide the research process, including data analysis. These include grounded theory, discourse analysis and phenomenology. Grounded theory (Strauss & Corbin, 1998) is not just a method, but also a methodology with inherent theory underpinning it. As a practice it follows a similar process to a general inductive analysis approach, however it has the explicit goal of the development of a theory. This does not align with the objectives of the current project. Discourse analysis and Phenomenology both seek to uncover the experiences and perspectives of participants through the analysis of language (Thomas, 2006). This has the benefits of illuminating the voice of service users, their whānau and practitioners, however it does not meet the objectives of the present study which seeks to also explore the impact of events and practices alongside

experience. As the present has an explicit methodology i.e., Kaupapa Māori methodology, and as a study sought to develop a framework of recommendations for enhancing collaborative practice, a general inductive thematic analysis was chosen to address the study objectives and as a method for applying a Kaupapa Māori methodology. As opposed to a deductive approach, inductive analysis starts broadly, by immersion in the data, and goes through a process of reviewing and reorganising data through meaning and relationships into higher order concepts.

The primary purposes underlying the general inductive approach include:

- To condense extensive and varied raw text data into a brief, summary format;
- To establish clear links between the research objectives and the summary findings derived from the raw data and to ensure that these links are both transparent (able to be demonstrated to others) and defensible (justifiable given the objectives of the research); and
- To develop a model or theory about the underlying structure of experiences or processes that are evident in the text data. (Thomas, 2006. p238)

Criticism of a general indicative thematic analysis approach have included that it is somewhat shallow and lacks a clear replicatable structure (Nowell, Norris, White & Moules, 2017). However authors have cited seeing thematic analysis as either shallow or simplistic as a dismissive approach (Brooks, McCluskey, Turley & King, 2015). Thematic Analysis has been identified as the most commonly used form of qualitative analysis used within health care research, increasing the likelihood health care practitioners will find the method and reporting accessible (Pope, Ziebland, & Mayss, 2005). More recently, Nowell, Norris, White and Moules (2017) identified thematic analysis as “a highly flexible approach that can be modified for the needs of many studies, providing rich and detailed, yet complex account of data” (Nowell, Norris, White & Moules, 2017.p2). It has also been referred to as useful for examining the perspectives of different populations (King, 2004), summarising large data sets and allowing findings to be presented in a number of ways (Nowell, Norris, White & Moules, 2017).

This makes the choice of analysis most suitable for the current project as this aligns with the intended target audience of the findings and recommendations of the research. Consumers of research need to be able to see a clear link between research objectives, the data collection and analysis of data to make the best use of the findings.

A thematic analysis was also conducted in several of the key studies that reflect similarities with the objectives and design of the present study, including exploring cultural aspects of collaboration within a substance use population (Taylor, Bessarab, Hunter & Thompson, 2013). Thematic analysis has also been shown to be appropriate for use in research on collaboration across health and social services organisations (Salmon & Rapport, 2005) and within interprofessional practice in substance use and mental health organisations (Ness, Borg, Semb & Karlson, 2014) and primary health care settings (McInnes, Peters, Bonney & Halcomb, 2017; Schadewaldt, McInnes, Hiller & Gardner, 2016); and the service use experiences of service users with mental health and substance use problems (Biringer, Hartveit, Sundfor, Ruud & Borg, 2017). Thematic analysis has also been utilised to explore interprofessional education experiences (Imafuka, Kataoka, Ogura & Suzuki et al., 2018), and the application of best practice guidelines within multi-disciplinary health environments (Lee, Arora, Brown & Lyndon, 2016). Another important objective of the present study.

Despite arguments that an inductive approach is solely a data driven ‘bottom- up approach’, Thomas (2003) identified that the research objectives provide an aspect of a deductive approach. The research objectives themselves are argued to “provide a focus or domain of relevance for conducting the analysis, not a set of expectations about specific findings” (Thomas, 2006. p239). The author also argued that data, categories and themes are selected, considered and written with relevancy to research objectives (Thomas, 2003). This aspect can be seen within the present study by the use of pattern coding early within the process. This was done to ensure the research objectives provided a form of lens (Structural coding) by which to increase the likelihood that the study would produce findings that addressed the needs of the population (Barriers, enablers, rurality and substance use), bringing the general inductive approach more in line with a kaupapa Māori methodology. However further data cycles were applied to ensure that data were not defined by these early structural codes. Data was further compared and contrasted across structural codes (pattern coding) in order to identify and explore the tensions within and between themes.

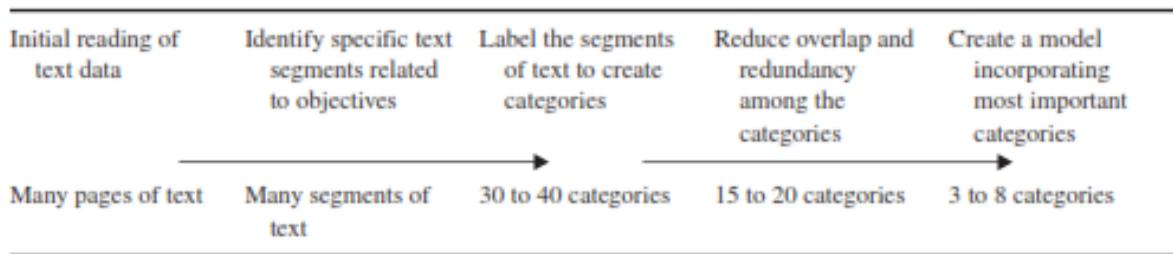
### **3.7.2 Thematic analysis aligned with a Kaupapa Māori case study**

There are three broad processes involved within thematic analysis. Saldana (2013) identified these as:

1. Organising the data
2. Data Reduction
3. Interpretive coding and development of broader concepts.

These three steps reflect existing models of thematic analysis (Braun & Clarke, 2006) and a general inductive analysis approach (Thomas, 2006). Organising the data reflects processes such as the preparation of raw data files and close reading of text (Thomas, 2006) and what Braun and Clarke (2006) called ‘familiarising yourself with your data’ and ‘generating initial codes’. Data Reduction incorporates the creation of categories (Thomas, 2006) and what Braun and Clarke called searching for themes. The third step, interpretive coding and development of broader concepts reflects Thomas’s (2006) ‘overlapping coding and uncoded text’ and ‘continuing revision and refinement of category system’. Within Thomas’s model the term theme is used interchangeably with category, and themes are viewed as ‘upper-level’ or ‘more general’ categories associated with the objectives of the study. Whereas, Braun and Clarke proposed steps such as reviewing themes, defining and naming themes and producing the report.

Thomas’s (2006) general inductive analysis approach can be seen in figure 3 below.



*Figure 3: General inductive analysis approach (Thomas, 2006, p. 242).*

Figure 4 presents the thematic analysis approach taken in this study. The thematic analysis model utilised in the present research was developed to extend upon the basic thematic analysis approach utilised in the pilot study for this thesis (McLachlan, Hungerford, Schroder & Adamson, 2012). This was done in order to provide a more robust, rigorous and replicable approach to data analysis, and to align with the kaupapa Māori methodology underpinning the conduct of the study, analysis and reporting of data. The thematic analysis approach presented within Figure 4 below, articulates the core aspects of the methods (Case Study and Thematic Analysis) in relation to the Methodology (Kaupapa Māori Research).

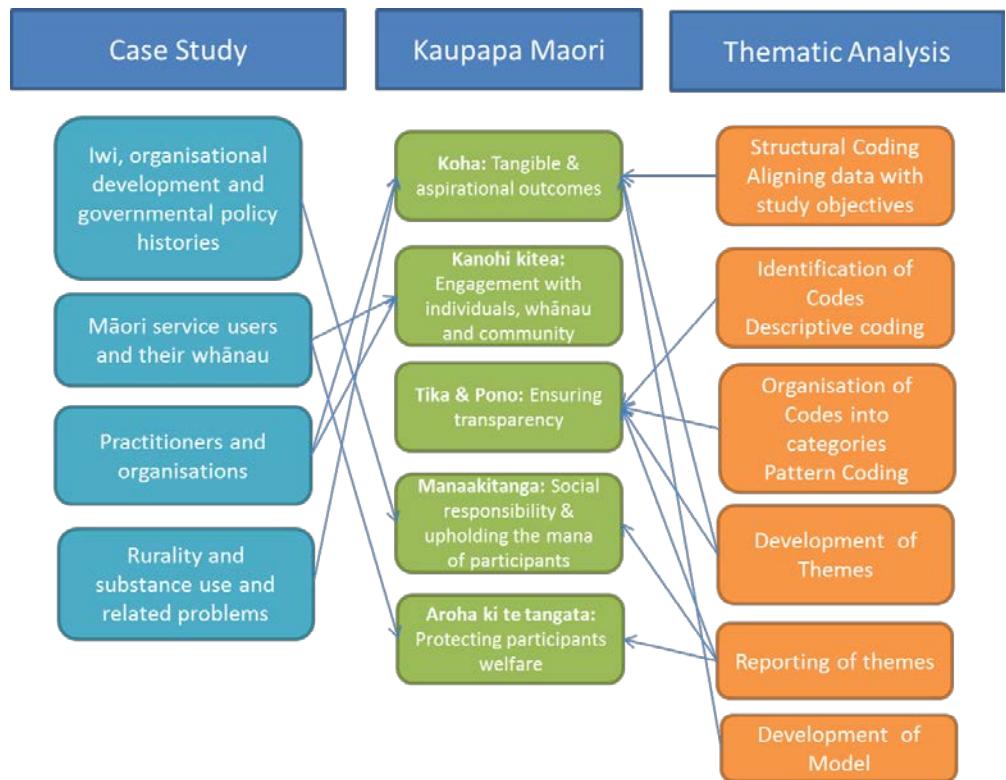


Figure 4: Thematic analysis aligned with a Kaupapa Māori case study

The central strand of the analysis is kaupapa Māori methodology, therefore five principles from section 3.2.5 ‘The guiding values and principles for this research’ are presented and discussed in relation to the steps taken, and also the embedded units of analysis from the case study of collaboration.

Rurality and substance use and related problems were selected as part of the case study as they reflect the context of the participants (rurality) and an issue identified as important to the participants (substance use and related problems). This ensure that the research is aligning with the first principle, ‘Koha: Tangible & aspirational outcomes’. Structural coding was selected as the first stage of data analysis, ensuring that the analysis was viewing data through the lenses of barrier and enablers of collaboration, rurality and substance use and related problems. This reflects a level of deductive analysis, however the next steps viewed data across these initial structural codes, therefore presented ongoing cycles of inductive coding. The development of themes and of an overarching model was also done to align with the first principle. Themes were chosen that reflect reality as opposed to a theory, and they then in turn contribute to a model that represents practices that enable collaboration - ‘Tangible & aspirational outcomes’.

The selection of three different participant groups, key community members, service users and their whanau, and practitioners reflects ‘Kanohi kitea: Engagement with individuals, whānau and community’. The selection of three participant groups also align with a preference within case study design and data analysis by which triangulation of data can occur with three different sources of data (Yin, 2012; Wolf, 1990; May, 2010).

The clear process of data analysis, the intent to reflect the context, practices and struggles experienced by participants, and the way the themes are presented reflect ‘Tika & Pono: Ensuring transparency’. As discussed earlier, much of data analysis is a murky process. Additional steps have been included in the current approach to increase transparency. Also the voice of participants are valued and promoted, as opposed to the voice of the researcher.

The inclusion of key community members and attention to the historical context of the community and the development of health and social services supported the principle of ‘Manaakitanga: Social responsibility & upholding the mana of participants’. Again, the way that themes were reported and the development of a practical model also upholds the mana of participants. Finally the way that themes are presented align with ‘Aroha ki te tangata: Protecting participants welfare’. Themes are written in a way that summarise their korero, without overshadowing their views with the views and experiences of the researcher, literature or other people’s views that may not align with the participants experience and view of the issues and context.

### **3.7.3 Organising the data**

All interviews were transcribed into Microsoft Word documents by a contracted transcriber who had completed a confidentiality agreement (see **Appendix H**). The transcriber used an intelligent transcribing method that omitted non-essential utterances such as um, ah, repeat words, false starts, sentence fillers, repeat phrases, and interjections. The transcribed data was then cleaned, that is, reviewed for instances where audio could not initially be transcribed. Data was then inputted into a computer assisted qualitative data analysis programme.

The NVivo 10 (QSR International, 2013) was selected for use in this research to assist in managing the data. This programme provided the opportunity for all data to be stored together, and the process of coding, organising and analysing the data to be transparent and traceable. NVivo 10 also assists in judging the strength of a node (or category) by calculating the number of respondents and the number of comments related to it. At the same time, though, the programme does not diminish the ability of the researcher to view important and rich outliers and then include them in the analysis. Lu and Shulman (2008) discuss the

benefits of computerised software packages as responding to criticism from quantitative researchers by providing “a clear pathway to rigorous, defensible, scientific and externally legitimised qualitative research via transparency” (p. 107).

Patton (2002) describes the process of data analysis as involving “creativity, intellectual discipline, analytical rigour, and a great deal of hard work”. The author points out that while computer software programmes can greatly assist in managing and organising the workload, they cannot take over the role of the researcher’s skills. Of course, there are also criticisms of the use of computerised software programmes in data analysis, as described by Lu and Shulman (2008) including:

- a) distancing the researcher from the raw data
- b) pulling effort away from the art of analysis because of the mental effort required to learn how to use the software packages
- c) using software in a quantitative fashion, which is, counting occurrences rather than finding meaning.

Within this study the primary author (AM) first coded the data using NVivo, a supervisor (SP) then reviewed the coding. Inclusion and exclusion criteria for each code, and then theme, was discussed, debated, negotiated and agreed upon based on the findings of the coding methods and process. This allowed for transparency in the coding process, and peer review of coding process.

### **3.7.4 Data reduction**

Before starting data reduction, audio file transcripts were reviewed as a whole in order to see the information in context (Thomas, 2003; Marshall & Rossman, 2011). The next step is what Saldana (2013) described as the first cycle of data reduction: coding.

To begin the coding process a structure was established (structural coding) based on the topics of enquiry from the semi-structured interview guide used in the interviews and focus groups. These structural codes would then house the descriptive codes (see below), which were:

- enablers of collaboration
- barriers to collaboration
- rurality
- substance use and related problems.

Within that structure, descriptive coding was then applied, which involves the attribution of a word or phrase that describes the content of a passage of data (Saldana, 2013). Each descriptive code is called a ‘node’ in NVivo 10, and each descriptive code houses a segment

of data. The node is then displayed on screen, and as further data is added to the node, visual tracking occurs, showing the number of participants that have contributed to the node and how many references have been made to that node (Figure 5).

## Nodes

Name	Sources	References
Development of Services in The Rangitikei	1	2
Central Maori Organisational Development	5	21
Dept of Maori affairs	1	1
Devolution of Services	4	11
Future of Maori service delivery	6	14
Introduction of Primary Health Strategy	2	3
Maori Health Outcomes Group	2	2
National changes for Maori and influence on regional and I	4	9
Restrictive Contracts	1	1
Te Korimako	6	26
Whanganui development board	2	3
Formation of Te Kotuku Hauora o Rangitikei	10	36
Leadership	9	64
Ngati Apa Iwi development - Historical	5	8
Relationships	8	52
Rural resilience	6	9
Take pu - Values contributing to collaboration	5	17

Figure 5: Node tree, sources and references.

It is important at this stage that description is closely associated with participants' comments rather than attempting to apply any interpreted meaning. King and Horrocks (2010) also caution the application of any pre-existing literature on the subjects in the analysis stage as this may act to 'blinker' the researcher from discovery. Descriptive coding is proposed to be appropriate for a range of qualitative studies, and is particularly appropriate for beginner researchers answering questions related to "what is going on here? and what is this study about?" (Saldana, 2013, p. 88).

### 3.7.5 Interpretive coding and development of broader concepts

A process of interpretive coding was then moved into, starting with pattern coding to identify themes (referred to as 'interpretive coding' by Saldana, 2013). This form of coding has been cited as appropriate for assisting in the development of major themes from data, and therefore in this research, in examining key aspects such as social networks and patterns of human relationship (Miles & Huberman, 1994; Saldana, 2013).

Pattern coding potentially moves away from (and in this research, did move away from) the initial structure established for data reduction purposes. Effectively, the researcher then starts to look across the nodes, examining the descriptive codes, looking for patterns. These patterns can be based on similarity, difference, frequency, sequence, correspondence and causation (Hatch, 2002).

Once a pattern is recognised, the researcher goes through what could be described as a meaning-making exercise. The pattern is then labelled to reflect the relationship amongst the nodes, establishing a theme. The node tree (originally based on the structural coding) is now reorganised according to these themes, and the data begins to take on a broader meaning of experience, rather than descriptive labels of comments that participants made.

Braun and Clarke (2006) propose that a theme “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun and Clarke (2006, p. 10). There is no agreed standard to what constitutes a theme, nor are themes solely guided by quantifiable measures, and in fact it has been argued that rigid rules do not work (Braun & Clarke, 2006). Themes can be developed on a continuum indicating the degree of transformation of data during the data analysis process, from description (semantic or explicit) to interpretation (latent) (Sandelowski & Barroso, 2003; Braun & Clarke, 2006). A general inductive analysis approach is argued to provide the flexibility to produce themes that sit along this continuum (Thomas, 2003; Thomas, 2006). The continuum from descriptive to interpretive depends on the research objectives, therefore themes could arguably reflect the realist representation of participants experiences and the implications of these, to theorising the meaning and assumptions underpinning these experiences.

The final step in the data analysis is the development of overarching/higher order themes from those themes that arose during the pattern coding process. Within this process, Braun and Clarke (2006) discuss ‘searching for themes’ ‘reviewing themes’ and ‘defining and naming themes’. This incorporates both a meaning making exercise, and constant revision of themes in connection to the data and objectives of the study. This often involves the development of theme maps where the relationship between codes, between themes and between different levels of themes (sub-themes and overarching/higher order umbrella themes). Themes and sub-themes may be re-organised, collapsed or expanded during this process. Sub-themes may represent aspects of a theme that has a relationship to the broader theme, yet represents an aspect of the theme that has value to the research objectives. The outcomes of this constant

revision should be the clear coherence within each theme and demarcation between themes (reviewing themes) (Braun & Clarke, 2006). Thomas (2003, 2006) discusses moving from 30-40 early categories (descriptive codes), reducing to 15 to 20 categories, and finally the production of between three and eight higher order ‘summary categories’ (themes) with associated sub-themes. Defining and naming themes incorporates the move from identifying themes to proposing the meaning attached. Braun and Clarke (2006) propose a series of questions to utilise within the latter phase of theme development: “what does this theme mean? What are the assumptions underpinning it? what are the implications of this theme?, what conditions are likely to have given rise to it?, why do people talk about this thing in this particular way (as opposed to other ways)?, and what is the overall story the different themes reveal about the topic?” (Braun & Clarke, 2006. P 24).

Table 1 presents an example of the process of data analysis used in this research, from structural coding to descriptive coding, pattern coding, and theme development. This example is from service user and whānau interview data. The process of constant comparison was used, in which pattern codes and descriptive codes within and across transcriptions were compared for similarities and differences, refined, and re-interpreted (Glaser & Straus, 1967; King & Horrocks, 2010). Overarching/higher order themes can then be extracted from the data, themes that have the ability to show a relationship thread between and across the research question, the context and the participants (Saldana, 2013). These themes are proposed to be like an umbrella that accounts for all the earlier categories developed, not only by quantity, but by quality (Saldana, 2013). It was at this point that interpretive themes were compared with key concepts identified in the literature, and the research objectives, as long as they were consistent and congruent with the interpretive themes (King & Horrocks, 2010).

*Table 1 - Example of the process from structural analysis through to pattern coding*

Text	Structural Analysis	Descriptive Coding	Pattern Coding	Theme Development
And if they don't want me there they just say we're going to do it by ourselves...we sort of have a bit of feedback talk afterwards.... sort of how it works and what's the new idea that came in to help you work with dealing with this situation and that...Even after they've had access .... they come around to my house and we have tea and just sit and talk; or if they've been to the lawyers (SU 6).	Enabler	Whānau hui and support	Whakapapa and kaupapa whānau community based support	Whare tū ki te wā, he kai nā te ahī; whare tū ki roto ki te pā tūwatawata, he tohu nō te rangatira. “A house that stands in open country is susceptible to loss by fire, while one that stands within a fence pa is the mark of a distinguished person”
We have a next door neighbour; we call her nanny eh, Super Gran. She is like a Super Gran. If I ask her to come over she'll come over and help me settle baby. (SU6)	Enabler	Kaupapa whānau support		

### **3.7.6 Presentation of themes and conceptual model**

The presentation of themes in the present study follows a general inductive analysis approach. Thomas (2003) describes a model used by Williams and Iruita (1998), which involves three components: 1) a category label; 2) the authors' description of the meaning of the category; and 3) a quotation from the raw text. The author states that this is used to present the most important categories that comprise the main findings. In the present study, participant quotes are used in this manner to reinforce main themes, but not necessarily every sub-theme. The themes are discussed within passive voice with the purpose of ensuring the participants voice is the main focus. This approach also aligns with a Kaupapa Māori approach, and can be seen within the writings of leading Kaupapa Māori researchers exploring issues of collaboration for Māori and Māori service user experiences of illness (Cram, Smith & Johnstone, 2003; Pipi, Cram, Hawke & Hawke et al., 2004; Walker, Signal, Russell & Smiler et al., 2008; Jones, Ingham, Davies & Cram, 2010; Te Karu, Bryant & Ellery, 2013).

However, qualitative research often utilise a first person voice to make explicit the impact of the researcher own beliefs, preferences and attitudes on the research process. However there are a range of ways to ensure reflexivity in practice, such as member checking, triangulation, peer review and forming of a peer support network (Attia & Edge, 2017). Reflexivity in the

present study is situated within the methodology, such as the discussion of insider and outsider perspectives, and within the summary of themes and the discussion session.

In the present study, each results chapter, and each theme will be labelled using a whakatauaki or a whakatauki. Both are Māori proverbial sayings, often related to an event or behaviour, and imbued with meanings and important teachings. A whakatauaki is associated with its author, place of origin, original audience and purpose/intent; whereas a whakatauki has overtime has lost its connection to the author and original purpose/intent (McLachlan, Wirihana & Huriwai, 2017). The whakatauki has been cited as reflecting “valued characteristics, personal virtues, modes of behaviour, life lessons and appropriate courses of action” (Patterson, 1992 cited in Rameka, 2016, p. 394). For the present study, the use of these proverbial sayings to reflect the experiences of participants provides a direct connection to the tūturu strand of the KMR methodology, that is, connecting with original knowledge and teachings. Particularly as these proverbial sayings have been identified as reflecting the interpretive system of Māori.

*Not only does the whakatauki stress the importance of a secure Māori identity to the well-being of the individual, but it also highlights an interpretive system that frames Māori world views, including the spiritual origins and direct connections to the gods (Berryman, 2008, Cited in Rameka, 2016, p. 394).*

Within the presentation of overarching themes, thematic analysis has been argued to be flexible in its ability to present themes in maps, matrices, models and diagrams to explore and display relationships and connections between themes. Allowing a deeper narrative into the overall story of the data (Nowell, Norris, White & Moules, 2017; Pope, Ziebland & Mayss, 2005). Thomas (2003, 2006) proposed that developing a model or theory about the underlying experiences or process within the data is one of the three primary purposes underlying the general inductive analysis approach.

As discussed in the introduction, enablers of collaboration have also been termed ‘facilitators’ or ‘best practice elements’ and their presence or absence are argued to reflect “opposite sides of the same coin” (Hazel & Hawkeswood, 2016, p. 24), that is, an absence of these elements can in itself be a barrier. Therefore at the end of each chapter summary, in which themes are summarised, the barriers of collaboration will be summarised and bullet pointed. However, the enablers of collaboration will be summarised, bulleted and presented in a separate shaded graphic. This is also done in line with a Kaupapa Māori approach which is focused on solutions and aspirations – building upon what works (Cram, 2001; Mahuika, 2008; and, G. Smith, 1997). Also, in line with a thematic analysis approach, this will allow these enablers to

be compared and contrasted against enablers from across the three results chapters, and built into an overarching and interacting framework.

### **3.7.7 Ongoing consultation and feedback loops**

From a positivist perspective, the quality of data collection and analysis involves attention to validity and reliability. Validity addresses whether a form of measurement is able to achieve what it seeks to measure, whereas reliability addresses how accurately this is achieved.

KMR acknowledges the historical and present contextual issues of participants, and the desired outcomes influence on Māori aspirations. The terms trustworthiness and authenticity are proposed to reflect and extend upon these positivistic concepts of validity and reliability (Simons, 2009; King & Horrocks, 2010).

Trustworthiness refers to credibility, transferability, dependability and confirmability. Credibility is concerned with the fieldwork methods undertaken and their ability to accurately define the context and comments, including the participants; and also the credibility of the researcher. Transferability refers to the potential for the research findings to be applicable to other peoples or contexts. Dependability, as opposed to a positivistic concept of reliability, refers to the ways in which the researcher plans and responds to changing concepts and understanding within the research process. Confirmability refers to the transparency of the data analysis, and the ability of others to see how findings were reached from the research. Guba and Lincoln (1989) discuss the importance of authenticity in qualitative research. Authenticity refers to fairness, respecting participants' perspectives and empowering them to act.

It can be asserted that all of these concepts are embodied in the researcher's guiding principles of tika, pono and aroha, which sit within the value of whanaungatanga. The consultation and on-going feedback loops (in collecting data, member-checking, debriefing, and reporting) are essential in maintaining whanaungatanga.

To support the attention and alignment with trustworthiness and authenticity, several tasks were undertaken. These included:

- a) providing a clear description of the data analysis process
- b) using clear participant identifiers such as age, ethnicity and role, and
- c) conducting peer debriefing.

Peer debriefing involved meeting following the collection of data for the first series of participant interviews (service users and their whānau). This included a two-hour meeting where two advisory group members with senior research experience were given two anonymised transcripts each to read and discuss. Key themes were presented, and differences and similarities were discussed. The advisory group was chosen as the appropriate group to be involved in this task, as in line with a KMR approach, tangata whenua are the appropriate people to interpret information relevant to their area. Also the members of the advisory groups represented key people involved in the community and services, and Kaupapa Māori academia. This ensured that the researcher could be made aware of key areas missed.

Finally, a written report including service guidelines, and a physical presentation was provided to the host organisation, participants and participant organisations (ensuring fairness and empowering them to act). Providing a ‘thick’ (as opposed to thin) description of the context and participants’ experiences increased the likelihood that other communities and researchers can identify similarities and make decisions of applicability and transferability of recommendations. The act of peer debriefing, member checking and reviewing national and international literature on collaboration supported the process of triangulation, that is, using multiple methods to “generate and strengthen evidence in support of key claims” (Simons, 2009, p. 129).

### **3.8 Chapter summary**

KMR as a methodology is centred on the needs, aspirations and preferences of Māori (both in a tūturu and tino rangatiratanga way), and that is why the methods involved kanohi kitea interviews, focus groups, ongoing feedback loops with participants, and why the oversight group involves both whānau and academic support. Interviews and group interviews were used to gather participants’ stories in their own voices, supporting the writer’s ability to retain their authentic narratives without allowing theory or academic approaches to unduly influence the results. Also, obligations to tikanga and the generally accepted ethics of academic research were satisfied during the course of this research.

The following three chapters will present the findings of this study, based within the context of KMR methodology using a case study method. Chapter Four presents the first of three results chapters. Chapter Four reports key community members’ (KCMs) experiences of the initial development and ongoing challenges and successes of Māori health and social services delivered by Māori for Māori within the southern Rangitīkei. This chapter provides an historical context for the service development in the southern Rangitīkei; provides participants

experiences of engaging at a strategic level with crown and other Māori organisations; and the views of leaders in the field of health and social services regarding collaborative practice.

## **4 Kia whakatōmuri te haere whakamua: Understanding the impact of past collective action and collaboration on present and future efforts**

### **4.1 Introduction**

The whakatauki ‘Kia whakatōmuri te haere whakamua’ has been translated as I walk backwards into the future with my eyes fixed on my past (Rameka, 2006). This refers to the importance of knowing, acknowledging and building upon past knowledge, understandings, relationships and connections in order to utilise the wisdom inherent within these for achieving Māori aspirations.

Previous research on practitioner collaboration in the field of health and social services for rural Māori with substance use and related problems identified that understanding the history of the development of health and social services within an area contributes to understanding ongoing tensions, conflict and strengths within and between health and social services (McLachlan, 2011; McLachlan et al., 2012). Examples provided included historical conflict between previous managers of different health and social service organisations, created through competitive contracting, created an ongoing cycle of mistrust and poor relationships between services. Understanding the unique cultural and geographic context and history of a community was argued as an important first step in addressing current relationships and providing culturally responsive services.

This chapter reports key community members’ (KCM) experiences of the initial development and ongoing challenges and successes of Māori health and social services delivered by Māori for Māori within the southern Rangitīkei. This includes the key events and culture of the communities themselves, instigating events for service development, government policy changes, Māori change movements, leadership and interdependent relationships between iwi and iwi health and social services. This chapter aligns firmly with a Kaupapa Māori research approach by first orienting the reader to the historical and cultural context of the peoples and communities; and Māori collaboration and collective action efforts. The purpose of this chapter is to guide the reader in understanding:

- the influence of the context and history of the area under study on the quality of relationships between services
- the ongoing nature of systemic challenges to collaboration between Māori and the crown

- the traditional Māori values, practices and aspirations that guide Maori collaborative efforts
- the development of new skills and supports that strengthens these traditional Māori approaches in the current political and social context.

#### **4.1.1 Participants – Key community members**

Semi-structured interviews were conducted with 10 key community members' (KCM). Interviews were between one and three hours each interview. The research advisory group including local iwi representatives and people with experience with regional iwi health and social service governance identified prospective participants that would be appropriate to approach for the purposes of this research.

Participants completed a demographic form (**Appendix G**). All 10 participants identified with Māori whakapapa, with the majority of participants identifying as Ngāti Apa, or Ngāti Apa / Ngā Wairiki (n = 8). Of note was the broad whakapapa of these participants to different hapū of Ngāti Apa, and also to surrounding iwi such as Ngāti Hauiti, Muaūpoko, Mōkai Pātea, Raukawa, Ngāti Toa, Ngāti Tūwharetoa and Ngāti Kahungunu.

The majority of the 10 participants were either in the 46-55-year age bracket (n=4) or 66+ age bracket (n = 3).

Of the 10 KCMs, three identified as never having lived in the area. Two of the three participants did have strong regional and inter-tribal relationships with the southern Rangitīkei, and all three had been actively involved with service development in the area. The remaining participants reported having lived in the Rangitīkei between 12 and 60 years, with the majority indicating having lived in the area for more than 30 years (n = 6).

Two participants identified as not having been directly involved in service delivery in the southern Rangitīkei. The remainder of the participants reported having been involved in service delivery from between one and 30 years, with the majority having delivered services for 20 or more years (n = 4) and between 15 and 18 years (n = 3).

It was evident that participants differed in their opinions of what they considered to be local or regional and/or national roles related to service delivery for Māori by Māori. As an example, some respondents identified Te Oranganui Iwi Health Authority as a regional health initiative, whereas others identified it as local. This is understandable as initiatives such as

this are often located within Whanganui, however they have an impact on service provision in outlying rural communities.

From the community and service delivery roles held by participants in the southern Rangitīkei, participants identified as having played key roles on a wide range of boards, committees and initiatives; however these were not limited to health. The boards or committees also included education, justice, and iwi research. This broad range of roles reflects Māori views of wellbeing being multidimensional. It was also interesting to note that several key local and regional roles had been held at different times by different participants, these roles included Manager of Te Kotuku Hauora o Rangitīkei (TKOR) (n = 3), Chairperson of Te Runanga o Ngati Apa (n = 3), and Chief Executive Officer of Te Oranganui Iwi Health Authority (n=2). This reflects the standing these participants had in their communities and the region as a whole.

Participants also identified having roles in other important local and regional groups including Nga Hau e Wha marae komiti, Marton (n = 2), Māori Outcomes Health Advisory Group (MHOAG) (n = 3), Rātana youth and church executive (n = 3), Hauora-a-Iwi (n = 2), Taumata Hauora Trust, Māori Development Organisation (MDO) (n = 2), Otaihape Māori Committee (n = 2), and the Lake Alice Psychiatric Hospital (n = 1). Alongside the two participants that identified as being previous CEOs of Te Oranganui Iwi Health Authority, an additional two participants identified as board members.

The above trend continued when regional or national roles in relation to services for Māori by Māori were recorded. Again, participants' roles were not limited to health, but included Fisheries, regional museum, food workers union, Māori Television, and the National Employment Initiative. Health related roles included the Māori Services National Body (n = 1), Health Care Aotearoa (n = 1), Department of Māori Affairs (n = 1), Te Puni Kōkiri (n = 3), Māori Health Directorate (n = 1), Midcentral Māori Inequalities Forum (n = 1) the Whanganui Regional Primary Health Organisation (WRPHO) (n = 2), and the Cancer Society Māori Relationship Board (n = 1). On one hand these broad roles again reflect the multidimensional view of health, and on the other hand they reflect the national standing of KCM participants.

#### **4.1.2 Process of analysis**

Using the analysis process set out in Chapter Three, a thematic analysis was carried out to identify common themes. The analysis identified two themes, and five sub-themes. The first

theme, ‘He toa takatini tōku toa, ehara I te toa takitahi’ reflects the experiences of Māori responding to historical events and challenges in coming together for collective action in the area of health and social service development for Māori by Māori. This theme is represented by three sub-themes. Tinorangatiratanga: Maori self-determination regarding health; Rangatiratanga: The role of individual and collective leadership and organisational skills in facilitating collaboration and collective action; and Institutional racism: The ongoing impact of colonisation. The second theme, ‘He punga I mau ai’ reflects the enablers of collaboration by Māori for Māori, along with collaboration between Māori and the crown. This theme is represented by two sub-themes, ‘Whanake: The evolution of Maori health services’ and ‘Whakapapa; Historical connections between groups providing the cement for ongoing collective action’. A chapter summary concludes the chapter.

## **4.2 He toa takatini tōku toa, ehara I te toa takitahi.**

He toa takatini tōku toa, ehara I te toa takitahi. My Bravery is that of many followers, not of a single person (Tūtohu-ariki of Ngāti Kahungunu; Mead & Grove, 2001). This Whakatauaki can be understood as the importance of people working together to effect collective action and achieve collective aspirations. This theme reflects the different ‘sparks’ or events and challenges that motivated collective action for Māori, collective action that was enabled by effective collaboration. The theme also discusses the barriers faced by Māori in collaboration and collective action, including the impact of colonisation reflected in systemic barriers, lack of consultation by the crown, and a general devaluing of Māori perspectives and roles in collaborative action between Māori and the Crown.

This theme is represented by three sub-themes. Tinorangatiratanga: Maori self-determination; Rangatiratanga: The role of individual and collective leadership and organisational skills in facilitating collaboration and collective action; and Institutional racism: The ongoing impact of colonisation.

### **4.2.1 Tinorangatiratanga: Māori self-determination**

This subtheme reflects participant’s experiences of gathering together for collective action. The focus of this collective action was proposed to be improving the wellbeing of whānau, hapū and iwi Māori. Participants reported a range of events and people that inspired, modelled and encouraged purposeful local Māori collaboration. Participants also identified the ongoing importance of Māori determining what health was, and designing and delivering services that aligned with this.

The majority of participants described the importance of Māori determining what was important for Māori, and the strategies for addressing what was important for Māori as an important enabler of collaboration between Māori groups and organisations. Participants mentioned that self-determination reflected a desire for Māori to improve outcomes for Māori, and acted as a unifying value for Māori collaborative action.

*It was incredible. Those were the things that sort of, I think, brought about that whole feeling of self-determination and I think that when you get that spark inside of you about all that, that's about your wellness; that's about the whole way in which you think about the world around you so that nothing becomes difficult. So you start your health services, you start your social services, you develop Te Kura Kaupapa. You start Kōhangā Reo on the marae and it just flows on because the moment you get the sense of, "What I can do." Rather than, "What I can't do." Because you get everything thrown at you. (KCM 10)*

Participants highlighted a range of personal characteristics that underpinned self-determination for Māori within collaboration, particularly in engaging in collaborative relationships with the Crown. These personal characteristics were reflected in leaders, however participants observed that groups, particularly whānau, often shared these characteristics. These personal characteristics included confidence, willingness to engage in conflict, adaptability and determination.

*So the recognition of our people, it made us think, "Well if she can do that we can start saying to each other, 'Well, what else do we need? What else can we do to better the last of our people here?'" So I guess it was on the model of Iriaka, the models of Te Reo; the models of, even Tariana that has pushed us to where we are today, so what can we do better? I guess the bottom line is we don't want to settle for mediocrity. (KCM 9)*

Confidence, determination and willingness to engage in conflict reflected the necessity to push through perceived and actual challenges to collaboration, whereas adaptability reflected beliefs that Māori needed to work innovatively in order to manage basic resources to meet complex needs, such as social and health needs of rural whānau.

A range of national exemplars of collective action, and local and regional collective concerns, were identified by the majority of participants as providing both purpose and pathways for collaboration and collective action. Some participants identified national Māori movements which evoked and affirmed the needs and desires of regional and local Māori for collaborative action. These included the revival of te reo Māori, the Treaty of Waitangi settlement process, and the springbok rugby tour and its associated anti-racism marches which were identified as being pivotal events in Māori engaging in collective action towards addressing Māori

grievances and aspirations. These movements provided impetus and facilitation for Māori to come together and speak about needs and priorities of Māori at a regional and national level. Participants noted that this enabled and facilitated Māori to engage in collaborative affirmative action.

*So that 1980s period was the devolution period as well the activation period and you had the black woman's rights movements and all of that stuff. ... the 1980s came out of that nice tidy clean 1970s thing, you are now into a stirring because the 1990s are about Mana Motuhake (Māori political party), that's the 150 years of the Treaty of Waitangi etc. but the 1980s - that's the stirring; "We can do it ourselves! If you think that we're failing give it to us!" The whole of the period of the 1980s was about that, it was a series of meetings. (KCM 6)*

Associated with the national Māori conscientisation in the early 1980's was an acknowledgement of poor health outcomes and lack of culturally appropriate health services for Māori. The majority of participants mentioned that Māori were dissatisfied with the fragmented nature of health and social services for Māori, particularly Māori coming from rural communities into the centralised district hospitals. Māori that were separated from their whānau by large distances, and staying in an environment that did not acknowledge or address Māori needs or preferences in relation to health and connection with whānau.

*That's born out of family coming to see their own, there was the whole business of coming from rural into the hospital and some inappropriate places for whanau to stay. (KCM 6)*

*We don't want our whānau sitting in their homes and just having to make do with what they've got; having to make do with the culturally insensitive services that are out there in this region providing services. (KCM 9)*

This dissatisfaction was identified by participants as an enabler of collaboration as the common dissatisfaction brought people together to collaborate in order to effect change, starting with community services engaging with hospital services to ensure Māori needs and preferences were heard, that non-Māori hospital staff were developing cultural competencies, and that whānau could visit and be involved in the care of their whānau staying within the hospital.

Coming together for a common purpose was identified by the majority of participants as an important and effective enabler of collaboration. Participants noted that Māori sought purpose through a shared vision, and in response to community needs. These community needs included responding to community crises; community celebrations and events; and the treaty settlement process and the resultant hapū development.

A common vision was identified by some participants as unifying people under a common cause, and motivating people to engage in collaborative action. Often this vision was related to responding to aspirations in the areas of Māori health, social development, and identity.

*I think it's a common vision really. I believe that, I think that even if we do things differently, each, all of us have a vision about what we want for ourselves, for our whānau, for our hapū. (KCM 10)*

Some participants commented that being able to communicate a common vision by the way of a common unified message was a key enabler of collaboration. Promoting a common unified message to collaborative partners, particularly the Crown, was identified by participants as a key enabler of collaborative action for Māori. Individual leaders, with whakapapa connecting them to people across the region, and who were articulate and inspiring were identified as contributing to developing a common vision and also presenting a common unified message. A common unified message added value and strength to the presenting concern, as it reflected consensus.

*And to me some of the kōrero from those old people, those kuia, were put in those moemoea to Tari, and Linda was the clinician and they actually, their brains put it all together. (KCM9)*

Some participants reported a range of natural disasters and industry closures that enabled collaboration at a community and regional level. These crises brought Māori together for a specific and meaningful purpose in times of need, that is, to respond to the immediate social and safety needs of people. Responding to crises allowed local Māori to show their strengths, awareness of whānau needs, and their ability to provide hospitality and care for large number of people experiencing crises in the community. This was not limited to the needs of Māori, but the needs of people in the community in general. This was seen as an enabler of collaboration for Māori, that is, a unifying event.

*Our Marae had burnt down. I think probably that was the first time that I saw what it meant for our hapū to lose something that we had come to treasure. And that was when our Marae burnt down. The night our Marae burnt down our families came from everywhere, within a really short space of time. There were at least 100 of us, standing at the Marae, watching it burning. (KCM 10)*

Māori taking leadership of coordinating and addressing community needs at times of crises was identified by some participants as a specific enabler of future collaboration between Māori and tau-iwi communities and organisations. Participants mentioned that during times of crises tau-iwi communities and leaders became more aware of the strengths and abilities of

Māori, particularly the strength and skills of hosting large numbers of people in crises, such as those isolated from their homes due to significant flooding. Participants commented that Māori had significant experience in hosting large numbers of people due to the practices of hui and tangi in which large numbers of people are housed, fed and entertained on the Marae.

Participants also observed that Māori values related to whānau as a cornerstone of wellbeing was reflected in the ability of Māori to acknowledge and attend to the basic needs of whānau. This was evident during times of financial hardship, such as families whose main income earner may have been laid off due to industry closure, or whānau not receiving income during periods where whānau were on strike (protesting for better conditions). Participants noted that Māori community leaders would form committees and identify those whānau in need and coordinate food parcels for these whānau, and also raise funds to meet family priorities such as mortgage payments, rent and power.

*I think it's about caring for each other. I think it's just inbuilt in us. You think of your manuhiri[visitors] first, while you can have a bread and the jam as long as the manuhiri get fed. Yeah I think that's the same Māori value. Even if you have a little bit you try and share, yeah. (KCM8)*

Some participants identified community events and celebrations as further examples of activities that brought people together on a regular basis. These activities included attendance at events such as Rātana celebrations, tangi, public health initiatives, and Matariki celebrations. These events were commented by participants to be an enabler to future collaboration as people were often brought together for a positive and socially oriented activity where people from different communities, such as rural farming, urban, Māori, pacific island and tau-iwi communities could mix. These activities strengthened personal relationships between community members and organisations as members from these communities were able to eat together, appreciate their respective cultures such as song and dance, and also engage in community activities together such as tree planting and recreation. Organisations strengthened their collaborative practices through working together for a positive outcome such as a successful community wide event. As these events are regular, such as Matariki celebrations, these organisational collaborations were able to improve through successive events over the years.

*We must have had about, oh gosh, about 500 odd that turned up for our walking day. Just that walk around the block thing, they brought back our gear; took the photos all of that. So yeah, those sorts of activities as good fun activities. (KCM6)*

A shift in health paradigm and dissatisfaction with the disjointed approach to Maori health and social wellbeing was noted by the majority of participants as a national concern for Māori, which flowed equally to regional and local communities. Some participants reported that contracts had previously specified the issue or illness to address, such as diabetes, which limited staff ability to address interrelated health or social factors. This restriction was a barrier to developing protective health factors such as economic stability, health routines and social and cultural participation. Participants observed that this change in approach involved services engaging the active participation of whānau in identifying what was important for them, building upon the skills and strengths of the whānau, with services targeted at addressing what participants called wellness.

Participants commented on a history of Māori health services being compliant with Crown health strategies, which involved Māori health services delivering limited services to whānau. Participants noted that Māori services were compliant with these contracts, as the services themselves required funding to continue operating. With the devolution of hospital services to the community, and the development of integrated services and contracts, Māori services were able to participate in delivering services to their people. However, the delivery method and intended outcomes continued to be prescribed by Crown contracts. Participants mentioned that staff had themselves attempted to meet both the Crowns prescribed outcomes, and what was important to whānau.

*No, no it's one that we've struggled with. We've struggled with it because quite often the contracts don't allow that to happen. I'll give you an example, they have been geographically focused and they were outputs focused. And we quite often were focused on being compliant or contract compliant to the detriment of our own, both development and strategic direction. (KCM7)*

Several participants described that the Crown's Whānau Ora model, which seeks to address comprehensive social, health and cultural needs and preferences, aligns with core Māori health paradigms which were inclusive of physical, mental, social, spiritual, and cultural participation and wellbeing.

These same participants observed that government initiatives that promoted and allowed for the integration of health and social service contracts had encouraged staff to identify and address interrelated health and social problems faced by whānau accessing their services. Participants noted that this supported a wellness approach to health that aligned with Māori health paradigms. Participants described how being able to deliver integrated services allowed staff to work with whānau experiencing mental health concerns, and also address the physical

health problems and financial concerns of the whānau. Participants observed that when these interrelated problems were incorporated within an intervention that whānau were better able to develop a baseline of wellness.

Participants identified multidisciplinary frameworks for practice supported a shift towards more comprehensive and integrated health and social service delivery. Multidisciplinary team meetings allowed staff from different professions and with different focuses to ensure that the outcome for the whānau was central to the team effort.

Several participants also commented that whānau experiencing complex health and social problems were often required to engage with multiple agencies. This was mentioned by participants to added additional pressure on whānau, as each agency had their individual objectives and approaches. These same participants described positive outcomes for whānau due to integrated and coordinated services, and collaboration with external agencies. Participants illustrated the positive impact of coordinated and collaborative intervention as reducing confusion for whānau as whānau were primarily engaging with a single agency and often a person from that agency supported the whānau to engage with other services where necessary.

Several participants observed that the integrated and coordinated approach to engage communities in health and social initiatives provided broader health and social outcomes for whānau. This was because it aligned with Māori concepts of health, which seek to engage whānau and hapū in participative health activities. Participants described a range of well-received activities in the community that illustrated aspects of engagement and broader concepts of wellness when engaging with communities. Participants gave examples of Rangatahi music courses that built on the skills and interests of young people as a method of engagement in education and the development of self-esteem and life skills. Other examples were of community health activities that promoted low-cost strategies for increased whānau engagement in physical fitness and recreation. Participants identified examples of health and social service initiatives that addressed community wide heating and insulation issues in whānau homes.

*About three years back one of our nurses came up with an initiative, painted pathways, green footprints. And what it was, was to pick four areas within our town and one down the junction where a lot of our poorer whānau live and two in town here and one out a bit. And it was a four kilometre one, so they painted green footprints, a two kilometre one and two one kilometre ones. So what that initiative was about is you don't have to pay any money, just get out, look for the green footprints and walk. (KCM4)*

The majority of participants identified innovation as both a necessity of rural health and social service delivery and a skill of rural staff. The necessity to innovate was driven from limited financial and practical resources available through Crown contracts, and the complex issues involved in both rurality, and Māori health. A history of restrictive targeted health or social service contracts had meant that staff were contracted to address specific issues and not others. Participants described how this had led them to make shrewd use of finances, saving in some areas of a contract in order to meet the associated but not funded need of the whānau.

*Yeah ‘cause we always get told from our boss, we’ve got no money, so we think out of the box. (KCM4)*

Several significant barriers to health care related to living rurally were noted by the majority of participants, including a lack of local specialist services, and long distances to access these specialist services in main centres such as Whanganui or Palmerston North. Participants noted that often whānau struggled to access funds, a car, or a licence to drive to specialist appointments.

*I would think that there are really many significant issues, because what we’re talking about families that have been; in a way, left almost landless and so you know, quite rural; quite isolated, not having good means of transport; not having access to good health services which is why I was always critical of the Rūnanga, because they were all focused on Marton so we weren’t getting anything out into the Hapū areas. I think families generally have struggled out in the rural areas. (KCM 10)*

Participants gave several examples of working innovatively to meet the barrier of transport for whānau. These included developing a mutually beneficial relationship with St Johns Ambulance service in Marton who would drive whānau to health appointments. In return staff at Te Kotuku Hauora would take turns as volunteers for St Johns. This was an example of rural services collaborating to meet the needs of the service and that of the whānau; other examples given by participants included the development of driver’s licence courses for unlicensed whānau.

Participants extended upon the concept of innovative rural services, it was mentioned that Māori health services had explicit expectations of staff to be flexible and responsive to the needs of whānau and community. This meant that staff were expected to be able to travel and work with whānau within their homes, and when required to, work outside of normal hours. One participant identified that the expectations of staff to work outside of their normal duties and normal hours when required was explicitly documented in contracts and reinforced in staff orientation.

*So, the kaupapa in this organization has always been, and I actually reiterated that to someone last week, and I said, "I don't know if it's still there in the job description," but it was always you may be required to work outside of your hours in the interests of your position. I think those are the kind of words, similar to that....You know do the job and everything that it entails within it. And if you're away from home for that long well it's... 'cause it's not about a nine to five job we tell them when they come to work here, eh, it ain't about working nine to five working for iwi, you should know that. And it's a big kaupapa and it's a big take that you're doing. So it's like once you step in the door, it's like you kind of end up getting married to it I suppose. So that's pretty much it. (KCM2)*

Participants commented that staff had primary roles, such as a nurse or a social worker, and they would step in and meet the needs of the whānau or community where and when needed. Participants provided a range of examples of staff working outside of their specific role in order to meet the needs of whānau. Participants identified that if these issues were not dealt with by staff then the whānau issue would worsen requiring more specialist service in the future. Participants expressed this approach as a responsive and responsible way to practice. Other examples of flexibility and responsiveness of staff included social workers bringing together community members to form working parties to meet the needs of isolated whānau following flooding. Participants observed that this responsiveness was quicker than local governments' ability to coordinate and provide disaster response. This flexibility and responsiveness reflects both the necessity of broad skills of staff in rural communities, and the core values of manaaki in meeting the needs of whānau and communities where and when needed, irrespective of roles, funding or contract limitations.

*February 2004. It was devastating; really devastating. And I'll say this about John again; John heard that WINZ were going to put together work teams to go out and assist with the floods and he found out that this was going to take about a week and he says "I'm not waiting a week." He went out into the community of Marton, hand-picked people and says, "Come on we're going out to help at these marae." And we were working before any of the work groups were established by WINZ. And we got out to Kaingaroa - eventually they let us through. They wouldn't let traffic through. (KCM3)*

A participant noted that feedback they had received from whānau service users of the local Iwi based health and socials service based in Marton in a recent evaluation of services in the Marton area had identified that both Māori and non-Māori were aware of the service and the services it provided, and had reported positive interactions with the service. Feedback received by several participants identified key aspects of engagement that increased Māori service user satisfaction health and social services. The first of these was the comprehensiveness and accessibility of a local provider. Participants commented that whānau benefited from receiving a comprehensive package of care as opposed to attending a range of

agencies for the different aspects of care required. Participants also mentioned that whānau benefited from receiving this package of care from a service that was locally accessible and staffed by local workers who were often familiar with the whānau service users.

*The Rangitīkei District Council took a stock of its services in the Rangitīkei and Marton did its own sussing out from the people. How well they knew the services, they knew our service better than anybody else's...even the Pākehā ones, they felt that...we always thought it was just a Māori service, well it's not. (KCM6)*

Participants observed that whānau service users reported appreciating the way they were greeted, treated with hospitality, and shown respect. Participants commented that as a Māori provider, they treated whānau service users as welcomed guests and whānau members. Participants noted that this reflected Māori values of manaaki and respect for manuhiri, particularly for koroua (elders). Participants gave examples of their own experiences and that of whānau service users that engagement in mainstream services can be a very isolating and cold experience, where you just sit in a waiting room to be seen. Whereas participants described engagement in a Māori service involving staff putting aside what they are doing when a visitor arrives, giving whānau service users a hug or offering them a seat and cup of tea when they arrive.

*Yeah, it's the manaaki but the pakehas call it welcoming. They felt welcomed. They felt like they were part of the group and they felt their people listened to them. (KCM6)*

Participants also identified an attitude from staff that respected the strengths, preferences and self-responsibility of whānau service users was an enabler of collaboration. This ensured that staff positioned themselves as supportive of whānau goals and strategies rather than the imposing staff preferences and priorities on whānau service users. Another important aspect of engagement was a positive and enjoyable experience within activities. Participants gave examples of “ladies day out” as a process for engaging women in diabetes checks while providing refreshments and social activities.

Several participants identified local credibility as a key enabler in developing collaborative relationships within rural communities. Participants mentioned that individual staff members could have local credibility with whānau service users, whereas organisations could have local credibility at a community level. Individual staff credibility was demonstrated by the trust whānau service users placed in staff due to good relationships and the ongoing presence of the staff member in the community. Participants commented that rural communities often have families and services with strong relationships with each other and the area. Participants

reported that introducing new services or collaborative initiatives into these communities can be responded to with weariness and suspicion.

*It took Apa five years before it could slightly stamp its mark in there, 10 to show that we were there and now that we're moving on to Bulls we're going to probably do the same thing there, we'll leave behind the health services to show that they're there. I think we made a solid enough mark to know Ngāti Apa is in the house type thing. But they resented it, the community resented our return and we haven't done a lot of things marvellously well there but that's basically the issue, that will happen. (KCM6).*

Local credibility at an organisational level was based on building trust over time through effective interventions, initiatives and presence in the broader community, such as attendance at community events.

The employment of staff that lived within these communities and/or had whakapapa to the community was identified by participants as an important enabler of collaboration between staff and whānau service users. Staff that lived within these communities were identified by participants as better able to understand the needs of the communities, and able to access and engage whānau that other services could not access.

A participants reported that whānau service users independently either maintained or developed initiatives that met their own needs, beyond their involvement with services as a unique outcome of effective collaboration. This outcome was observed by participants as reflective of effective collaboration between services, communities and whānau service users. Participants noted that effective collaborative relationships with whānau ensured that they were active participants in their wellness, and responsible for defining their needs and aspirations, as opposed to being a passive recipient of health services. It also led to the development of whānau driven initiatives. These initiatives included cultural activities such as waiata for koroua (elders), and social outreach such as koroua being paired with tamariki (children) who didn't have koroua, on grandparents' days at school. This positive outcome also reflects the relationships between services and the community, which assisted in connecting whānau service users with each other and with community resources that were able to support these initiatives, such as community halls to host activities.

*The first one in 2006 was based on our initiative with our kaumātua forum that we used to have and we used to do Sit Be Fit; cooking; go and do activities; go and join in other providers when they do hākinakina things like that. And then they came to us and said to us one day, "See ya Lydia, see ya Te Kotuku we're going out on our own." Now that was the aspiration that they were so well in doing what they wanted to do that they decided they'd like to do it on their own now.*

*And so they're still going since 2006. On Thursday's they have waiata hui's up at the local church. But now that this place has been reshuffled around we'll have a venue for them if they want to come. So it was about them and all the initiatives that we've done with them in that previous year. And the actual fact that they had completed their aspirations as doing it on their own, doing it for themselves.* (KCM4)

#### **4.2.2 Rangatiratanga: The role of individual and collective leadership and organisational skills in facilitating collaboration and collective action**

This sub-theme reflects the importance of different leadership models for supporting collective action for Māori, along with the different values and principles needed to maintain collaboration across collaboration within and between Māori and non-Māori.

The process of iwi and Māori organisations gaining consensus of opinion in relation to preferences, expectations and process when entering into collaborative relationships with the Crown and other tau-iwi groups was identified as a significant barrier to collaborative efforts. Participants commented on the specific complexity experienced by Māori organisations, where Māori had to consider both Crown and iwi imperatives, imperatives which may be philosophically or practically opposed.

Several challenges to Māori navigating the complexities of iwi and Crown imperatives were identified by several participants, complexities which were observed to delay decision making by collaborative partners, ultimately delaying the progress of the collaborative collective. The challenges noted by participants included a lack of understanding by Māori representatives of the issues being addressed within the collaboration, or a lack of consistency in representation by key Māori stakeholders at the collective.

*There's a number of pathways and quite often they end up not being managed. One of the pathways is, they don't get managed because you've got conflict or you've got people putting up barriers to prevent things happening and so nothing moves.... Gosh, what kind of barriers? Delaying tactics really is the biggest one. "I've gotta go back to my iwi to see what they want," you know. Add into that inconsistency of representation So depending on who turns up at the hui, it might be going this way one meeting and another way the next meeting. And of course when the next one comes back, gonna get it all revisited again, all over again.* (KCM7)

Participants described strategies for navigating through the complexities of gaining consensus for Māori in order to ensure progress with collaborative initiatives. These strategies included representatives taking time to understand each person or groups perspectives and barriers. It was apparent that this work, commonly referred to as 'behind the scenes' work, was significantly time consuming, and was proposed to lead to better collaborative outcomes.

Leadership was identified by a majority of participants as a key enabler of collaboration. Participants identified a range of factors related to the function of leadership in collaboration and the development of leadership. These factors included facilitating and maintaining collaboration and creating pathways to leadership. Participants identified leadership within collaboration as a key challenge to engaging in and maintaining collaborative initiatives. Participants commented that often collaboration was led by a key agency, which was more likely to be larger and better resourced. This had led participants to express concerns that these larger organisations were not meeting the needs or aspirations of the smaller organisations or the whānau the smaller organisations provide services to. Several participants also mentioned that smaller Māori organisations held fears that not only would larger organisations control the collaboration, but also that the larger organisation may end up controlling or taking over the smaller Māori organisation. This level of fear presents as a barrier to collaboration contributing to apprehension and lack of confidence and commitment to collaboration from smaller Māori organisations.

*That was a flag-up for some our Māori providers, thinking oh my gosh, what do we do then? Do we jump in with this mainstream or no, we don't want to? What's the opportunity locally?... that was quite a confusing time for providers, they didn't know which way to jump and the expectation that Whānau Ora would be collective and that it made Māori providers feel quite nervous; they felt like they'd be gobbled up by a big collective. (KCM1)*

Despite the report that smaller organisations held fears of larger organisations taking over or controlling collaborative initiatives, it was observed by some participants that at times it was necessary for larger organisations to step in and meet the needs of whānau whose needs were not effectively being met by smaller Māori organisations. Participants commented that larger Māori organisations had at times engaged in assertive negotiation in order to ensure the needs of whānau were being met. This assertive approach was reported to be unpopular within a Māori framework of collaboration, however necessary.

Participants reported that leadership provided vision and inspiration for collaborative ventures. Participants commented that an inspirational individual who had well established relationships within their communities often provided leadership. Participants noted leadership that was able to promote vision and engender aspiration was an important factor in attracting people into collaborative ventures, such as banding Māori health and social service organisations together to compete for regional contracts.

*She's hard to describe but she actually held something very dear inside her, Tari... she was like our people could speak through her. You know those kuia, all*

*of their momoeā come out through Tari's mouth. And you know Linda with all of the clinical stuff but all of the vision - you know they're both very visionary women, very visionary. (KCM2)*

Leadership was also described as an important factor in addressing conflict between key stakeholders. This included leaders applying specific skills and strategies to clarify the concerns, needs and preferences of key stakeholders in order to ensure effective collaborative communication, negotiation and planning.

*Leadership is about really binding the people, uniting the people. So you can say you're a Rangatira all you like, but if you ain't uniting the people you're not leading anyone. So what's the most important? From my perspective it's that unity that can come through a common purpose. (KCM7)*

Participants identified several specific skills and resources that leaders brought to collaborative ventures. These included established networks and institutional knowledge, whānau, hapū and iwi support, being able to read and respond to political changes, and the ability to develop policy. These skills and resources were mentioned by participants to increase the success of the collaborative venture, and in turn increase the confidence of key stakeholders in committing to collaboration.

A participant commented that Māori leaders working for the Crown were in unique positions to model the aspirations and values of Māori. Participants observed the importance of Māori leaders placing the needs of whānau, hapū and iwi before the needs of Crown, often to the detriment of the individual Māori leader. An example was where Māori leaders had risked their employment by standing for the needs of their people, and opposing Crown and employer imperatives and directions. This was proposed as necessary for inspiring Māori towards independence and ongoing collaborative pursuit of wellbeing for Māori.

*I became a thorn in their side and said to them, "Well no, kei te hē tēnā. You know, if you're gonna say something to my people, you need to follow it; you need to follow it through because I'm not going to allow you to takahia on the networks that I have or the hononga that I have with my whānau around this motu, around this rohe; so that you can get some runs on the board, kau; yeah sorry. (KCM9)*

Participants noted that leadership succession planning processes were important factors for ensuring ongoing successful collaboration. Participants identified that leadership pathways were evident within families, with whānau members often replacing their elders in leadership roles. This reflects both the benefit of modelling leadership within the home, and also personal and public expectation on young people to follow their whānau members into leadership roles.

Faith, hapū and iwi structures were also identified by several participants as important structures that provided opportunities for leadership across age groups. Participants commented the importance of attending, participating in, and then actively taking roles on committee as important leadership structures and processes.

*So I think that's an achievement for us is that we're good at identifying who, within the tribe, is really good, who has skills in one specific area or in a particular area and how can we use those. And we're not afraid to say, "Cuz you're really good at that we want you to help. (KCM9)*

Participants reported that there were a strong group of young leaders in the Rangitīkei that were actively involved in iwi and health developments. Participants mentioned these young leaders, as coming through the whānau, hapū, iwi and faith structures mentioned earlier. Young leaders that often took senior roles due to both their skills, and the loss of traditional leaders in the form of kaumātua and kuia through death. Participants identified that these young leaders brought passion, innovation, new ideas and strong organisational skills into collaborative initiatives.

*Well I think they bring strong whakapapa; they, each of them, have quite strong whakapapa; and when you look at all of them they all come from leadership people. There's no doubt in my mind that they come from families that have always shown very strong leadership within Ngā Wairiki, Ngāti Apa. (KCM 10)*

Participants identified a range of values and principles that were key enablers of collaborative relationships. These values and principles were reported by participants to be important in establishing and maintaining collaborative relationships between key stakeholders across organisations, and between health and social service staff and whānau service users. Participants reported take pū (Māori values and principles) as important enablers of collaboration between Māori communities and organisations, and also between Māori and tau-iwi communities and organisations. Take pū were identified by participants as a core element of Māori life that assisted Māori in collaborating with both Māori and tau-iwi. These take pū were identified as manaaki, kotahitanga, tika, pono and justice. These values and principles reflected humility, respect for others, the respect for self, and the importance of behaving in ways that supported this mutual respect.

*And I think that's something that's been intrinsically passed down from our tupuna to us, is to always be humble. (KCM 9)*

*Yeah and so I can't speak from own true understanding of the way that Maori work together, although I've learnt a hell of a lot over the last few years and still am. But I think that Maori can work collectively just by their own natural way of*

*working together. Like their natural relationships are about collectiveness and if we just take a whanau and think about a tangi, everyone gets together, gets their own jobs, they've got their skills - they're recognized for that, they have their mana and they come together and they work extremely well together in that situation.* (KCM1)

The majority of participants identified these values and principles as being reflected in and promoted through tikanga in activities participated in at the level of whānau, hapū and iwi. These activities included responding to crises, tangi, and hosting guests.

Some participants discussed Māori spirituality and tau-iwi religion as an enabler of collaboration, providing a unifying force in the Rangitīkei. Participants identified Māori spiritual beliefs and tau-iwi religion as having a clear influence on Māori values and principles. Participants observed that tau-iwi religion brought a conciliatory attitude to hapū and iwi groups that may have historically warred. The influence of both Māori spirituality and tau-iwi religion were identified as promoting peacefulness. Participants encouraged different communities and organisations to have a platform of commonality, which is belief in a God or higher power; a platform in which coming together was being facilitated through beliefs and values that have some commonalities.

*Well the sense of spiritual togetherness that's for sure because they saw everything there, from those who were in Taranaki, from all of the prophets from right around the country came to Parewānui.* (KCM 6)

*I'm quite clear in my mind that Christianity offered an alternative to these people to that pretty ruthless culture of retribution. It's a lot like, "Let's bury the hatchet and get on with this new way of living." I'm pretty sure they embraced that.* (KCM 5)

The majority of participants identified trust as an important foundational principle for collaboration between individuals within a collaborative relationship and across organisations engaged in collaborative action. Lack of trust was identified as a barrier to engaging in collaborative relationships. Participants noted that when collaborative partners have not met their obligations or stated actions within a collaborative venture that they have lost trust in that individual or group. Participants mentioned that lack of trust has led them to become hesitant in committing to further collaborative ventures with these individuals and organisations. Participants commented that addressing lack of trust as a key enabler of collaboration.

*I suppose to me things will always come back to trust, that you know that something that you hold in your heart that needs to be looked after... its about*

*looking after the whanaungatanga...because if you start losing people's trust they'll stop engaging with you. It'd be like yeah, well yeah we tried to do this, but then you know. So you're allowed to fall off the wagon every now and then, but if you keep falling off the wagon well it undermines the trust. (KCM2)*

Participants also commented that trust was increased when participants experienced support and commitment from other individuals and organisations. Participants identified that trust was often built through mutual support, that is, external organisations engaging in collaborative action important to local organisations. Local organisations would then be more likely to engage with external groups on issues important to these external groups and organisations. Participants observed that a history of mutual concern and support in collaborative action increased the likelihood that key stakeholders would engage in further collaborative relationships.

Commitment to collaboration by all stakeholders was identified by several participants as an important enabler of collaboration. Commitment to the collaborative relationships was seen as reflective of the importance placed on the kaupapa (objective of the collaboration) by key stakeholders. Participants referred to this commitment as the attendance of key stakeholders at collaborative hui, and whether or not key stakeholders followed through on their obligations. Participants saw personal commitment as important for Māori. Personal commitment was reported to involve face-to-face contact and communication, rather than formal collaborative processes such as Memorandums of Understandings (MOUs).

#### **4.2.3 Institutional racism: The ongoing impact of colonisation**

This sub-theme reflects the ongoing challenges and tensions in Māori-crown collaboration relating to Māori aspirations for health and social services by Māori for Māori. This includes the systemic barriers to effective Māori representation and participation in health care design and delivery, and the different mechanisms the crown uses to maintain the status-quo that does not meet the needs or aspirations of Māori.

Several participants reported a range of historical and ongoing factors that have contributed to challenges for Māori engaging in collaborative relationships with Crown and other tau-iwi groups. Participants identified that a lack of Māori representation on local and regional health and council boards was as an ongoing challenge for effective collaboration between Māori and the Crown. It was also observed by participants that DHBs had a lack of knowledge of Māori health needs and how to work with Māori, and if Māori were not present at higher levels of planning and decision making that Māori views would neither be tabled nor addressed.

*And I mean the only reason why, I always make sure I try and get to it, is because of like Rowena and I said, “If her and I don’t talk about the inequalities and how they’re supposed to be addressing them.” They just swan straight over the top of it.* (KCM2)

Participants commented that there had been several instances of the DHB having a lack of Māori representation within key strategic positions such as General Manager of Māori Health. Positions which were important for ensuring the engagement and participation of Māori in the process of planning and decision-making. This was a challenge to collaboration as there was a lack of coordinated representation of Māori needs and preferences at a strategic level.

The majority of participants identified that when representing Māori on different Crown boards, their opinions were not heard or valued. Participants viewed the boards as driving through their own agendas. This led participants to be hesitant in supporting the agendas of these boards.

It was also noted by participants that often they may have been the sole Māori representative on a large board, which led them to feel isolated and overlooked, in turn they found they were unable to actively engage in the collaborative process. This situation is further challenging to effective collaboration as participants mentioned that when Māori do not oppose certain views then other key stakeholders perceive that they must be supporting the views and agenda of the board. For those that do speak up, their perspectives are not understood by the board and are therefore overlooked. These examples highlight the pressure placed on Māori representation on Crown and other tau-iwi boards, in which they are outnumbered and not supported within the context of the boards.

Participants described that when entering into collaborative relationships with the Crown, there was a perception from Crown representatives that the Crown was the authority on what was needed for Māori. This led to participants experiencing criticism when voicing their opinions, and perceptions from participants that the Crown was operating from a paternalistic paradigm rather than from within a partnership paradigm. This experience had reduced the willingness and confidence of Māori to engage in collaboration with the Crown.

*She essentially said to us, who did we think we were challenging the DHB, who were doing great work for Māori people. She was quite derogatory in the way she spoke to us.* (KCM 10)

The lack of confidence in collaborating with Crown representatives was evident in participants reports that collaboration with the Crown did not necessarily transfer into

commitment from the Crown to constructively work with Māori, or that there would be any beneficial outcomes for Māori. Current collaborative processes such as Memorandums of Understandings (MOUs) were seen as arrangements made on paper without the personal commitment of key stakeholders to a collaborative relationship.

*This person said to me that collaboration was a tau iwi word that meant that ‘we may or may not work with you. (KCM9)*

Not only did participants view collaboration with the Crown as unbeneficial for Māori, participants commented that perceived authority by the Crown reduced the ability of the iwi organisations to actively respond to Māori at times of crisis. Participants reported that Crown priorities and imperatives at times of crisis did not always take into consideration the needs of rural whānau, marae, hapū and iwi.

Several participants also highlighted that collaborating with the Crown may actually disadvantage Māori organisational development. This was particularly important when considering the desire of Māori to increase the provision of specialist services for rural Māori. Current approaches to providing access for whānau to specialist services involves local Māori health providers referring on whānau to visiting providers or providers based in main urban areas. This was seen as hindering Māori organisations from accessing the personnel and financial resources to deliver these services for their own peoples.

Despite the common reports from participants that Māori were required to respond to Crown imperatives and be compliant with Crown contract requirements, other participants proposed that Māori organisations needed to develop clear health priorities based on rigorous strategic planning and research. This was argued by participants to be necessary for moving Māori from a junior partner in collaboration into a senior partner when it comes to collaborative relationships directed at meeting the health and social needs of Māori.

*There’s not a substance coming from them saying, “Well, here’s our collective iwi plan and this is where we believe we should be going and what we should be doing and why.” That’s not there … at the end of the day you’ve got to have enough guts and trust in yourselves to stand up and say, “Right, we are a Māori organisation, this is what we believe in and we can prove it, and that’s it. (KCM1)*

Participants reported a long history of engagement with Crown representatives regarding Māori health service development in the Rangitīkei. A number of these collaborative interactions led to participants being let down, overlooked and perceiving that the aspirations of Māori were actively blocked by Crown representatives. These negative interactions further

reduced the trust and confidence of Māori engaging in collaborative ventures with Crown representatives.

Several participants observed that the Crown and other tau-iwi organisations often spoke about the importance of collaborating with Māori, however this was seen by Māori as rhetoric, with no intention of these groups to follow-through and collaborate with Māori. This has contributed to some scepticism on the behalf of Māori when considering engaging in further collaboration with the Crown and other tau-iwi groups.

*Yeah. And I mean services, we always talk about, “Oh we've gotta have robust relationships,” and “...we've gotta work in collaboration.” It’s like, yeah it’s all lip service... there was no action. It was a Pakeha organization said it out front but there was no action and no changing of infrastructure that allowed that to happen. (KCM9)*

A participants reported hearing similar rhetoric from government ministers regarding the importance of collaboration across healthcare; however participants noted that the rhetoric was not supported by significant changes in policy or practice at ministry level. This was argued by participants to reduce the ability of DHBs to create changes to funding contracts that supported the application of collaborative models of healthcare.

This same participant described the negative impact on Māori who have been implicated in this rhetoric. It was noted that Māori often sit on Crown and other tau-iwi boards in order to represent the interest of specific Māori groups, and as part of this role, these boards gain access to the broader Māori networks that these participants represent. When boards do not follow through with collaboration, the Māori representative is implicated in this failure, and is left feeling used.

*So I became a thorn in their side and said to them, “Well no, kei te he tena. You know, if you're gonna say something to my people, you need to follow it; you need to follow it through because I'm not going to allow you to takahia on the networks that I have or the hononga that I have with my whānau around this motu, around this rohe; so that you can get some runs on the board, kau; yeah sorry.” (KCM 9)*

Several participants highlighted a range of significant concerns with the way that Crown agencies developed and applied planning and funding processes. These concerns included the complex and changing nature of Crown contracting, and the geographical constraints of contracts. Participants reported that the needs of Māori were not considered when making decisions about allocating funding towards projects and services. The lack of consideration of Māori needs was proposed to be a challenge to meaningful collaboration as Māori needs and

aspirations were perceived to be unmet. This is a further example of power and perceived authority.

Participants identified that the reporting requirements and expectations of contracts created difficulties for Māori providers, particularly providers who were contracted by different Crown agencies, such as health, mental health and social services. Participants mentioned that significant effort and time needed to be allocated into understanding and being compliant with significantly different reporting processes. Therefore collaboration between Māori providers and the different Crown contractors was deemed by participants to be ineffective.

*But Māori providers have always felt restricted by the funding and the way it comes in and the way they need to report on each of the funding lines. (KCM1)*

Participants also observed that changes in Crown imperatives, through either change in health policy or change in government, led to loss of contracts for Māori providers leading to further problems for whānau in accessing services. Change in policy was also noted to contribute to the breakdown of promising Māori collaborative health initiatives.

One of the primary concerns identified by a majority of participants was the geographical focus of contracts; contracts which designate the area by which organisations can deliver services. Participants commented that iwi organisations were not able to meet the aspirations of delivering services to their own people who may live outside of the contracted geographical boundaries. Participants mentioned that this forced a range of collaborative relationships, by which Māori felt that they were meeting the imperatives and aspirations of the Crown rather than their own people.

*It has been frustrating that most of our population is elsewhere and yet our contracts are confined to this geographic area that's our rohe. There's a disconnect there. (KCM5)*

Participants also observed that a lack of specialist services in the Rangitīkei led to difficulty for whānau to access or engage with specialist clinical service providers, which were not based within the Rangitīkei. These whānau often lacked transport, or finances to travel or take time off work to travel to specialist appointments. These were identified as key barriers to accessing services. Participants commented that funding contracts did not account for the additional resources required by rural health and social services to support whānau to attend specialist services that were based within regional centre such at Whanganui or Palmerston North.

*So we realized that the rural women and the children and whānau, really were isolated from the client centre. (KCM8)*

*The biggest one is transport and then the other, I suppose the other second one is appropriate specialist care. (KCM4)*

Urban based specialist services entering into iwi boundaries to engage with whānau service users was identified by some participants as challenging for whānau service users, rural health and social services, and the urban based provider. Participants noted that neither the whānau nor the local Māori services have established effective collaborative relationships with these external providers. Participants reported that they perceived that particularly medical specialist services did not value or acknowledge the important role that local Māori organisations played in the life and wellbeing of whānau. This led to a lack of commitment by specialist medical services in engaging and maintaining collaborative relationships with local health and social service providers. Collectively the lack of familiarity between specialist medical services, whānau and local Māori organisations, and the lack of value placed on local Māori services contributed to poor health service collaboration for whānau with high and complex health needs.

Several participants described the complex challenges related to accessing specialist services in rural communities. Those challenges necessitated Māori organisations and mainstream tau-iwi groups (who may not traditionally have collaborated) to collaborate. This was particularly true in the case of the introduction of the Primary Health Care Strategy (PHCS). However, participants commented that this collaboration was at times forced and created challenges as different groups had different philosophical positions on health, and significantly different practice and procedure processes.

*It's become bigger than Ben Hur for some and the development has been quite slow, because again; relationships will have been forced in some ways. You know, "Yes it's a great idea, you and I could get together - we could be a business case. Oh whoops, our philosophy's completely different." Some of our practices want to come in and some of them don't, systems and processes are completely different, IT systems... the whole thing and it's like a forced marriage in some cases. (KCM1)*

The fundamental differences in health philosophies between Māori and tau-iwi were identified by the majority of participants as contributing to tension. Participants reported that Māori had a desire to focus attention and resources on whānau and hapū development. Participants identified that without a focus on Māori aspirations; attention and resources would continue to be directed solely with a deficit lens. Participants observed that focusing

on whānau and hapū development contributed to preventing negative health outcomes for Māori and promoting sustainable wellbeing for Māori.

*I don't see our health and our social and our cultural and economic as separate things. I see them as encapsulated in everything that we do. It doesn't matter what it is, that we have to have an understanding of how that all fits together. And how that strengthens us and helps us to grow. (KCM10)*

Participants noted that Crown health paradigms produced funding contracts that focused on specific national health targets, which did not necessarily align with the needs of the local community. Several participants identified that regardless of their own beliefs and preferences of what the focus of Māori services should be, that Māori providers were required to focus on compliance with Crown imperatives for organisational sustainability. Participants identified the importance of Crown funding from these health contracts in maintaining the ongoing viability of the iwi organisation as a whole. It was reported that iwi organisational administration had in the past heavily relied on health contracts to allow Māori organisations to meet some of its hapū and iwi priorities.

*No, no it's one that we've struggled with. We've struggled with it because quite often the contracts don't allow that to happen. I'll give you an example, they have been geographically focused and they were outputs focused. And we quite often were focused on being compliant or contract compliant to the detriment of our own, both development and strategic direction. (KCM 7)*

Therefore these differences in philosophical approaches to health priorities have contributed to internal and external challenges to collaboration for iwi. Internally, when key stakeholders within organisations hold different philosophies about the direction the provider should pursue, and/or externally when iwi and Crown organisations hold different philosophies, the ability to progress strategic direction is stalled, and issues of needs, outcomes and processes require more intensive navigation.

*I quite often feel conflicted internally when I look at what is the best thing to do from a rational management perspective compared to, well, actually if you do that, how do we protect our Ngāti Apa identity? It wouldn't make a hell of a lot of sense to pool all our fishing assets with every other iwi and we get this big company up and running and go and perform heaps better and give us a better return. But then how does that serve Ngāti Apa? You know, there's that bit of a tension there. (KCM5)*

#### **4.2.4 Summary of theme: He toa takatini tōku toa, ehara I te toa takitahi**

The theme ‘He toa takatini tōku toa, ehara I te toa takitahi’ was reflected within three subthemes, ‘Tinorangatiratanga: Maori self-determination regarding health’, ‘Rangatiratanga:

The role of individual and collective leadership and organisational skills in facilitating collaboration and collective action', and 'Institutional racism: The ongoing impact of colonisation'.

The subtheme 'Tinorangatiratanga: Maori self-determination regarding health' reflected participants experiences of forming for collective action. Self-determination was identified as a key consideration when engaging with other groups in collective action. In order for self-determination, Maori needed to gain strong collective organisations and to reinforce relationships and enable aspirations. Participants described how Māori movements in the 1970's and 80's including Te Kōhanga Reo and Nga Tama Toa were the catalyst for early collective action. National and regional Māori models of collaborative action that grew out of these, and were proposed as enablers of local collaboration due to their ability to provide frameworks for local Māori to develop governance and operational structures, and also for local Māori organisations to access training and support from established providers and specialists. A range of opportunities for Māori development came out of the evolution of health and social services. These came out of changes in government policy and funding priorities. One of these opportunities was the parallel development of hapū and iwi identity and organisational structures.

Mechanisms important for initiating and maintaining collaboration were also identified as important, these included the importance of coming together for a common purpose, under a common vision, and with a common message as key enablers of collaborative action. Leadership was identified as a key factor in both motivating people to engage in collaboration and to address challenges within collaborative relationships. The development and maintenance of trust between key stakeholders within collaborative relationships was also noted as important in maintaining collaborative action, and also in increasing the likelihood of future collaborative action.

As a researcher, listening to these stories, it was evident that participants were enjoying reminiscing about the influential events and movements of the past. What also occurred in discussing these events, were the referencing of participants to the names of the different people involved in early collaborations. Often participants would appear flustered when they couldn't remember names, and often near the end of the interview they would randomly state the name of a key individual. This reflects the reverence and mana in which these early key stakeholder were held in. Of note, was that the participants were often talking about each

other, which affirmed for me, the selection of these individuals as key community member participants.

New Zealand research on collaboration has identified the importance of exemplars of collaboration for enhancing learning around collaboration (Eppel, Gill, Lips and Ryan, 2008), however, these did not focus on Māori led initiatives, and the literature I did access on Maori collaborative exemplars was unpublished and unreleased, requiring direct communication with both the funder and researcher to access the information (Kōwhai Consulting, 2008). This shows a significant gap in research literature in New Zealand. There was support within the literature reviewed for the issue of trust and distrust between indigenous organisations and crown or governmental organisations and representatives Mauriora Ki Te Ao - Living Universe Limited, 2010; Taylor, Bessarab, Hunter & Thompson, 2013; Widmer, 2011; and Kania & Kramer, 2013). However this is logical seeing that trust is an element of relationships, and collaboration is built upon relationships. There was less acknowledgement of the importance of clarifying common goals or vision within the literature (McLachlan, 2011; Easterling, 2013). This is an important and possibly overlooked aspect, as according to participants of this study, collaboration was often called by crown representatives, for issues of importance to the Crown, not for Māori.

A focus on whānau wellbeing as opposed to whānau deficits or problems was an approach identified by participants as having had a positive impact on collaborative and integrative health paradigms, and this was becoming more common in health and social contracts. The delivery of more integrative and comprehensive health and social services were identified as aligning with Māori health paradigms. Collaboration was also noted to be a core component of integrated practice and comprehensiveness, particularly in rural communities. Participants identified that rural Māori health services have responded to a lack of resources and limited scope in service delivery by being innovative and collaborating with other health and social services in the community for mutual benefit. Participants also reported that rural Māori providers had expectations of staff to be flexible and responsive to the needs of whānau and of the community.

Engaging with these key community members as a researcher, allowed me to see that the current health and social service approach and government policy ‘Whanau ora’ was something that reflected traditional views, as opposed to a new or modern paradigm. Participants spoke of this approach as an innate and organic process that they fought hard for, and were now seeing as part of government policy. The importance of Indigenous and Māori

models of practice and paradigms of health were well covered within the literature, along with the need for flexible and responsive services (National Health Committee, 2010; Ihimaera, 2007; Jansen, Bacal & Crengle, 2009; Smith & Ovenden, 2007; and Ministry of Health, 2010).

Traditional Māori values and practices were reported as important factors in enabling collaboration between Māori organisations, and between Māori organisations and tau-iwi organisations. Māori and non-Māori service users were noted to have experienced positive engagement with Māori providers. The welcoming and respectful processes inherent in manaakitanga were identified as the key for this engagement. Service users and whānau also supported the need to maintain responsibilities for their own health care, and through creative and fun community health initiatives. Service users maintaining their involvement in health activities and in some cases developing their own health and social activities was reported as a positive outcome of effective collaborative relationships between the service, whānau and community.

I attempted as a researcher to reflect these values and practices within my own interactions with participants, however my koha felt well overshadowed by the koha of the participants time, wisdom and stories. The literature review provided support nationally and internationally for the importance of traditional practices in developing collaborative relationships between indigenous groups, and between indigenous groups and government groups and representatives (McLachlan et al., 2012; Dougherty, 2013; Marrone, 2007; Taylor, Bessarab, Hunter and Thompson, 2013; Local Partnerships and Governance Research Group, 2005; Knox 2004; and Ministry of Education, 2009).

The subtheme ‘Rangatiratanga: The role of individual and collective leadership and organisational skills in facilitating collaboration and collective action’ reflected participants experiences of leadership. This was identified as a key factor in both motivating people to engage in collaboration and to address challenges within collaborative relationships. The development and maintenance of trust between key stakeholders within collaborative relationships was also noted as important in maintaining collaborative action, and also in increasing the likelihood of future collaborative action.

Several culturally specific challenges and enablers to collaboration were identified. Māori experience challenges in gaining consensus when engaging with the Crown or other tau-iwi groups. They also experience tensions representing the interests of and allegiances to hapū, faith, iwi and employers in collaborative initiatives. Whakapapa and the application of Māori

values and practices were cited as important enablers for collaboration with other practitioners, services and whānau, by establishing and affirming relationships, and guiding relationships within collaborative initiatives. Leadership is an important component in motivating people to engage in collaboration, ensuring all participants have a voice, and addressing challenges that arise through collaborative initiatives.

Participants noted a range of challenges to collaboration for Māori. This included tensions for Māori between allegiances to hapū, faith, iwi and employers; and several challenges for Māori in gaining consensus when collaborating with the Crown and other tau-iwi groups. This included the lack of consistent key Māori stakeholders engaging in the process. This often led to the use of delaying tactics as the key stakeholders did not have adequate information or confidence to make decisions for their group; and that rural communities have limited access to specialist clinical services. This was noted to place pressure on collaborative relationships. Leadership in collaborative initiatives was also noted as a challenge to effective collaboration. Participants reported that large and better resourced Māori organisations would often take the lead in initiatives this led to participants perceiving other groups had more power and more influence on the goals and outcomes of a collaborative initiative. Participants also reported fears that smaller organisations may be taken over by larger organisations.

The importance of leadership, and the challenges Māori face when engaging in collaboration at the level of leadership was evident in the report by Kōwhai Consulting (2008). This was also identified in literature on collaboration between Australian Aboriginal groups and the Australian government (Taylor, Bessarab, Hunter & Thompson, 2013). The literature noted the important role of leadership, however that government did not match indigenous leadership in commitment nor attendance at meetings. This reflects systemic racism, where indigenous populations are expected to have senior management present at meetings, yet government organisation can send lower level representatives, who often are not in a position to make equal decisions.

The subtheme ‘Institutional racism: The ongoing impact of colonisation’ reflected participants experiences of engaging with crown agencies and representatives. Participants noted a lack of Māori representation on local or regional governance boards. This was seen as a challenge to collaboration as Māori needs and preferences were not being considered. When participants did engage with the Crown, they reported experiencing a lack of commitment. Participants further noted that within collaboration, Crown organisations and representatives minimised the legitimacy of Māori health and social service paradigms and practices, whilst promoting

their own knowledge and strategies. This was seen as an issue of safety for Maori representatives who were often isolated and pressured within collaborative initiatives or committees/boards. Alongside this use of power, Crown health contracts were aligned with Crown imperatives, and these did not often align with Māori needs, paradigms or preferences. Participants expressed a desire for Māori organisations to engage in more research and development in relation to Māori needs and preferences.

Racism is acknowledged within the literature at the level of service user experiences (Jansen, Bacal & Crengle, 2009; Rameka, 2006; and Marrone, 2007), however less so at an organisational level. This may not be a gap in the literature as such, but a gap in the ability of the literature review to capture all aspects of collaboration at each level of collaboration (e.g., policy, organisational, practitioner and whānau). The experience of systemic racism is best captured within the literature review in the unpublished review of collaboration between the Crown and five Iwi groups by Kōwhai Consulting (2008).

### **4.3 He punga I mau ai**

He punga I mau ai. An anchor that holds. This whakatauki can reflect the stabilizing role of whakapapa in joining people together (Mead & Grove, 2001). This Whakatauaki can be understood as the importance of connections between people and place across time.

This theme reflects the enablers of collaboration by Māori for Māori, along with collaboration between Māori and the crown. This theme discusses the approach to Māori health and social service development which occurred within an overlapping and integrated regional and local approach, across both Iwi and Māori health and social service organisations.

This theme is represented by two sub-themes, ‘Whanake: The evolution of Māori health services’ and ‘Whakapapa; Historical connections between groups providing the cement for ongoing collective action’.

#### **4.3.1 Whanake: The evolution of Māori health services**

This sub-theme reflects the evolution of Māori health and social services and the key mechanisms that enabled this process. This includes the role of treaty settlements in providing a vehicle for collective action and the development of organisational structure, to the opportunities that came about through changes in government health policy such as the devolution of health services to the community.

Participants identified the treaty settlement process and hapū development as an enabler for Māori collaboration. Participants mentioned that, running parallel to Māori service development was the development of iwi structures and identity. The treaty settlement process brought whānau together for a common collaborative purpose, that is, whānau, hapū and iwi were required to clearly demonstrate their identity and connection to land and local resources in order to engage in a settlement process with the Crown. This involved research, hui and the development of organisational structures in order to engage in the treaty process. The treaty settlement process has in turn spurred further collaborative efforts at a marae and hapū level, again providing a unifying purpose.

*Certainly it's a collaborative sorta thing. I think our hapū development's focussed from; right from the start was something that attracted a lot of people and got a lot of support. Especially from the Marae groups who have sort of become the conduits for the hapū development. They've got on-board with that vision; they could see how it served them. (KCM5)*

Participants reported that the development of iwi health services had a parallel impact on the development of iwi identity and infrastructure. Participants commented that the devolution of health services from hospitals to community providers in the 1990s gave iwi an opportunity to apply to deliver these services. Participants observed that this led iwi to focus on strengthening their own identity and infrastructure in order to be able to apply and obtain these contracts. The development of iwi health services and accessing of health contracts provided funds for operations and administration for not only the health service but for the iwi organisation itself. Participants noted that this parallel development was necessary in order for the iwi organisation to be able to successfully go through the rigorous Waitangi Tribunal claims process, and later to engage with Crown organisations such as those involved in fisheries and forests.

*So, yeah to me that helped spark up the reason to have these conversations, about who, actually know who we are and where we're going to. And so it was that devolution stuff and I can remember being at hui on our marae and God people crying and asking their grandparents, "Well I thought we were this?" and being really confused about stuff. And so it takes some time, you know, it's taken time for us to become unconfused I suppose and become confident and strong in what we're doing. (KCM2)*

Participants identified a further impact of parallel iwi and iwi health organisation development, which was the ability of the iwi to be able to have a stronger role in developing strategic health and social objectives for their people. Participants illustrated this by expressing the objective of iwi for iwi health services to deliver services on Marae, and for

hapū and marae having designated workers. Staff with whakapapa (genealogical connections) and/or other relationships and connections with marae and hapū, such as having a history of living or working in the area were actively sought for employment. Participants commented that staff with strong connections to marae and hapū were better able to address the health, social and cultural needs of whānau service users. Staff designated to hapū also allowed for these staff to work more closely with hapū to identify the needs and aspirations of whānau.

Participants highlighted navigating the tensions between iwi aspirations and organisational needs as creating a challenge to effective internal organisational collaboration. Participants reported that iwi imperatives often drove decision making around who sat on organisational boards, and at times this led to organisations lacking necessary skills and expertise to operate and collaborate within a modern competitive health and economic marketplace.

*And I think also another factor that needed to be considered is our capacity to run it. Both at an operational level and secondly at a governance level, where you have governance members that are appointed according to iwi imperatives rather than skill or the interests of the organization. (KCM7)*

Participants commented that a lack of organisational robustness for some Māori organisations had led these organisations to lack the innovation to create and take opportunities that meet the needs of their people. This was mentioned by participants to be reflected in the trend for Māori organisations to deliver based on Crown imperatives rather than defining and promoting their own agenda. This was proposed by participants to place Māori as a junior collaborative partner advocating for the needs of Māori and monitoring the effectiveness of the services that are working in their area, rather than as an active partner in collaboration.

A lack of organisational competence at both a governance and financial level was identified by several participants as leading to the loss of significant Māori services in the Rangitīkei, particularly Te Orakeinui services in Rātana. Participants observed this loss as a reflection of the complex nature of health and social service contracting in the modern competitive health marketplace. The loss of Te Orakeinui was used as an example to suggest that other smaller rural Māori organisations may need to enter into closer collaborations, or even amalgamations with larger Māori organisations, in order to be commercially viable in a modern and ever-changing health marketplace.

*And so they thought they were doing the right thing and then when it all turned to custard and they had no money left they had to shut the whole thing down. The businesses closed; the health service closed; the courses finished and it was a really, really sad time. (KCM9)*

Participants reported that staff and organisations not knowing each other's processes, expectations or resources led to challenges for organisations in establishing effective collaborative relationships and initiatives. This was reported to have led to significant confusion and delays when developing collaborative relationships between Māori organisations and funders. One of the collaborative initiatives between Crown agencies and Māori providers identified by participants as delayed due to poor knowledge of each other's processes was the integrative contracts held by TKOR, one of the first contracts to integrate health and social service contracts in the New Zealand.

*Now that was a very interesting process and it still brings me back to the basics of relationship building because at the table we had two funders, which was MSD and Health, Health was by far the biggest funder but we didn't know anything about one another. I didn't have a clue really what the services were that MSD purchased from Ngāti Apa, what their expectations were, what their auditing was, what any of their legal requirements were; I didn't know a thing. (KCM1)*

Participants commented that Māori providers experienced delays and challenges in establishing collaborative relationships with other Māori providers due to a lack of knowledge of their own and others' abilities and needs. It was noted by participants that it was important for each organisation in a collaborative initiative to be able to clearly communicate the strengths and needs that its organisation brought to the collaboration, in order for the collaborative collective to make the best use of resources.

Some participants identified the relationship between clinical health services including hospital and GP services and local Māori health and social services as a challenge to effective collaborative health care for rural Māori service users. Participants mentioned that primary and specialist health care services historically have lacked knowledge of and devalued the services provided by local Māori health and social services. Participants commented that this led to poor communication, lack of consultation and generally poor pathways of care for rural Māori with complex and chronic health and social problems.

*I used to have to go and visit at the hospital any of our Māori patients in there. And I remember being chased down a corridor by these three Pākehā nurses, shoved, bundled into an office and they wanted to know "What are you doing here? Why are you here? How come you've been coming here every day, we've been watching you, what are you here for?" (KCM2)*

A lack of knowledge of Māori needs, resources and preferences was reported by participants to have led to a lack of effective collaboration between Crown organisations and local Māori providers when it came to addressing child welfare issues. Participants observed that Māori

knowledge of the resources of whānau and the needs of children in child welfare cases were not valued. This was proposed to lead to ongoing poor collaborative outcomes for Māori children and whānau involved in the child welfare system.

National and Regional Māori health, education and social service initiatives were also commented on by participants as important for local development, as these external initiatives provided examples of successful and culturally congruent models of practice for local Māori to work from. These included Mātua Whāngai, Te Korimako Community Health workers Network, and Te Kohanga Reo movement. These exemplars provided culturally congruent models of governance and operational structure, and also provided access to training and ongoing collaborative support between existing providers and further development of providers involved in these initiatives.

*And so we slowly started. So we got the health contract which had, well which were overheads for a worker, so not only did we have the overheads, there was also a vehicle that came with the position. So we got the Matua Whangai position going and we had four staff came on board for that. They weren't full time, they were part timers. Then we had to end up, because we were growing so much, we had to end up getting an administrator for the committee. (KCM 2)*

Participants identified accessing Māori and non- Māori experts for advice and support as an enabler of collaborative initiatives. Experts were seen as those with experience, knowledge, and access to networks of other professionals. These persons were seen as a resource that could further enhance Māori development in areas of organisational development, developing policy and improving practice. It was also identified that these persons were accessed because of their ‘heart’ for Māori development and support of Māori aspirations for self-determination in the areas of health, social and educational development. Participants observed that experts provided inspiration, practical support and links to further contacts and opportunities which allowed Māori to work through institutional barriers, and ensure services were able to engage and compete in changes in health care delivery strategies such as the PHCS.

*He came to see us and he said, I will help you in any way that you need help. I'll provide you with statistical data. If there's any issues about you getting your medical centre established, I will come to Whanganui. I will meet with the GPs. I will do that. (KCM10)*

Participants commented that changes in health policy and Crown imperatives provided opportunities for Māori to participate in health care service development and delivery. This

included the devolution of health service from hospital to community care, Māori Development Organisation (MDO) models, and the introduction of the PHCS. The devolution of hospital services to the community provided an opportunity for Māori health and social service organisations to strengthen their role in the community, and voice the needs and preferences of Māori. Participants identified that the opportunity to deliver services prompted hapū and iwi to focus on developing identity as a group, and strengthening their organisational structures in order to compete for health and social service delivery contracts.

*So, the MDO had a forum, the Provider Forum they called it, then their member providers came together on a monthly basis and talked about different service issues. It was a networking opportunity but also an opportunity perhaps to change the way services were being delivered or talk about commonalities or look at opportunities perhaps when the Maori Provider Development Scheme came into being and it was distributed once a year, there was an opportunity to come together and talk about that and how workforce development might work collectively. (KCM 1)*

The MDO model provided a structure for Māori organisations to access organisational and practice support, and a centralised source of government health funding. The PHCS provided an opportunity for Māori to engage in delivering primary health care, an area which lacks delivery by Māori organisations, and shows a significant lack of Māori whānau engagement.

Participants identified that the Crown Whānau Ora health care strategy was a significant turning point in collaboration for Māori. Whānau Ora was proposed to have been motivated by the needs of local Māori in the Rangitīkei and Whanganui, and was argued to encourage Māori and tau-iwi groups to collaborate at both a planning and a service delivery level. Participants noted that this was a position of partnership within collaboration, a partnership by which Māori had significant knowledge and influence in planning and service delivery.

*Tariana's been very straight here and told providers to get their act together and get into bed together and get it into a collective. (KCM9)*

#### **4.3.2 Whakapapa: Historical connections between groups providing the cement for ongoing collective action**

This sub-theme reflects the role of historical connections and tensions within and between Māori groups seeking to engage in collaboration and collective action. The complex nature of relationships between hapū, iwi and Māori providers was both a challenge to collaboration and a core-binding characteristic of collective action. Participants identified that there were often tensions between expectations and aspirations of each stakeholder group. Addressing these internal hapū, iwi and Māori provider tensions were identified as vital for Māori in order

for Māori to develop strong coherent collaborative strength when engaging in collective action, and in collaboration with external groups such as Crown funders and other providers.

Participants identified whakapapa and land as important enablers of collaborative relationships between peoples and groups. Whakapapa was seen as a strong bond between people that implied a natural connection between people and groups, and a history of living and working in the community was identified as an important connector between peoples and groups.

Whakapapa, was identified as a key foundation for successful collaboration for Māori. Whakapapa was proposed by participants to form a natural historical bond, cement between iwi and within whānau, hapū and iwi. Participants observed that whakapapa to waka (traditional migrating canoes) provided historical bonds that allowed iwi groups to come together based on shared history. This was seen as a starting point for acknowledging connection between groups that may have historically fought with each other, and more recently competed for national and regional social, health and education contracts.

*Well you know, funny, we looked through the history about all of our, all of the war and that happened, ‘cause there was heaps of it. And it was really funny. Well yeah, yeah, we may have warred all those years ago, you know all those hundreds of years and all that, but hey it’s as though we’ve found another reason for us to stop warring and start looking after each other. (KCM2)*

Whakapapa was identified as an important enabler of collaboration for Māori stakeholders to engage in collaboration with other Māori stakeholders and groups. Participants commented that often having knowledge of one's whakapapa allowed key stakeholders to make personal connection with other key stakeholders. Whakapapa also allowed for key stakeholders to be seen in a positive light, particularly if the key stakeholder had leadership whakapapa.

*You see, so knowing some of the history behind how groupings happen and as each merge is... The Rangitikei is a big binder of all of. If we might get a little bit tight about things, we know that the Rangitikei is swallowed by Manawatu and Whanganui, the greatest thing for Ariki I tell you. Fly the Rangitikei flag and that's Pakeha and Maori alike. So if you're talking relationships, even to the Pakeha communities now, it's about that; who are we and where's our identity in the Rangitikei River? Even if the Pakehas call it "Rangi Tiky," what the hell.*  
*(Participant 6)*

Participants noted that key stakeholders would often cite their whakapapa, and their knowledge of others whakapapa to build relationships and resolve conflicts. This process

reflects the values and principles of Māori, the importance and acknowledgement of whakapapa, and the respect held for the deeds and standing of past leaders.

Participants identified shared history, experience, and connection to the land as a further representation of whakapapa, which enabled collaboration. These factors provided a central shared history that allowed for a common anchor to collaboration.

*... that's that whole business that they chose to put it together like this because of our whakapapa links with each other and the waka thing; Aotea, Tokomaru, Kurahaupo Waka for the region you know, still working with that kind of linking.*  
(Participant 6)

Participants mentioned that tau-iwi with a strong family connection to the region or with a personal history of working and living in the area was respected as a connection to the land and commitment to the community. This was seen as an important enabler of collaborative relationships, as key stakeholders with a personal connection to the area were seen as having a personal connection and commitment to what was important to local people.

*We moved back and his family were highly regarded and still are there, so because I married into his whānau, then I must have been okay...And so that gave me a foot in door to anywhere really - and still does.... It is the insider type thing.*  
(KCM1)

Participants identified that a barrier to collaboration had arisen when a person's affiliation/membership to a specific group reduced their willingness to engage collaboratively with those who did not hold the same affiliations/memberships. Within this research affiliations/memberships within and between specific religious faiths and/or iwi emerged. Participants commented that a key challenge to collaboration between those in service delivery and whānau service users arose when historical conflict between their respective whānau, hapū or iwi had occurred. This led to mistrust and at times personal conflict that impacted the service delivery relationship.

*Yeah. You know, you try doing that 15 years ago, woulda been downright dangerous 'cause, you know, half a chance is, "Oh your tupuna ripped us off. You guys can piss off back where you came from." That's the kind of thing that happened; I've seen it happen with my own eyes.* (KCM5)

Alongside whānau, hapū and iwi challenges to collaboration, there is a further membership complexity to consider. Within the Rangitīkei region, is Rātana Pā, a strong Māori faith community with peoples from a wide range of iwi membership. One participant reported a perceived barrier to collaboration occurred when a staff member's group membership

impacted on their willingness to engage with external groups. This led to the worker not meeting the employer's expectations that the needs of the broader communities' needs would be met.

*...was very focused on [their] Morehutanga rather than [their] iwitanga. So [they] found it quite difficult to come out of Rātana. [they] would do things up at the Rangitīkei but would very rarely venture down into the Rangitīkei. So we didn't think that that was a really successful placement, because we wanted somebody to work with the iwi down there. (KCM 10)*

#### **4.3.3 Summary of theme: He punga I mau ai.**

In summary, participants reported that whakapapa and connection to environment were key binding factors for Māori collaboration.

The theme 'He punga I mau ai' reflects the enablers of collaboration by Māori for Māori, along with collaboration between Māori and the crown. This theme discusses the approach to Māori health and social service development which occurred within an overlapping and integrated regional and local approach, across both Iwi and Māori health and social service organisations. The theme was reflected within two sub-themes, 'whanake: The evolution of Maori health services' and 'whakapapa; Historical connections between groups providing the cement for ongoing collective action'.

The subtheme 'whanake: The evolution of Māori health services' reflects the participants experiences of the evolution of services for Māori by Māori. A range of opportunities for Māori development came out of the evolution of health and social services. These came out of changes in government policy and funding priorities. One of these opportunities was the parallel development of hapū and iwi identity and organisational structures. These opportunities and changes posed both challenges and opportunities that required a collective collaborative effort to develop iwi structures and relevant responsive organisations. A key enabler of this process was a small group of courageous leaders that had the clinical and cultural connections to build upon needs and aspiration, and most importantly to bring iwi together to form a strong and united voice.

Despite the range of tensions for Māori collaborative initiatives and challenges in collaborating with the Crown, the evolution of iwi health organisations has led to iwi having a stronger position and voice for ensuring the needs and preferences of Māori related to health and wellbeing are met.

As an Iwi member and researcher, I was able to see the strong familial lines running through not only leadership, but through the development of services and through political parties. Some whānau had two generations of politicians, whereas others had two generations of people working within the same health and social service industry and at times organisations. As a Māori clinician who has worked within Māori health in another region for approximately 20 years, it was striking to me how the service development across iwi, based within Whanganui had been such a joint collective action. In my experience, Māori providers in the region where I have the most experience are fiercely competitive and disjointed. Whereas in the Whanganui and Rangitīkei, the fact that the leaders had strong whakapapa links across iwi, ensured a groundswell of support and an intention that as the central regional services developed, they would in turn use this strength to plant and support rural services within iwi.

There was very little acknowledgement within the national or international literature regarding historical conflict between services, and the impact of this on present and future collaboration. The only study addressing this was the pilot study for the present research (McLachlan et al., 2012). This presents as a gap in the literature. This may lead people to take a simplified set point (focused on current state) view of collaboration, without understanding the historical experience of staff and organisations in working together. This may be even more important to take into consideration for Māori and other indigenous populations that view government funded services as products of the Crown or government, therefore a product of colonisation.

The subtheme ‘Whakapapa; Historical connections between groups providing the cement for ongoing collective action’ reflects participants perspectives regarding whakapapa and connection to environment as key binding factors for Māori collaboration. Participants noted a range of challenges to collaboration for Māori. This included tensions for Māori between allegiances to hapū, faith, iwi and employers. Connection between Maori groups was noted to be foundational to the establishment of any collaborative relationship for the purpose of collective action. It was also noted to be vital for the addressing of common goals, vision and for addressing conflicts within collaborative relationships. This whakapapa was dynamic and based on several different pathways. These included waka, awa, whenua, and whānau. Participants also noted that a connection to the environment could also be used as a binding strategy between Māori and non-Māori.

In reflecting upon my own whakapapa, and my ability within the research process to use this as a platform for both legitimacy of researching in this area, with my own people, it was

evident that this is again, a traditional practice, which despite whakapapa being innate (within and between us), knowing my whakapapa and being able to state the connections between my families and others was a vital practice, a practice that was recommended by participants for building and mending relationships between groups and individuals.

The importance of whakapapa and its value in developing relationships with others is evident in national literature (Ritchie, 1992; McLachlan et al., 2012; Ministry of Education, 2009; and O’Leary, 2014). In relation to the issue of whakapapa and rituals associated with whakapapa, this was also supported by the pilot study for the present thesis (McLachlan et al., 2012) and also in the study by Taylor, Bessarab, Hunter and Thompson (2013) on Aboriginal Australians experiences of collaborative relationships between indigenous and government services.

#### **4.4 Chapter Summary**

This chapter presented two broad themes and five subthemes that were developed from participants’ reconstruction of the historical development of services in the southern Rangitīkei. The two themes that were developed provided significant insight into the impacts of those events as well as the learning that can be taken from them. Those themes (and associated subthemes) were:

1. He toa takatini tōku toa, ehara I te toa takitahi
  - tinorangatiratanga: Maori self-determination regarding health
  - rangatiratanga: The role of individual and collective leadership and organisational skills in facilitating collaboration and collective action
  - institutional racism: The ongoing impact of colonisation.
2. He punga I mau ai
  - whanake: The evolution of Maori health services
  - whakapapa; Historical connections between groups providing the cement for ongoing collective action.

The results identify many of the enablers and barriers that exist within collaborative relationships between Māori, and between Māori and non-Māori. The results highlight the importance of meaningful events in bringing people together to collaborate. These events have traditionally involved collective issues for Māori, requiring collective action. This included having a common purpose, under a common vision, and with a common message. Collective action is also important in the development of strong governance structures and a

critical mass of organisational capacity that was disseminated from collaborative health and social projects and services, seeding and supporting rural health and social services to develop locally responsive services.

The collective action of Māori through this time, along with iwi engaging in health and social services provision, had increased organisational capacity and governance structures for both iwi and Māori health and social services. The ability of iwi to engage in health and social service development led to iwi also developing stronger governance and organisational capacity. That in turn contributed to Māori having stronger voices in collaboration with the Crown, and the ability to promote Māori needs and aspirations at a local level. Then they were able to work collaboratively with other iwi at a regional level. This also allowed services to be better prepared to survive and even to take advantage of changing government priorities and funding when the opportunity arose. Examples of changing government priorities, which necessitated Māori to innovate or wither, was the move of Te Oranganui Iwi Health Authority from a relationship with an MDO (when this funding was stopped) to engagement in the PHCS.

Several culturally specific challenges and enablers to collaboration were identified. Māori experience challenges in gaining consensus when engaging with the Crown or other tau-iwi groups. They also experience tensions representing the interests of and allegiances to hapū, faith, iwi and employers in collaborative initiatives. Whakapapa and the application of Māori values and practices were cited as important enablers for collaboration with other practitioners, services and whānau, by establishing and affirming relationships, and guiding relationships within collaborative initiatives. Leadership is an important component in motivating people to engage in collaboration, ensuring all participants have a voice, and addressing challenges that arise through collaborative initiatives. Māori retaining self-determination within collaborative initiatives was a further factor related to leadership. A whānau ora approach to wellbeing, one that keeps whānau at the centre, and provides comprehensive, integrative and responsive care was cited as an approach that addressed a lack of services available in rural communities, and also aligned with Māori models of health and wellbeing.

The main gap in the literature identified within this chapter, is the lack of literature reflecting successful Māori collaboration and collective action which could be used to inform and guide Māori collective action at an organisational level. Barriers to collaboration identified within this chapter can be summarised as:

- loss of organisational support for Māori by Māori national organisations
- distance and terrain in rural communities
- lack of service options and employment in rural communities
- different Māori groups gaining consensus within collective action
- Maori representatives on boards and committees with non-Maori being isolated, and people expecting more from them than they are able or mandated to give
- inconsistent and low commitment from Crown representatives within collective action with Māori
- systemic racism
- Crown contracts aligned with Crown priorities and imperatives, not Iwi priorities or aspirations.

As discussed in chapter three, enablers of collaboration will be summarised and promoted. These are presented within the shaded box below. This will provide the start of an overarching framework that will be built over the next two results chapter.

### **Enablers of Collaboration by Māori, for Māori and with Māori.**

- Māori in positions to exercise self-determination
- reinforcing whakapapa between Māori (iwi and organisations)
- traditional Māori values and practices guiding collaboration
- common goals and vision
- organisational support for Māori by Māori
- strengthening iwi organisations alongside health and social service organisations
- strong leadership and leadership pathways

Chapter Five will present the second set of results: a summary and analysis of the experiences had by service users and their whānau. While this set of results has arisen through the perspectives of practitioners, the next sets of results arose from the perspective of people (and their whānau) accessing those services.

## **5 Ahakoa kai tahi, tērā a roto te hahae kē rā**

### **5.1 Introduction**

Ahakoa kai tahi, tērā a roto te hahae kē rā “although they share meals, within them is jealousy” (Ihaka, 1958, in Mead and Grove, 2001, p. 13). The proposed meaning was that true unity is more difficult to achieve than its appearance. Another way to translate the term hahae is to lacerate or harm. This allows for an analysis of the meaning to incorporate the difficulty of unity when there is harm taking place, or that harm has taken place.

New Zealand and international literature discussing health and social service collaboration has identified the importance of understanding the experience and perspectives of service users’ participation and self-determination in collaborative relationships (Tucker, 2012). But it has also been identified that “there are few studies on service users’ perspectives and the longer-term impact of collaborative care on the delivery of safe and effective care” (Tucker, 2012, p. 1). These views are also shared when the focus of research is on whānau roles within collaboration. Whānau have been identified as underrepresented when exploring this level of collaboration, and the need to be equipped “to play an active role in all aspects of planning, decision-making, implementation and service delivery” (Fitzgerald & Galyer, 2007, p. 16).

This chapter discusses the experiences of service users (SU) and their whānau (families) experiences of addressing their own substance use and related needs within their whānau. It also discusses their engagement with practitioners and the systems and processes associated with the practitioner’s profession and organisation. This chapter also explores the impact of rurality and substance use and related problems on the service user, their whānau, and their ability to engage in and maintain involvement within collaborative relationships with health and social service practitioners. The demographics for this participant group will be described below (5.1.1).

#### **5.1.1 Participants – Service users and their whānau**

Semi-structured interviews were conducted with 10 service users and their whānau. The inclusion criteria for participants were service users who:

- were age 18 years or over
- self-identified as having a substance use problem
- had or were receiving services from two or more health and/or social services.

Participants were invited to bring along people 18 years or older who formed part of their whānau support system. This included whakapapa whānau (blood relatives) or kaupapa whānau (non-family members considered close and part of their support system). This increased the total participants at the interviews to 22. Interview participation ranged from one to six participants and sometimes included two generations of whānau with experiences with the same services. Interviews were between one and one and a half hours each interview.

Participants completed a demographic form (Appendix G). The majority of participants identified as Māori (with whakapapa links to iwi of the Rangitīkei and Whanganui regions). Twenty were female, two were male. They ranged in age from the 18 – 25-year bracket through to the 56 – 65-year bracket with the majority in the 18 – 25-year bracket (n=7) and the 36 – 45-year bracket (n=8).

Participants reported living within the southern Rangitīkei between 7 months and 52 years (20 – 40 years = 5, 10 - 19 years = 3, 5 years = 1, <12months = 5). They lived in households with 0 – 7 whānau members, averaging three in each household.

Eleven participants reported receiving benefits from Work and Income; three were in full time employment and one in part-time employment. The majority reported receiving an Unemployment or Job Seekers benefit (n=6), a Domestic Purposes benefit (n=4) and either Disability, Invalids benefit or Sickness benefit (n=4).

Participants identified working with between one and five organizations at the time of the interview, with an average of three services. The majority of participants were engaged with Te Kotuku Hauora Limited (n=15), Work and Income (n=11); and a Marton GP (n=10). Participants also noted engagement with statutory services including Child Youth and Family (n=5) and the Department of Corrections (n=5).

Participants also reported engagement with the Rangitīkei Health Centre (WDHB) for health services including public health nurses, social workers, mental health services, and a diabetes clinic at the Whanganui Hospital.

### **5.1.2 Process of analysis**

Using the analysis process set out in Chapter Three, a thematic analysis was carried out to identify common themes. The analysis identified three themes, and six sub-themes. The first theme, ‘Whare tū ki te wā, he kai nā te ahi; whare tū ki roto ki te pā tūwatawata, he tohu nō te rangatira’ reflects service users and their whanau experience of gathering together at times of

distress and addressing concerns as a collective. The second theme, ‘Rōrī taura, pā taku panehe; rōrī tangata, rōrīwaiho’; describes service user participant’s perspectives on reflecting upon their own concerns and needs necessary to address in order to engage in collaboration. This theme is represented by two subthemes, ‘Noho puku: Personal reflection, motivation and commitment to change’ and ‘Te Ariari o te Oranga: Co-existing problems’. The third theme, ‘Mātua whakapai I tōu marae, ka whakapai ai te marae o te tangata’ reflects participant’s experiences of the availability and complexities of health and social services. This theme is reflected by two subthemes, ‘Te haerenga hauora: The journey of health and social service care’ and ‘Whanaungatanga centered practice’.

## **5.2 Whare tū ki te wā, he kai nā te ahi; whare tū ki roto ki te pā tūwatawata, he tohu nō te rangatira.**

Whare tū ki te wā, he kai nā te ahi; whare tū ki roto ki te pā tūwatawata, he tohu nō te rangatira. “A house that stands in open country is susceptible to loss by fire, while one that stands within a fence pa is the mark of a distinguished person” (Williams, 1908. In Mead and Grove, 2001, p. 425). This whakatauki identifies the importance of whānau being together for wellbeing and to face challenges. This whakatauki also reflects the challenge of isolation faced by some service users who may have moved away from whānau, or who may be disconnected from whānau due to the impact of whānau or service users substance use and associated mental health and social problems.

Service users and their whānau (participants) identified a range of roles, practices and implications related to the involvement of and interaction with the wider whānau system. They discussed factors that significantly influenced whether service user and whānau challenges would and could be addressed, either collaboratively as a whānau or in collaboration with practitioners. This theme reflects service users and their whanau experience of addressing concerns as a collective, and the importance of gathering together for safety when collaborating with new and/or larger external groups such as health and social service organisations.

The majority of service users and their whānau reported that it was important for them as a whānau to meet and discuss what was important for them and what they were looking for out of engagement with services. Participants mentioned that often services were making plans for practitioner roles and service needs as opposed to the whānau needs and priorities. Participants also noted that at times it was practitioners that encouraged service users to hui with whānau.

Several participants also discussed how it was important for them to meet as a whānau after engagement with services, particularly regarding important and sensitive issues. Service users and their whānau identified that meeting together as a whānau following appointments allowed them to debrief and also review the outcomes. In this sense a whānau hui appeared to play a role in self-care as much as ensuring positive process and outcomes.

*And if they don't want me there they just say we're going to do it by ourselves...we sort of have a bit of feedback talk afterwards... sort of how it works and what's the new idea that came in to help you work with dealing with this situation and that...Even after they've had access .... they come around to my house and we have tea and just sit and talk; or if they've been to the lawyers. (SU6)*

When discussing support systems, the majority of participants identified friends as key support people. Participants reported that their friends were at times key people they would share their concerns with and seek emotional support from.

*Probably my friends and my partner. I find it hard to talk about my problems with people 'cause it's like having to let them in. I find it hard but mostly my friends. (SU4)*

Several participants also identified neighbours and other community members (such as kindergarten workers) as kaupapa whānau, key confidants and support people in their support systems. Participants reported that these community supports helped them feel connected and wanted in the community, this was particularly so for isolated service users and whānau who had moved into the area.

*We have a next door neighbour; we call her nanny eh, Super Gran. She is like a Super Gran. If I ask her to come over she'll come over and help me settle baby. (SU6)*

Several participants also recognised some community members as key community figures that had helped service users and their whānau for long periods of time. Participants reported that they trusted these people, and sought various types of support from them. Service users reported that due to the strong history and trust, they were more likely to be open and honest when involving the community member in their engagement with health and social services.

There were differing opinions and experiences regarding the involvement of whānau in appointments with health and socials service practitioners. Several participants highlighted that they were aware they could take whānau with them but chose not to involve their whānau in appointments, but others preferred to just inform their whānau about what was happening as opposed to inviting them to participate.

Despite participants having mixed views on whānau participation and attendance in appointments with services, several participants discussed the value of involving a whānau member as an advocate when engaging with services during difficult times. An advocate from within the whānau was reported by participants to be a strong and determined ally, particularly when the service user was feeling confused or overwhelmed.

*No its just that my dad knows what the system is like and if they tried to tell me something he would turn around and tell them this is how it goes. So that's why they don't... that's why I have my dad with me 24/7 'cause he knows how the system goes. (SU8)*

Along with the use of whānau or kaupapa whānau advocates, participants identified several practices that supported them to maintain their safety and wellbeing when engaging in collaborative relationships with services. These included: how much information they shared when engaging with services; how they managed their time to ensure they maintained their wellbeing and collective whānau commitments; and the important role of whakapapa, identity, te reo Māori and te ao wairua in bringing whānau together and providing support through difficult times.

The majority of service users and their whānau reported being hesitant to share their personal information when engaging with practitioners, particularly those from government statutory services. These hesitations were based on mistrusting how information would be used, and previous negative engagement experiences with practitioners from these services. Several participants reported that this distrust of services had led some to discourage other whānau members to seek support from services. Participants reported that this distrust in services not only related to cross-service information sharing but also maintenance of privacy amongst whānau members.

*We asked him for some tips on what should we do to get the kids back and he went back and rang CYFs [Child Youth And Family Services – Child Welfare Services] up and told them what we were saying. (SU8)*

*Yes, there are times when I feel I can't be truthful. I think my biggest thing is; I don't want their father involved in anything that happens to me, where it may affect him saying to me, "Well, I'm going to take the kids." (SU2)*

Despite the evidence of hesitancy and distrust of practitioners from some services, participants also reported a sense of relief through being open with practitioners. Several whānau participants reported that it was important for the service users to be careful when they share information, taking small steps in doing so. Some whānau discouraged service

users from lying, but some service users reported that telling small lies supported them in maintaining their safety when engaging with services.

Participants reported that it was important to manage their personal wellbeing in conjunction with managing the demands of appointments with different services. This included things like maintaining a diary, and ensuring they were engaging in activities that were relaxing and conducive to wellbeing. Participation in te ao Māori as a source of personal and collective strength. Service users reported the importance of Pā life, their faith, and engagement with the temple as an important part of their wellbeing and ability to manage stress. But some identified that seeking solace or support through spirituality was more prevalent in older generations as opposed to young adults and teenagers.

Several participants described knowledge of their whakapapa, te ao wairua, and te reo Māori as important aspects of their identity and wellbeing. They reported that knowledge and engagement in these areas provided access for them to traditional wellbeing practices and sources of comfort.

*We got to be whole. Well, for me as a Māori, I was brought up by my grandmother, from birth. Whole is above, below and around us. Her kōrero she said was, to the Atua, to Papatūānuku, to Ranginui, to Rarohinga, to the Ngāhere; to everything. That's what sustains and feeds your wairua. Your whakapapa comes into play when you have an understanding of that. That's how I was brought up. (SU2)*

Participants highlighted that a focus on whakapapa had facilitated whānau to come together for positive activities, and had personally helped them reduce their substance use. Several participants spoke how engaging in hapū programs and through Iwi health and social services had supported them to understand their own whakapapa, and to start their journey of learning about who they were.

*My great grandparents built that [marae]. We used to have a homestead out there but it got burnt down. But that's where my mum comes from. I don't really know my dad's whakapapa; I'm learning that from these ones. (SU8)*

Several participants highlighted that conflict within the family made working collectively to address issues a challenge. This included attitudes of whānau members towards supporting each other in their engagement with statutory services. Several service users and their whānau reported that isolation from broader whānau systems contributed to increased whānau stress. This increased stress was related to fewer resources and practical and emotional support available at times of need. Participants identified several reasons for this isolation, including

moving to rural areas for cheaper accommodation and moving towns to get away from negative influences of peers, whānau, and at times, service practitioners.

One issue raised by participants as an issues particular to small rural Māori communities, was the high likely hood of having a whānau member who worked within local health and social services. Participants discussed differing views on the benefits and challenges when whānau members work with or receive support from the same services as each other. Several participants reported that this reduced the likelihood that they would access these services, as they feared their information would not be kept private.

*I got one, two, three, four in one outfit; five aunties and cousins in one outfit and then you've got another outfit which has got another five; and Child Youth & Families we've got some more in there. It just felt like that everybody was having tea and lunch, breakfast smoko on us, and we were talk of the topic. That's what it felt like to us. When they came around they were all looking for something wrong; they were never looking for anything good and that's what really upset us the most and we were trying to get ahead and not to go backwards; and they were trying to make us fail. (SU7)*

Several other participants reported that having whānau working at the same provider provided a sense of safety and ease. These participants identified a greater understanding of their whānau member, by seeing them in their professional role. Participants also commented that they were confident that if sensitive issues arose, that whānau working within the service would ensure other practitioners would be able to step in. In this case, whānau working in services increased their likelihood to engage in collaboration with services.

### **5.2.1 Summary of theme: Whare tū ki te wā, he kai nā te ahi; whare tū ki roto ki te pā tūwatawata, he tohu nō te rangatira**

In summary, participants reported several issues that impacted on their willingness, readiness and ability to address issues as a whānau collective and to engage with services. Whānau practices that were identified as supporting collective whānau action included: whānau hui and planning; whānau participating in treatment and attending appointments; and whānau support and advocacy. Participants also noted the importance of self-care amongst the demands of practitioners and services, and being careful when engaging with practitioners. Knowledge of and engagement in Te Ao Māori was reported to be an important aspect of self-care and whānau wellbeing, whereas being aware of confidentiality and personal and whānau safety when engaging in collaboration with practitioners was also reported as part of self-care. Participants reported that negative previous engagement with services by participants or their whānau reduced the likelihood they would have positive expectations, and at times reduced

their willingness to engage with these services. For some participants this was an intergenerational issue.

As a researcher, I was both humbled and saddened to see in one interview, three generations who had all had at one time or another adverse experiences with statutory child welfare services, and for the whānau, child welfare were still actively involved. For other participants, the intergenerational issues related to substance use and crime had led to generations of whānau to have done time in prison and had ongoing involvement with community probation services. Historical and intergenerational issues was also supported by the literature review (Marrone, 2007). However, this was briefly mentioned within the literature, and it is important to explore how these issues are mentioned within the literature so they do not become a further stigmatizing statistic for Māori.

There was little guidance in the literature regarding helpful ways for whānau to manage engagement in collaboration with external organisations, and nothing in the way of exemplars of helpful whānau practice that could guide whānau in effective Māori practices for addressing complex and at times sensitive whānau issues. However this information may be present in organisational and government grey literature.

### **5.3 Rōrī taura, pā taku panehe; rōrī tangata, rōrīwaiho**

Rōrī taura, pā taku panehe; rōrī tangata, rōrīwaiho. “A tangled rope can be cut with my small adze but if it is a human entanglement, let it alone”. (Williams, 1908, p.12 In Mead and Grove, 2001, p2.). This whakatauki identifies the complexities of human experience and the need to take a comprehensive and flexible approach to issues. This theme reflects service user participant’s experiences of the impact of substance use and coexisting health and social problems upon wellbeing and their ability and motivation to engage in collaboration. This theme is reflected by two subthemes, ‘Noho puku: Personal reflection, motivation and commitment to change’ and ‘Te Ariari o te Oranga: Co-existing problems’.

Service users and their whānau discussed a range of interpersonal issues that influenced whether they were willing and/or able to engage and maintain their involvement in collaborative relationships within the whānau and with health and social service practitioners. Participants identified willingness as reliant upon motivation and commitment to change, whereas a range of issues were identified that impair this willingness. But substance use and related mental health and social problems were discussed as barriers to willingness and ability to engage in collaborative relationships to address their substance use and related needs.

### **5.3.1 Noho puku: Personal reflection, motivation and commitment to change**

Service users identified personal motivation and commitment to engage in collaboration with whānau and health and social services as an important factor for the likelihood and success in the formation and maintenance of a collaborative and collective effort.

Several service users reported that an important aspect of engagement in a collaborative relationship with health and social service practitioners was personal motivation to change and engage in a collaborative relationship. Participants also identified the importance of personal commitment and effort to help themselves address their own issues. Participant's identified that helping themselves was an important part of becoming independent and confident.

*I chose to just do it on my own. I've always been so grown up. I've always had my parents do everything for me so I just wanted to do it on my own and be independent. (SU4)*

Self-help was also recognised by participants to be an important aspect in addressing substance use. Several participants commented that addressing substance use was first and foremost a personal choice, and that there was little point in practitioners pushing them to make changes. Participants also mentioned that reflecting on the consequences of substance use on themselves, their whānau and their relationships was a key motivator for personally addressing their substance use.

Participant's also mentioned that whānau, particularly their children, were key motivators to engage in collaboration with practitioners in order to address a range of issues. Participants discussed the positive intergenerational outcomes of seeking help and addressing issues, identifying that making personal change contributed to better outcomes for their children and whānau in general.

*I think my biggest motivation is first and foremost, you've got to want it. Once you know that you do, strive to try and get it there and with it, your tamariki should be the focal point because that for me is they're my nucleus to keep going to where I want to be. My goal was in a three year plan. It's taken me... how long to earn my son's trust, my god, I'd say five years to earn my son's trust. That's got to be important with whānau but what I would say to my whānau is be enthusiastic about it because (1) it's for ourselves as well as our babies, (2) it's for the future of what we may never live to see and, (3) to know that you're going to be part of making a difference in your own life as well as others and our kids. (SU2)*

Several participants also discussed the importance of their attitude towards practitioners and the process of collaboration. This included remaining positive and optimistic, and avoiding

unhelpful behaviour such as anger. This was associated with an increase in positive attitudes and behaviour from practitioners in return towards the service users and their whānau.

However, participants also identified challenges to taking this positive and optimistic approach. Several participants reported that seeking help from whānau or practitioners could leave service users feeling embarrassed and weak. Participants related this to how help seeking was perceived by them and others. Participants recognized that this left them avoiding seeking help and trying to address their problems alone or within the whānau.

*No we just deal with our problems ourselves. Try not to do that ‘cause that just looks weak going and asking other people for stuff. (SU3)*

Several participants also noted that when practitioners directly addressed their substance use that service users would minimise their substance use in order to normalise their use. Participants also identified that they minimised their use, and did not seek help for substance use problems for fear of a critical response from the practitioner.

Participants reported that when substance use was identified by a service they were engaged in, that the practitioners did not explore the issue in a sensitive or helpful way, and in some cases did not provide follow-up support to address the problem. Participants commented that this left them feeling judged and unsupported.

*No nothing, he just reckon x, x and then gave me my paper and he was like, “See you later,” ... See that’s where the Pakehas they don’t know like that, whereas the Māori would have been, “Do you want a hand with all of that, I can advise you to this and that.” Yeah I just done it all myself. (SU 3)*

Several service users and their whānau distinguished that previous negative or unhelpful involvement with services, had led them to have low expectations that the services can or are willing to provide the support they are looking for or need. Whānau service users reported a long-term and often intergenerational involvement with these services, with a consistent negative experience.

Participants identified that negative expectations of engagement with services involved a fear that engagement in collaboration may result in their already tenuous situation becoming even worse. Participants reported that this reduced their willingness to engage in a collaborative relationship with health or social service practitioners.

*CYFs took him off me, ‘cause apparently I’m violent and there was family violence and my son wasn’t in a stable environment. Then I went into like a month*

*of drinking and smoking weed; I was so unhealthy. But after a month they said I could see him so I went to this drug and alcohol place that I'd been in since I was 13 and I went to go and refer myself; self-referral. (SU 6)*

Several service users reported positive outcomes of addressing their substance use problems; this included becoming more active with their children, having a clearer head, more finances, and a better quality of life. Service users and their whānau also identified that engaging in alcohol and drug treatment had provided important learning that allowed service users to better understand their problems and needs, and also to be more open with their whānau.

Participants also acknowledged that they were motivated and able to take what they had learnt to help their whānau members this included providing direct support based on what they had learnt, or referring whānau members to services where they had had positive experiences.

*I tried to do the best I can. If I don't know how to though, especially with my younger nieces and nephews, I refer them to certain ones that I know that can help. I've done that in the past since I've sought help for myself. (SU2)*

Several service users and their whānau described different views on the motivation and ability of services they engage with to provide help or support. Participant's recognised that services, particularly statutory services were often focused on specific tasks and expectations as opposed to the needs and aspirations of the service user or their whānau. Participants reported that this left them seeing these services as individual, isolated services that were outside of their support system.

*Yeah, Probation – I just do it because I'm on community work. Work and Income, I just do it so my benefit keeps going, to help me survive. And CYFs, I don't really get involved with them no more. Really, they're just in and out people; they don't even help the kids that are in CYFs. They're hopeless – that's all I've got to say with them. (SU8)*

### **5.3.2 Te Ariari o te Oranga: Co-existing problems**

Service users and their whānau identified co-existing substance use, and poor mental health as an outcome and maintaining factor for both substance use and ongoing health and social problems. Participants identified the uneasy relationship between substance use as a coping strategy, and the unhelpful consequences of substance use, reflecting a circular problematic pattern of behaviour that impacted on the service user and their whānau. This contributed to problems for service users to address their substance use, and for service users to engage with practitioners in collaborative relationships to address their substance use and related problems.

Servicer users highlighted the intergenerational nature of substance use problems, by discussing their experiences of living with parents with substance use problems. This included several participants talking about the impact of parental substance use on parenting and the ability of the parent to engage in community and cultural responsibilities.

*'Cause she's an alcoholic and she's the reason why I don't like alcoholics. I see the effect that it has on my little brother...they get shoved aside like they don't matter. Tea doesn't get cooked 'cause of the drinking or tea gets burnt because of the drinking. They're not a priority. (SU4)*

These service users reported that having whānau members who have a history and/or ongoing substance use problems, reduced the likelihood that whānau would identify a substance use problem or a need for support to address substance use. Substance use was discussed more through gossip as opposed to friends or family addressing substance use with the service user. This led some service users to perceive their substance use as normal, and some friends and family as unhelpful and critical.

*When it comes to alcohol, it's a big gossip thing that everybody talks about out here. To me, I don't think they have the right to really because they should look in their own back yards before they talk about other people. (SU4)*

One service users discussed how growing up with a parent who experienced a mental health problem had impacted on their life, and had contributed to them experiencing a mental health problem as they grew up. Several service users also discussed growing up in whānau with strong gang affiliation, and how this contributed to exposure to violence and engaging in gang affiliation as they aged. For some participants the desire to engage in a gang was evident from as early as six years, and for many they experienced both ongoing engagement in Child Youth and Family's youth justice residence and then adult prisons.

*Chased you around the house with a knife and "I'm going to cut you up, I'm going to get you." That's how it was for her most of her journey through her life I suppose. Her intellectual disorders come from the home within; her being the mother to her own mother, trying to stop her mother from cutting and all that sort of stuff. (SU7)*

Participants mentioned that having friends and family bring up the issue of their substance use directly with them was powerful and influential in them changing their substance use or considering making changes to their substance use in the future.

*She knows I'm on it. Even my bros that use the old meth tell me slow down. Go yeah, I'll slow down on it. I just only have so much and then I just sit back and*

*watch them, and see their reactions. I gave it up one part there after I had my thing I gave it up. (SU9)*

Service users reported different perceptions of their level of substance use and whether their substance use was a problem for them or not. Service users and their whānau reported the development of substance use problems evolving across time, including increased amount and frequency of substances used. Their perception of substance use was an important aspect of whether they sought help for their substance use from whānau or services.

Participants described their substance use as a normal and important part of their day and their social relationships. Participants reported that if their substance use was not impacting on their finances and ability to provide for their whānau, particularly their children, then they did not consider their substance use was a significant problem.

*I just get high and sit here smoke cigarettes. Get high and have a kai. Now and again I might have a beer. That's all I do. Just stay home, get high. (SU9)*

Despite the normalisation of substance use, participants were able to identify significant physical and social health complications related to their substance use. This included serious health complications and engaging in theft, fraud and other crime to support their substance use.

Participants also acknowledged that their substance use directly impacted on their ability to engage in a collaborative relationship with practitioners. Examples from service users highlight the negative effect of substance use can have on a tenuous relationship.

*Yeah. But I don't know if it was my thinking because I was under the influence too, but you always got paranoid about that manager down there or that work broker down there... just paranoia. (SU5)*

One participant reported that their whānau member's substance use had a direct impact on their health and wellbeing. This included whānau wanting to participate in social interactions where substance use was occurring, which led to negative consequences related to passive smoking of cannabis. Whereas several service users themselves identified how consequences of their substance use, such as a drink driving conviction had negatively impacted upon their role in the whānau. Whānau participants also recognised multiple impacts of service users engagement with agencies or incarceration. This included the ongoing stress of services home visiting, parents being arrested in front of children or a parent being sent away to prison (incarcerated).

*It was horrifying. My son was six at the time and my baby was only eight months. That was horrifying because he wouldn't let go of my leg and he just screamed. The neighbour walked down and I had to walk him out to the car. He wouldn't let go of us and by the time we got out to the car, he still wouldn't let go. That was horrible because I will never forget that. (SU2)*

Several participants reported that the day-to-day struggle of earning money, and dealing with the pressures of multiple health and social services had led to a deterioration of mental health and the use of substances as a coping strategy.

*She wasn't her. It was like she was a different person. Even though I had seen her sad, I knew there was something wrong 'cause she's never always like that. It was a dark stage for her. Everybody could see it though, that she wasn't normal. (SU4)*

*When I was pregnant with my son for the first three months I was drinking and smoking weed and eating toothpaste because we had no food in the house. So that was the only way I could survive. We got alcohol and weed from friends; they wouldn't give us food; they'd give us more alcohol. And then after like three months my ex-partner decided to go and steal food from the shops and my dad tried to for the family but our family was pretty poor. (SU6)*

The majority of participants discussed the chronic problem of suicide in their area, spanning 10 years. Participants reflected that the high rate of suicide was related to poor employment opportunities, ongoing stress and drug use.

*In the last 10 years, Marton's had a bad stigma of suicide. I've lost three members to suicide in my own family. Recently, the youngest was 18. The eldest was 29. My cousin and I worked with my first cousin. Those have been horrific things we've had to get through. (SU2)*

Several participants expressed that the development of their substance use problem was either created by or exacerbated by a trauma or situational crisis. Substance use was identified by participants to initially be helpful, however over time became more problematic. Service users also discussed the negative traumatic events and co-existing substance use on their ability to regain stability and wellbeing. Service user participants recognised that their distress worsened following intervention by statutory services, particularly the removal of their children. Service users and their whānau reported that they felt powerless in their collaborative engagement with these services, and also felt unsupported in addressing their own issues. It was often these issues, such as substance use or domestic violence that contributed to the removal of their children.

*Nah. Yeah, I don't have a problem with alcohol, or drugs; I just take it – I don't know – ever since my son has been taken away from me I've just been going... yeah. (SU8)*

The sequelae of the trauma and co-existing substance use was identified by participants to interfere with their ability to fulfil their roles in their whānau, or to engage in collaborative relationships with services.

### **5.3.3 Summary of theme: Rōrī taura, pā taku panehe; rōrī tangata, rōrīwaiho**

In summary, participants identified substance use as a coping strategy in response to poverty, crises, stress, and trauma. Having their children removed by statutory services was one of the examples provided of trauma, and in response to these types of trauma participants reported that substance use or mental health symptoms generally increased. Coexisting issues such poverty and mental health problems were reported to negatively impact on participants' ability to prioritise and engage in collaborative relationships with practitioners. Personal awareness of the impact of their substance use was as an important determiner of seeking access to treatment for substance use.

As a clinician, I was at times shocked to see significant clinical issues that were not being addressed, despite these service users were within a health and social service organisation. It was evident form the interviews, that an in-reach clinic based approach was not preferred nor effective for service users or their whānau. Urban centres were sending out specialist practitioners at specific items to run clinics. If your need, or desire to engage fell outside of that, you were required to travel to the urban service centre.

The overlapping nature of rural poverty and increased substance use and mental health concerns was supported by the literature reviewed (McLachlan et al., 2012; Marrone, 2007; Jansen, Bacal & Crengle, 2009; Gibsin, Lisy, & Davy et al., 2015; Ramage et al., 2005; Ihimaera, 2007; and National Health Committee, 2010).

For those participants that did access substance use services, engagement in substance use treatment was reported to have had positive impacts on the individual and whānau as a collective. Voicing concern over whānau substance use, and encouraging engagement in collaboration with practitioners were identified as whānau practices that contributed to improved access to substance use treatment.

## **5.4 Mātua whakapai I tōu marae, ka whakapai ai te marae o te tangata**

Mātua whakapai I tōu marae, ka whakapai ai te marae o te tangata. This whakatauki is translated as “Clean up your own marae before trying to do the same for someone else” (Brougham 1975, p104. In Mead and Grove, 2001, p. 288). The authors propose a meaning for this as “a ready reply to criticisms of a family, an organisation, or an operation” (Mead and Grove, 2001, p. 288). From the perspectives of service users and their whānau, this theme highlights the importance of practitioners and health and social service organisations addressing their own barriers to access and quality of care provided. This theme reflects the participants’ experiences of engaging with and in compartmentalized and fragmented services and systems. Processes that reduce Māori engagement in collaboration, and contribute to ineffective care. This theme is reflected by two subthemes, ‘Tairo: Obstructions and complexities in care’; and ‘Whanaungatanga centered practice’.

### **5.4.1 Tairo: Obstructions and complexities in care**

Tairo is a term for a thicket, or dense scrub. This term is also used for an obstruction. Both of which apply to this theme. This subtheme reflects participant’s experiences of the availability and complexities of health and social services, and the impact of this on participant’s willingness to engage in collaboration, and the quality of care received. This lack of service availability and supportive systems of care was noted by participants to have a profound effect on rangatahi in the area.

The majority of service users and their whānau members reported a lack of service options available within their rural communities, which led to a range of challenges for them. The lack of service options meant that any collaborative effort was either incomplete or significantly hindered, as they needed to travel to urban centres to find and access service options.

Not surprisingly, the lack of local options resulted in the need to travel to one of several urban centres such as Whanganui, Palmerston North or Wellington for service options. Participants also discussed how some service options available in local rural communities were only available sporadically, and not always when service users required them.

*No. I don’t go into Wanganui quite a bit. Yeah, it is quite an issue ‘cause sometimes I won’t go to the doctors ‘cause I don’t have a ride. (SU 4)*

The majority of participants also highlighted that along with limited service options in their rural area, the services that were available had further limitations to who could access them or how much service they were eligible to receive.

*To be honest, I think I get more support in town than out here. It's just depends on what everyone out here needs I guess. You can't bring in providers if only two or three people need it when it took the providers to come all the way from Wellington. (SU4)*

Participants reported that this limited the ability of services to adequately address their complex, and often chronic, needs. The majority of service users and their whānau described the added stress of travelling to urban centres to access services not available in their communities. This stress was related to navigating a wider range of services and particularly the financial and practical strain of travelling to an urban centre. Participants reported that they either did not have a vehicle, have access to a vehicle, or if they did may not have had the finances to afford the petrol or bus fare to travel.

*Well, me myself, when he was going through all this we had all these services. I ran all over the place. They suck. (SU5)*

*Financially like Phil said it can be hard because if they haven't got the money that means mum's got to make sure the petrol is in the car. We normally all go over together. (SU6)*

Participants mentioned utilising a range of strategies to address the issue of travelling to urban centres. These included scheduling appointments at times that work with other appointments, visits or shopping needs, catching rides with friends who travel in for work, or catching the bus and staying in the urban centre, and accessing health travel funding schemes through local services.

Despite the difficulty in locating and accessing services, there were a range of difficulties in utilising the services which were available. Several service users identified service processes as confusing, unrealistic and at times excessive. Participants were unsure of the appropriate services to have their needs met, and when they did access the appropriate service, the service processes were often distressing and caused delays in them having their needs met. Participants cited organisational forms and requirements as a necessity, but one that made engaging with services impersonal, confusing and at times distressing. Participants recognised complex service processes and consistency of care as important issues in engaging and maintaining collaborative relationships. They reported that complex systems acted as a barrier to developing a collaborative relationship with practitioners and delaying access to care.

*I was running around like a chicken, like my head was chopped off. What the hell is going on, why can't something simple be done?...I was wondering why things were going wrong and nobody had told me she had a diagnose of an intellectual disorder when she was 12; they told me at that time her frustration was building and the services were starting to pile on 'cause I was getting angry and everything was starting to pile up. I couldn't understand the easy things she couldn't do.* (WSU 7)

Service users and whānau found that attempting to identify and navigate the expectations of services was a barrier to engagement and, in turn, to developing confidence in a collaborative relationship. Participants reported feeling as if they were constantly working towards goals for an outcome, however the goals seemed to shift leaving them feeling powerless and at times hopeless.

*Oh my God here we go again. Everything what they're doing with [her adult children] I can see its going to be exactly the same. And they have, they've dug their heels in and they're saying, "No you need to do this and you need to that and you need to do this," but then when they do that they say, "Well we've done it." That's the biggest problem; they haven't really asked us to do anything. We've put our hands up to say, "Shall we be doing this, shall we be doing that?" and they're just sitting there like...Keep doing what you're doing. I'm not going to say nothing to you; I want you to trip up.* (SU6)

Participants also reported being more confident to engage with, and satisfied by, practitioners who were easy to access, responsive to the different health and social needs of the whanau, and able to visit whānau in their own homes. The majority of participants identified a preference for services that were able to address more than one issue, this included health and social issues for several whānau members. Participants discussed that services that could provide comprehensive services reduced the number of practitioners they needed to engage with, and increased the coordination of services for their needs.

*And they also helped when [she] was in labour; they come and checked on her. Yeah they are our support system actually; it's them that we actually lean on more than anyone else. And like they'll come in and do health checks on [her] and see if she's all up to scratch when she was having baby; both of them actually.* (SU3)

*... they had our babies in care for 48 hours and then they were returned. Whānau sent them; my cousin and her tāne took my two children and through [service advocate], we were able to get them back, within 48 hours.... I think the biggest thing that was effective for her, in her healing side, was the support that we got through Ngāti Apa. The support that we had from the clinic.* (SU2)

The majority of service users and their whānau discussed the importance of services being available, responsive and accessible. This included service users and their whānau being able

to ring for advice or support, or in many cases for whānau to call in for support. Participants reported that this increased their sense of comfort with practitioners and services, and strengthened their maintenance within collaborative relationships due to ongoing and often unplanned interactions.

The majority of service users and whānau also identified rangatahi as a particular group that required increased service delivery, attention and resourcing. Participants commented that a lack of opportunities in their rural communities led to rangatahi engaging in alcohol and drug use, crime, becoming physically unwell and at times being sent away. Service users and whānau also reported a recent history of suicide amongst rangatahi in the community, which increased their concern. Participants recognised the need for education support, alcohol and drug counselling, a focus on sports, music and identity.

*Heaps bro, they need heaps to keep themselves busy so they're not on the piss and getting stoned you know. They need focus. My baby needs focus. "Oh well what are we gonna do this weekend? Yes, yes, stuff to do." Like a hangout place and all that sort of stuff. (SU1)*

### **5.4.2 Whanaungatanga centered practice**

Participants recognised a range of interpersonal attitudes and behaviours displayed by practitioners that enhanced or reduced their willingness to engage in or maintain their involvement in collaborative relationships with practitioners. These interpersonal attitudes and beliefs were identified by both service users and their whānau, and represent how service users and whānau perceive their own value and level of self-determination in relationships with practitioners. This subtheme is reflected in two further subthemes: 'Practitioner attitudes, beliefs and behaviour'; and 'comprehensive and flexible care'.

#### **5.4.2.1 Practitioner attitudes, beliefs and behaviour**

The majority of service users and their whānau reported the importance of engaging with culturally appropriate practitioners and services. Participants reported that they perceived non-Māori practitioners did not share an understanding of Māori needs or preferences. Having Māori staff to engage with was reported by participants to increase their willingness to engage with the service. The majority of participants reported that access to Māori practitioners increased their confidence and comfort in engaging in collaboration. Several participants described examples where the practitioners they were engaging with were unable to meet their cultural needs, and at times appeared unwilling to do so. This lack of cultural competence led whānau to disengage from services.

*When I went through mental health for my daughter in 2005, we actually weren't given, I felt, the services that we needed and one of them was that when we took our daughter, we weren't allowed to have karakia...I actually don't know. I'm not sure whether it was the Pākehā nurse or whether it was the doctor.. It upset my girl. It also upset me and I ended the meeting there....The first visit we had, he wasn't there. It was just me and my daughter. When we asked if we could have a prayer to start, the doctor got up, he walked out and the nurse followed him and then she was sent back in while me and my daughter we left sitting in the room and she came back in and said that no, that it would be preferred that they just do the diagnosing. I said no 'cause my daughter was still in that unstable state and she had a reaction to that so we had to leave anyway. (SU 2)*

Participants described the importance of Māori health and social workers from within an organisation or from other local agencies supporting service users and their whānau in the engagement process. This included the facilitation of karakia and whanaungatanga. This involvement was seen as supporting both the tau-iwi practitioner and the whānau in establishing a collaborative relationship.

Despite a preference for Māori practitioners, service users and their whānau discussed examples of mainstream practitioners who displayed cultural competencies, and supported the use of tikanga Māori within the collaborative relationship. Participants highlighted that irrespective of the practitioner's ethnicity, their willingness to engage in whanaungatanga and be aware of and supportive of tikanga Māori such as karakia, contributed to successful engagement in collaborative relationships. One participant gave an example of an interaction with a non-Māori doctor who had excellent cultural competencies, including whakawhanaungatanga and te reo Māori.

*On our second meeting of the same doctor from the first one, my daughter wouldn't talk to him at all so we had to actually request, through the Māori nurse that came in, another doctor. When we got the other doctor that was absolutely wonderful. ... he was coming over here every week and baby loved him, plus the fact that he could kōrero Māori I think that's why baby took to him. And he was absolutely wonderful...And that's I think, was what made me really like him, because his first introduction to us, he went straight into who he was, where he was from and then who he married. And Amohia related because her grandmother comes from the same place as his wife. (SU2)*

Several service users and their whānau reported that other attitudes displayed by practitioners through their behaviour, had a direct impact on the service user and whānau willingness to engage in and maintain involvement within a collaborative relationship. Along with racism, several participants reported experiencing discrimination, which reduced willingness to engage. Others discussed experiencing positive attitudes from practitioners and a resulting

sense that practitioners understood the reality of their context. This increased their willingness to engage and maintain their involvement in the collaborative relationship.

Participants described experiences of being judged by practitioners, where they felt practitioners were looking for problems as opposed to strengths. Participants reported that this judgement was related to the service user's substance use or gang affiliation. This sense of judgement decreased the participant's willingness to engage in collaborative relationships with practitioners.

Service users and their whānau recognised that when health and social service practitioners took a position of judgement, then the practitioners were less likely to identify or address a service user's needs. Participants gave examples of when health practitioners had identified an alcohol and drug problem, they had offered no follow-up advice or support. Service users commented that these experiences led them to not have trust that services were there to help, or had the skills to help, particularly substance use problems.

*You should be able to walk into any department, regardless of colour and creed, feel relaxed enough to be able to sit there without a thought of, “Is this person going to sit in judgment on me?”, “Is this person going to support me in what I need, in the right way or is this person going to say, ‘Well, you don’t qualify for that.’”* (SU2)

Participants reported that they were more willing to openly and actively engage with practitioners who had a positive attitude, listened to them and sought their perspectives. Participants discussed how this led them to feel comfortable, engaged and hopeful of a positive outcome.

Participants also identified that practitioners who understood their needs, and the context of their lives, were perceived as more responsive, understanding and effective. Participants noted that services that understood the struggle and reality of their substance use problem were better able to offer more responsive and appropriate service options.

*Yeah, I have my own case manager. I only just met with her a couple of weeks ago so it was my first time but she was real cool. My case manager didn’t put pressure on me to go out and find a job. She just wanted me to really think about what it is I’m wanting to do.* (SU4)

Service users and their whānau discussed the importance of effective practitioner communication skills and responsive case management processes in increasing their

willingness to engage in collaboration; maintenance within the collaborative relationship and satisfaction with the outcomes of the collaboration.

Several participants reported that when engaging with services, they often felt ignored, not listened to and at times talked over. This led them to feel disempowered and less likely to feel they were in a collaborative relationship, and more likely to be in a submissive position under practitioners. Participants also commented that the way practitioners spoke to them, as opposed to listened to them, led the practitioners to make assumptions, and at times for service users to struggle to either understand what is happening within the interaction or process, or to be able to express their needs and perspectives.

*No, they don't answer my questions because when it comes to things like that I do need support because I don't know what they're talking about. Like I'm blank. It's hard for me to understand, I need it to be broken down to me; like, the exact words. (SU8)*

Several participants also noted that some social service practitioners were not open and honest about what services or options were available to them. Participants mentioned that this left them feeling that services were meeting their own needs as opposed to meeting the whānau needs. Participants identified that services that took the time to listen and understand service users and whānau needs, were better able to support the whānau with understanding what was happening. Participants discussed that having a good understanding of what was happening in their own lives reduced stress on the whānau, and increased their trust in the practitioners.

*I just believe these people just need to listen to them and give them a helping hand now and then; that's all. Just sit down and listen to them. And they've gotta be able to help themselves too. (SU10)*

Participants also identified that when they engaged with a service, they often did not understand what services expected from service users and their whānau, which contributed to mistrust towards practitioners. Several participants noted that a clear understanding and agreement around confidentiality, and information sharing between themselves and practitioners, contributed to service users being more confident in disclosing their challenges and needs. Participants also discussed how despite receiving several different health and social services from within one organisation, they were still confident that their interactions were confidential with that practitioner, and would not be shared with other practitioners within the service.

*They said, "Hey, it's confidential so it stays here." I'd had problems with Probation in the past but this was up in Auckland. So I relayed it to them and I*

*said, “Well, you’re not gonna do this are you?” and they said, “No, no; we don’t do that sort of stuff”. (SU5)*

Several service users and whānau also expressed a lack of clarity around who could or could not share information between services. Participants discussed how this contributed to a lack of trust, and at times fear of services, particularly statutory services. Participants reported that government departments such as the Police, Department of Corrections and Child Youth and Family all openly discussed their cases.

*I don’t wanna share nothing with CYFs, nah, nah; they’re very dangerous people to myself. (SU1)*

Due to distrust in confidentiality, participants mentioned that they distrusted the intent of services in collecting information, as they felt practitioners were often incongruous, using information against them to punish them or liaise with other government agencies. Participants had recognised that practitioners had been pleasant towards them, however written information had not matched how they felt the collaborative relationship had been, and at times had led to sanctions and other negative outcomes for service users.

Several service users and their whānau described incidents of breaches of confidentiality that led to mistrust of services, particularly statutory government services. These incidents involved practitioners providing false information to third parties outside of the collaborative relationship, information about themselves being shared as a form of gossip, or genuine help seeking from the service users being used against them.

*It just felt like that everybody was having tea and lunch, breakfast smoko on us, and we were talk of the topic. (SU7)*

#### **5.4.2.2 Comprehensive and flexible care**

Service users and their whānau identified that practitioners often focused on their own role, and their service’s priorities and requirements as opposed to developing a comprehensive understanding of family strengths, needs and preferences. Participants reported that this left them feeling not in control of their journey within a collaboration, and as a passenger rather than a driver of the collaboration. Participants highlighted that services that engaged service users and whānau around their needs and goals led to a more comprehensive shared understanding and platform for collective action.

Service users and their whānau described hesitancy in engaging with some services, particularly statutory services, as they reported that they had experiences of organisational

involvement contributing to worsening an already complex situation. At times these stories of service intervention contributing to worsening outcomes were shared as an intergenerational experience.

Participants discussed examples of where service intervention by multiple agencies contributed to increased distress and poorer whānau outcomes, particularly during times of crises. Participants reported that either the services would disengage from the service user (if they were parents) if children were removed from their care, or following a crisis. Service users mentioned feeling that agencies often acted as either the police or an ambulance as opposed to helping professionals supporting service users and whānau to strengthen, become resilient and prevent further problems.

*We had Super Grams, we had Jigsaw, we had Plunket and we had PAFT Parents as First Teachers. Their involvement, those four organisations, is basically around because of the child being in the home. (SU6)*

Participants recognised that engaging in collaborative relationships and dealing with crises in a collaborative manner required the development of whanaungatanga, as opposed to standard organisational requirements or processes. This included participants preferring to know who they are working with, the option of whānau and community support, and having a good understanding of options and choices.

*The first thing she did was apologise to us and then she introduced herself and told us what she does for CYFs. [statutory practitioner] introduced herself, gave us a rundown of what everything was all about and why it was an allegation and what they've got to do. (SU2)*

Service users reported positive benefits of consistent engagement with practitioners. Participants reported that this ongoing and long-term collaborative relationship gave them a sense of confidence, in that they knew and trusted the practitioner, and the practitioner better understood them as a person, along with their needs and preferences.

*All my life. He knows a lot about me so it's pretty good. Every time I see him, he's like, "Don't do this, don't do that, you're putting on too much weight, blah, blah blah." ...I find that I've got a close relationship with my doctor which is a good thing, I think. He should know me inside out. (SU4)*

Service users described that engaging in services was complicated by having to see different practitioners or having their case manager replaced. Participants reported that a lack of staff in some services reduced the availability of practitioners. They also reported that this delayed

the continuity of their care as they needed to re-establish trust with a new practitioner to form a collaborative relationship.

The majority of service users and their whānau reported that their relationships with practitioners were maintained through active practitioner follow-up, where whānau were having multiple needs met by a team of workers. Follow-up was not always of a practical (task oriented) nature, but also included personalised calls to enquire on wellbeing, representing a whānau centred as opposed to task centred approach to working with whānau.

Participants reported that services, which provided home-visits, reduced stress on service users and their whānau. This was particularly important to those participants that had children and broader whānau commitments, or lacked transport to access services in either rural or urban service locations.

The majority of participants also commented on the importance of being able to contact practitioners for support or advice around a range of health and social issues. Participants described how the availability of practitioners resulted in service users and their whānau feeling that support was not far away, and that issues could be addressed early, before an issue became a crisis.

*Services come to us; they come to us easier ‘cause we’ve got a child eh? Whatever they want there’s a phone there so they can do it then if it’s a meeting here they come down and pick us up. (SU7)*

Part of services being seen as flexible and supportive, was their ability to support service users and their whānau with transport. The majority of participants identified transport to rural centres and urban centres as an ongoing challenge, and the support with transport helped them engage in collaborative relationships with different health and social services by being able to attend appointments they usually would not have been able to.

*They hooked me up to Te Oranganui for the drug counselling and provided free transport from there and back, to Wanganui. Yeah, three days a week. They were the only ones that would do that; they went all out. That might have been three to six months, something like that. And if you wanted to do your shopping, they would accommodate it. Yep. They went out of their way. (SU5)*

#### **5.4.3 Summary of theme: Mātua whakapai I tōu marae, ka whakapai ai te marae o te tangata**

This theme highlights the importance of practitioners and health and social service organisations addressing their own barriers to access and quality of care provided. This theme

reflects the participants' experiences of engaging with and in compartmentalized and fragmented services and systems. Services which have a wide range of practitioner, all with different attitudes, values and approaches in engaging with and working with service users and their whanau. This theme was reflected by two subthemes, 'Tairo: Obstructions and complexities in care'; and 'Whanaungatanga centered practice'.

In summary, participants identified a range of issues regarding the impact of rurality on service options and access. Participants reported a lack of specialist services in rural communities. Health and social service options for rangatahi (young people) were identified as a priority for their communities. With a lack of specialist services in rural communities, participants were often required to access these from urban centres, and transport to these urban services was identified as a barrier to care.

As a practicing clinician, I was taken back at times by the severity of the issues faced by the individuals and whānau I had met. The social issues were chronic and at times disabling, whereas the substance use, violence and mental health problems were significantly compounding these issues. Despite this, the participants spoke fondly of their rural identity, Māori identity and Iwi identities. They were open about their view of practitioners however they were also explicit in acknowledging their own roles and responsibilities, and that of their whānau, and by extension of this, their community. Participants spoke of the community as very much part of their whānau, and at times this included health and social service practitioners.

There is strong support within national and international literature for the impacts of rurality upon service delivery, reported by participants (McLachlan et al., 2012; Fraser, 2006, Rameka, 2006; Jackson, Judd and Komiti et al., 2007; and Marrone, 2007). These included lack of clinical service, geographical, environmental and economic barriers associated with accessing service users and their whanau; and likewise for them accessing services in urban centres. There is also support for the rural values, attitudes and behaviours that both help and hinder service access, such as avoiding accessing and tending to keep things 'in-house' so as not to appear 'weak' (Fraser, 2006).

There was no mention by service users of their whānau of any telehealth options, which was noted in the literature to be a recommendation for addressing many of the access barriers identified (Fraser, 2006). This presents as a lack of service option in the rural areas that the interviews took place.

Participants noted service comprehensiveness, flexibility and responsiveness as important factors that contributed to effective outcomes in collaborative relationships with practitioners, and that rural practitioners and services were noted to have particular strengths in this area. Service complexities such as service processes and expectations was reported by participants to reduce their willingness to engage with these services, and when they did engage, their satisfaction with the services was reduced.

As a researcher, it was evident that participants appreciated the flexibility and availability of local Iwi health and social services, particularly as they also had nursing staff, and staff that could provide guidance and advocacy around interactions with specialist health providers. Participants also noted that the availability and active follow up by social workers and whānau ora navigators meant they felt supported, particularly when engaging with statutory services such as Work and Income New Zealand, CYFs). The main gap in service provision appeared to be alcohol and drug, mental health specialists and rangatahi services.

There was no discussion of whānau, community or practitioner advocacy in the literature reviewed. However, it is likely that this was due to the difficulty in reviewing all literature related to the multi-layers topics under investigation in the present thesis. This literature would most likely be accessed through the social work literature. It is possible that more information could be provided to service users and their whānau to guide them in interacting with health and social service organisations, particularly statutory services. These would need to be from an objective group. This would address issues of confidentiality, privacy and full disclosure of service options and associated rights available to each service user and their whānau.

Participants identified that services with a focus on service needs and priorities reduced the service's ability to adequately identify or meet service users and their whānau needs. Practitioners' lack of cultural competencies was reported by participants to be a barrier to service users and whānau engaging in collaborative relationships with practitioners, with participants preferring to engage with Māori practitioners. Practitioners who supported service users and their whānau, to identify their own needs and direct their intervention increased service satisfaction within the collaborative relationships. Participants reported experiencing discrimination by practitioners due to culture, gang affiliation and substance use that then reduced participants' willingness to engage in the collaborative relationships. Practitioner's positive and realistic expectations towards service users were reported by participants to improve service user willingness and commitment to engage in collaboration with

practitioners. Good listening skills, ensuring confidentiality is explained and upheld, and engaging in active follow-up were reported by participants as important practitioner skills that contributed to effective engagement with service users and their whānau.

As a researcher, I was at times dismayed to see that participants were experiencing stigma and marginalisation at a number of levels, ethnicity, affiliation, and poverty. Interpersonal and systemic racism was identified within the literature, as impacting upon service users and whanau accessing, receiving and maintaining engagement in health and social services (Jansen, Bacal & Crengle, 2009; Rameka, 2006; and Marrone, 2007). The importance and preference for more integrated and comprehensive health and socials service fields as identified by service users and their whānau, was also well supported within the literature reviewed (Widmer, 2011; Mauriora Ki Te Ao - Living Universe Limited, 2010; Ministry of Health, 2010; and Smith & Ovenden, 2007). And a move towards culturally fluent practice ‘beyond the rhetoric’ was identified by (Gray, Wilson, & Allsop et al., 2014).

## **5.5 Chapter summary**

The whakatauki ‘Ahakoa kai tahi, tērā a roto te hahae kē rā’ used as the title of this chapter highlights that importance of looking beyond the mechanics of collaboration, to the values, beliefs and behaviours of all involved.

This chapter presented three broad themes and four subthemes that were developed from participants’ discussion of their experiences of working together within whanau to address individual and collective issues; and also in engaging with community supports and health and social services. The three themes that emerged provided significant insight into the different interpersonal, intrapersonal and systemic factors that impact on service users and their whanau ability to address their needs, and also to engage with services at times of need. Those themes (and associated subthemes) were:

3. Whare tū ki te wā, he kai nā te ahi; whare tū ki roto ki te pā tūwatawata, he tohu nō te rangatira
4. Rōrī taura, pā taku panehe; rōrī tangata, rōrīwaiho
  - noho puku: Personal reflection, motivation and commitment to change
  - Te Ariari o te Oranga: Co-existing problems.
5. Mātua whakapai I tōu marae, ka whakapai ai te marae o te tangata’

- te haerenga hauora: The journey of health and social service care
- whanaungatanga centered practice

The results noted the influence of intergenerational problems, including substance use and related problems on service users and their whānau identifying and addressing substance use problems as a whānau, and the influence of past negative experiences with services on whether or not they would engage with practitioners and services. Participants described substance use as a coping strategy used in relation to stressful events and trauma. Of note was that often the substance use or related problems such as mental health problems would be exacerbated by interventions by statutory organisations, such as the removal of children from the home; also that these co-existing problems reduced both the willingness and ability of service users to engage in collaboration with practitioners.

Service users and their whānau reported a range of practices that contribute to collective wellbeing in the face of substance use and related problems. These included: whānau hui and planning; whānau participating in treatment and attending appointments; whānau support and advocacy; and also whānau expressing concerns and encouraging access to treatment. Self-care, including knowledge of and engagement in Te Ao Māori by service users, and being aware of confidentiality was identified as an important behaviour for enabling service users to manage the risks, demands and associated expectations of multiple practitioners and services.

Rurality was noted to pose both challenges and enablers to effective collaborative care for service users and their whānau. Rural areas were noted to lack access to specialist services, particularly for rangatahi (young people). This lack of availability created not only a barrier of availability of options but also the need for travelling significant distances to access services. This travel was a particular barrier for many service users and their whānau who may not have a vehicle or be able to afford to take their vehicle into the nearest regional service hub. Rurality also was noted to increase the need for collaborative practice, particularly in delivering comprehensive, responsive and flexible care. At the same time, complex service processes were noted to be a barrier to service users engaging in or maintaining collaboration with practitioners. Working with Māori practitioners was identified as important for service users, particularly as the lack of cultural competencies in non-Māori practitioners was cited as a barrier to engaging in collaboration with practitioners.

The approach, attitudes and practices of practitioners acted as either enablers or barriers to collaborative relationships. Practitioners were noted to either focus on the priorities and needs of their service or the priorities and needs of service users and their whānau. Those that

focused on supporting service users and their whānau to identify and address their own needs were noted to better enable the formation of collaborative relationships and attain collective outcomes. Discrimination by practitioners regarding gang affiliation, culture or being a substance user were noted to be a barrier to service user and their whānau engaging in or maintaining engagement in collaboration. A range of practitioner skills and attitudes were also noted to be enablers to service users and their whānau engaging in collaboration with practitioners, these included: positive and realistic expectations towards service users; good listening skills; ensuring confidentiality is explained and upheld; and engaging in active follow-up.

There was not necessarily any significant gaps in the academic literature, however there is possibly a lack of material available for service users and their whānau regarding confidentiality, and privacy; working with multiple agencies, particularly statutory agencies; what options are and should be available; and examples of helpful whānau practices for discussing and responding to complex and at times sensitive whānau issues. This would warrant an evaluation of current whānau information packages used by services and government departments. Also the field of telehealth warrants further research and updating, particularly an updated look at the usability and interface between, whānau, rural health and socials services and specialist urban services. In relation to intergenerational problems experienced by whānau and service users, there is scope to extend the current literature by exploring both intergenerational strengths and problems, with a focus on exemplars of addressing intergenerational problems. There is also the clear need for local research regarding the unique needs and aspirations of rangatahi in the southern Rangitikei, in response to the reported high number and frequency of youth suicide in the area. Barriers to collaboration identified within this chapter can be summarised as:

- entrenched whānau beliefs normalising substance use as a coping strategy for distress
- past negative experiences (personally or by whānau members) with services reducing willingness to engage with services
- lack of confidentiality within and between services
- whānau working in services
- poor understanding of mental health issues, and substance use as a health issue
- poverty
- lack of service options, particularly specialist mental health and addiction services

- lack of transport, cost of transport, large distance/amount of time required to travel to access employment or specialist health and social services
- urban in-reach clinic based services
- discrimination and racism by staff and statutory service systems
- practitioners lacking cultural competencies
- complex service systems (paperwork) and entry criteria.

Following on from Chapter Four, the enablers of collaboration for service users and their whānau are presented below.

### **Enablers of Collaboration by Māori, for Māori and with Māori.**

- understanding confidentiality and privacy
- whānau hui and planning
- whānau participating in treatment and attending appointments;
- whānau support and advocacy.
- self-care amongst the demands of practitioners and services,
- knowledge of and engagement in Te Ao Māori, including whakapapa and connections to place.
- whānau and friends bringing up concerns
- personal reflection of current concerns and the impacts of these.
- flexible and responsive services
- integrated health and social service options
- assertive outreach services with drop in/responsive capacities
- staff cultural competencies
- availability of Māori health and social services
- availability of Māori staff
- practitioners listening, taking time to understand whānau realities and aspirations
- whānau and community advocates
- knowledge of local communities.

### Chapter Five and details

Chapter Six will present the third and final results set: a summary and analysis of the experiences of practitioners in collaborating with other practitioners and services in meeting

the needs and preferences of rural Māori; along with collaborating with service users and their whānau in collective action.

## **6 Tātai korero I ngaro, tātai kōrero e rangona. Health and social service practitioners experience of collaboration**

### **6.1 Introduction**

Tātai korero I ngaro, tātai kōrero e rangona. “Some concerted schemes come to nothing, while others are heard” (Grey, 1857, p. 84. In Mead and Grove, 2001, p. 362). This whakatauki has been proposed to mean “While there are many good ideas around only a few are ever attended to and grasped” (Mead and Grove, 2001, p. 362). New Zealand health and social service delivery has undergone significant change in the ten years since the introduction of the governments Whānau Ora model. The initial literature describing Whānau Ora stated that “assurances will be required from a number of government departments and a spirit of collaboration must be embedded between funders, providers, practitioners and whānau” (Taskforce on Whānau-centred Initiatives, 2010, p. 5). The whakatauki above reflects the reality, that despite a drive for increased collaboration and collective community action in New Zealand, there are barriers to its implementation, including an understanding of its human interactional elements, and the practices that maintain effective relationships within and across collective action.

This chapter reports health and social service practitioners’ experiences of engaging in collaborative relationships with service users and their whānau, and collaborative relationships with other practitioners within and across services, organisations and health and social service sectors. The demographics for this participant group will be described below (6.1.1).

#### **6.1.1 Participants – Social service practitioner focus groups**

Three focus groups were conducted with a total of 22 participants. Focus groups lasted between one and one and a half hours per focus group. The inclusion criteria for participants were that practitioners were aged 18 years or over, and employed or voluntarily working within a health or social service that worked with people experiencing substance use and related problems that lived in the southern Rangitīkei. The resulting demographic coverage provides a representative sampling of practitioners in the health and social service sector that work within the southern Rangitīkei region.

Participants completed a demographic form (**Appendix G**). The majority of participants identified as Māori (n=15), all with whakapapa links to iwi of the Rangitīkei and Whanganui areas. Six identified as New Zealand European Pākehā and one as Samoan. Twenty were

female and two were male. They ranged in age from the 18 – 25-year bracket through to the 65+ year bracket with the majority in the 36 – 65-year brackets (36-50yr = 8, 51-65yr = 10,).

Participants identified a range of roles that reflected both health and social service practice, and either management, supervision or administration. The most common roles (where 100% of the participant time was dedicated to that fulltime role) were social worker, nurse, and whānau support. Others included psychologist, manager, and kaumātua. One participant divided their role across nine professions including traditional Māori roles such as kaumātua and rongoā practitioner and more common mainstream roles such as social worker, supervisor and counsellor.

The majority of participants reported working for a mix of iwi social service, Māori health service, and non-governmental organisations.

#### **6.1.2 Process of analysis**

Using the analysis process set out in Chapter Three, a thematic analysis was carried out to identify common themes. The analysis identified three themes, and ten sub-themes. The first theme, ‘Ko Apa whare rau: Collective community action starts with understanding of and engaging with the community’ reflects the role of rural communities in addressing unique rural challenges to service delivery, and the strategies used to engage in collective action with communities. The second theme, ‘E kore e taka te parapara a ūna tūpuna, tukua iho ki a ia: Intergenerational solutions to intergenerational problems’ reflects practitioners perspectives of intergenerational problems, and the importance of understanding, identifying and addressing varying forms of culture within whanau, practitioners and organisations. The final theme, ‘Taku rākau ka hē ki te maraheia: The importance of applying collaborative practice, and addressing tensions and mistakes in collaborative ventures’ reflects participants personal and professional roles; and barriers and strategies within collaborative practice with whānau and with other practitioners, professions and organisations. Health and social service practitioners are identified according to the focus group that they attended, e.g., Practitioner Focus Group one (PFG1). A chapter summary then concludes the chapter.

### **6.2 Ko Apa whare rau: Collective community action starts with understanding of and engaging with the community**

Ko Apa whare rau, Apa of many houses (Grey, 1853, p. 89. In Mead and Grove, 2001, p. 225). From a superficial level, this whakatauki can reflect the many homes of Ngāti Apa as communities across the geography of the southern Rangitikei, from the Whanganui river in

the north-west and the Manawatu river in the south-east. However, this whakatauki is also used to reflect the many stories of the whakapapa and migration of Ngāti Apa as an Iwi. Therefore, this whakatauki reflects a theme of communities and the multiple realities of Māori and tau-Iwi within these communities.

This theme is about the importance of community and communities in addressing social issues, the importance of knowing the cultural and historical fabric of these communities, and what strategies to use to bind a community for collective action. This theme is reflected in three subthemes, ‘Communities: Engaging with resources, skills and solutions’, ‘Multi-skilled and multifaceted: Service delivery in rural communities’, and ‘Rural practitioners: Insiders and visitors’.

#### **6.2.1 Communities: Engaging with resources, skills and solutions**

Health and social service practitioners noted that communities hold unique strengths, resources and skills. Participants identified that these collective abilities were in some ways a firstline response to growing health and social problems, and were often able to identify and respond to health and social issues quicker than health and social service organisations. The majority of participants noted that community action was most often awoken by common concerns or significant events.

Participants reported that through awareness of and engagement with local community groups, networks and leaders, practitioners were in a better position to develop local solutions to complex problems. Participants observed that this was particularly important for rural communities where there were a lack of employment opportunities and specialist services.

Participants identified a range of events and practices that reflected the need for and ability of health and social services to engage with each other, and at times with community groups and whānau to address a collective issue. The majority of participants identified locally relevant need driven events that often drove the need for services to collaborate, whereas several participants also identified the need to collaborate in response to external pressures and changes such as changes in funding contracts.

Several participants observed that there was often a ‘spark’ or event that formed part of this common goal. Within the southern Rangitīkei, geographical crises, particularly flooding, and suicide in the community were seen as significant events that contributed to a common goal or call to collective action. This call to collective action formed the motivator for people to form collaborative relationships. Due to the long history of significant flooding within the

Rangitīkei, participants reported that the community had particular skills and attitudes that contributed to them banding together to meet their own needs, and those of other community members.

*I think they are more likely to have that kind of “can-do” attitude and “make-do”. I’m just thinking about the floods. I live Whangaehu and I have lived in town. I lived in town through the 2004 floods and this recent flood and we were blocked off from civilisation and its incredible how everyone just pulled together. We had our whānau from Rātana helping and people were saying, “Where’s Civil Defence?” Who needs Civil Defence we can just do this for ourselves. That was just the attitude. (PFG1)*

Participants recognised that the event of several suicides of young men in Marton had led to local community, and health and social services coming together to discuss the issue and identify what skills needed to be brought into the community.

Whatever the instigating ‘spark’ was, participants reported that it was important that there was a common goal or vision to rally around. Several participants reported that a common goal provided an incentive and motivating factor in bringing practitioners and services together for the purpose of collective action. Participants described initial common goals that brought practitioners and services together as attaining positive outcomes for service users and their whānau.

The common goal identified by participants was the service users and their whānau, what participants called being whānau centred. There was specific comment on the focus on mokopuna (children) as both vulnerable and taonga (treasures).

*That’s right and it’s not about you and it’s not about me. There is something much more important than us and that is our mokopuna Māori or mokopuna and whānau. (PFG1)*

The majority of participants noted the importance of practitioners having a good understanding of the community fabric, that is, the history, preferences, relationships, leaders and groups within the community. Participants observed that by understanding the communities within an area, the practitioner is better able to access and work with local resources. This is seen by participants as a significant enabler of collaborative practice in rural communities.

*I think isolation to start with. We’re not like in a big city where you’ve got all the services there and you can just ring up. You haven’t got that here. So sometimes I think when you’re isolated you’ve got to know your community well and therefore*

*then you'll be able to plug into different ones that are around. But you've got to be known in the community as well. (PFG2)*

Participants noted that for practitioners and services to join together for a common purpose or goal, there needs to be some direct benefit to the services participating. Participants considered that activities that had direct benefits for services were professional development activities and joint funding opportunities.

Several participants commented that community events such as fairs, and health and social service training were also activities that commonly brought practitioners together and strengthened collaborative relationships between practitioners and between practitioners, whānau and the community. Several participants mentioned that having likeminded people supported a common goal. Having people with ‘egos’ or that were not familiar to each other were cited by participants as a barrier to working towards this common goal.

*I suppose joint interests really is one that sometimes we are all on the same, or we hope that we are all on the same wave length; so interest to achieve a common goal. (PFG1)*

Participants highlighted that collaboration was strengthened by the opportunity to be with likeminded people, with a common interest, at community and specialist meetings. Participants reported that the common focus increased the likelihood that they would attend and engage in these meetings.

*Like-minded people all passionate about the same thing, all wanting to make a difference, all have a vested interest and wanting to support the community. (PFG2)*

Participants mentioned that specialist community meetings, which allowed discussion of shared cases, were an important point of access to different professions, perspectives and supports. Participants noted that health and social service practitioners could access much needed clinical support, much like that of a large multi-disciplinary team. Participants recognised that this contributed to better outcomes for service users and their whānau, and reduced stress and isolation for practitioners.

External practitioners, those practitioners that were based within urban centres and delivered services within local rural communities, reported the benefits of engaging in rural community meetings as strengthening relationships between practitioners, and increasing the likelihood that future collaboration would be more effective.

Participants reported that in order to mobilize community strengths, skills and resources practitioners need to be aware of community leaders, groups, cultures and organisations. Participants acknowledged that better awareness of these resources led to local solutions. This was seen as a key enabler of rural collaborative practice.

*You have really got to know your community for one thing; you need to know what's going on. It's not all the vulnerable things that are going on, all the issues that are going on; you need to know who potentially - they may not even be working in the health or social service area – within that community you can bring on board to be part of your collaboration? I guess that's the beauty of a smaller community because you do get to know your community really quickly and who you can rely on and who you can't. (PFG1)*

The majority of participants reported that community meetings, described as either hui or forums, were a vital aspect of initiating collective action and maintaining collaborative relationships. Participants mentioned that some meetings were general community meetings about what events were coming up, where different local and external organisations would familiarise meeting members about their services. Other more specialised meetings were focused on specific issues such as paediatrics, health or education. Some of these specialist meetings also allowed discussion of service users and whānau they were working with.

Participants noted that some meetings had over 30 external health and social services from Whanganui and Feilding attending local rural meetings in Marton. Participants reported that in order to engage effectively with these practitioners, services and community groups, practitioners must understand the different cultures of each respective practitioner, service or community group. Participants described culture as ethnic, therapeutic and philosophical, and rural.

Several participants reported a range of positive outcomes from engaging in community and specialist meetings. Participants noted that by bringing together practitioners in general meetings, even if service users weren't being discussed at the meeting, they could still access practitioners after the meeting. This kanohi-ki-te-kanohi contact enabled relationship strengthening and allowed practitioners to update each other on practice issues related to their shared work.

*They've all got something in common. I love the meeting. I can't miss it because the value that we get from that for this handful or whatever that we're working with is phenomenal. So it's like after that meeting, right, I need to talk to you, you and you, and so going around face to face is just so awesome. But taking it away from that meeting and then going and doing that individual stuff. It is so powerful. (PFG2)*

Participants acknowledged that prior to engaging in community Hui, they felt they were working in isolation. When engaging in community meetings they were able to engage with health and social service practitioners and access a much broader range of support.

Several participants also observed that rural practitioners were in a better position to develop robust collaborative relationships due to the smaller location and smaller number of practitioners to engage with.

Participants reported that active engagement with communities involved kanohi kitea, that is, the seen face, the importance of having a community presence, being seen and available. This is as opposed to being considered a visitor. Participants acknowledged that it was important for practitioners working in rural communities to establish relationships through kanohi-ki-te-kanohi, that is, face to face contact, and that it was important to maintain this relationship by being consistent and delivering what you have offered.

*You just have to be involved whether it's at the Kōhangā, at the kindergarten, at the school sports is another one. Connect to the networks. For experience. Physical presence is huge. You have just got to rump on up. You don't just take; you have got to give back as well. It's the whole sharing; so you have got to have that relationship as well and knowing what can you contribute before you can ask them of something. That's really important and I think that sets the whole foundation of building that relationship in the beginning. (PFG 1)*

Organised community events were noted by participants as another method of bringing together diverse groups of people in the community. Participants gave examples such as market days, fairs, kapa haka and music shows. Participants observed that these organised events provided opportunities for people to share their cultural heritage, food and crafts.

Participants discussed that it was also important for practitioners and organisations to have an active role in supporting other community groups and organisations. This can involve supporting other projects or actively consulting to identify what can be offered to these groups and the whānau accessing them.

Participants recognised the importance of consistent engagement between practitioners, and practitioners following through with their commitments as key aspects of maintaining collaborative relationships. Participants observed that practitioners provide service users and their whānau better outcomes when they develop robust relationships within communities. Participants reported that with robust community relationships, practitioners are more aware of service and community options and processes. With this knowledge practitioners are better able to support service users and their whānau to access these options.

*So if you haven't been out there and done the hard yards yourself and actually established some relationships that can be a real barrier and of course follow up when you are engaging with the agency and making sure you stay true to your word; that can be a barrier if you don't follow up what you say you are going to do. We're the same in Whanganui; we're working with an agency in Taumarunui and if we don't keep that communication going with them that can be a real barrier for us. (PFG 1)*

### **6.2.2 Multi-skilled and multifaceted: Service delivery in rural communities**

Participants identified a range of barriers to delivering collaborative health and social services in rural areas. Producing, recruiting and maintaining local practitioners was identified as a challenge. Participants reported that when they did maintain practitioners who lived and worked locally, these practitioners faced additional challenges to engaging service users and their whānau, challenges that externally based practitioners did not experience. Travel and transport were also identified as barriers for service users and their whānau accessing specialist practitioners and services based in urban centres. Participants also mentioned that when specialists were coming out to rural communities that this was in a minimal capacity and lacked responsiveness to need.

Participants reported that there was a lack of specialist services in rural communities. This reduced the options of what services were available, and meant that service users and their whānau needed to travel to urban centres including Whanganui, Palmerston North and Wellington.

*I think isolation to start with. We're not like in a big city where you've got all the services there and you can just ring up. You haven't got that here. (PFG2)*

Participants commented that due to a lack of service options, there was an even lower likelihood that service users and their whānau could have options relating to the gender or culture of the practitioner. Participants mentioned that this was a barrier to service users being able to have their preferences met, further reducing the likelihood they will engage with a service. Participants highlighted the role of local services hubs, multi-skilled staff and addressing transport barriers in rural areas as overcoming barriers.

*I was working with the AOD services at the DHB in Whanganui and that's sort of been identified that in the rural communities like this, this is like a one-stop shop; you are not spoilt with all the different clinicians, all the different social workers, all the different professionals that are there where you can walk through the door and "Oh no, I don't like that one, I don't like this one." (PFG1)*

Several participants identified that local service hubs, or one-stop-shops were an example of efforts to provide access to specialist practitioners that provide in-reach services to rural communities. Participants recognised that these service hubs were provided by either iwi or DHBs, however they were more likely to be available in independent urban communities as opposed to satellite urban communities.

Participants reported that in-reach specialist practitioners tended to deliver services in these service hubs based on a clinic model, where services are provided on certain days and times. Participants noted that these clinics were less responsive to the needs of service users and their whānau, therefore reducing the likelihood that they would receive support when they needed it.

*In terms of you talking about people to Marton here from Whanganui on certain days. [group participant] knows; [this person] is here most of the time now but you will get this service coming to the health centre on a Tuesday, someone else on a Wednesday, and someone else on a Thursday. Well what if you didn't need them on Thursday? Move them on for the next Thursday. (PFG1)*

Participants identified that one of the common responses to a lack of specialist practitioners in rural communities, was the development of practitioners with broad skills with the ability to ‘think outside the box’. Participants reported that rural practitioners are particularly resourceful in addressing complex issues, and this is built upon a foundation of solid collaborative relationships.

*Working in these rural communities from what I have seen is a one-stop shop; the clinicians, the social workers and that. They have to be very rounded with all the aspect of their job and that's probably what [group participant] was saying about being particular about getting the right one because they have to be the right ones; you can't get someone that chooses to work solo. There's a team that I work with and they are there to support me but working at the DHB there was a whole sea of people that I could use to come and support me with different things. The staff here are very rounded and experienced and I think that's a real bonus actually for the rural community. (PFG1)*

Participants note that due to a lack of access to specialist practitioners, particularly from the mental health and addictions sectors, practitioners were required to have a broad set of knowledge and skills to be able to provide timely responses to the needs of service users and their whānau. Participants observed that this was a specific aspect of both rural practice and the influence of a Whānau Ora practice model.

Participants also commented that despite being ‘well rounded’ and having a broad set of skills, at times they needed to work outside of their scope of practice. With barriers to

accessing specialist practitioners, local practitioners could not ignore issues as they arose or wait for a specialist practitioners to become available on the next clinic date.

Participants mentioned that cultural and spiritual knowledge and skills were also important when working collaboratively with other health and social service practitioners, particularly when issues of cultural or spiritual significance occurred.

*When he's at the hospital, if he comes across someone who's a Rātana, he always contacts me, you know what do to do? I said, "Well you have a prayer. Is it a Catholic prayer?" "No, it's a karakia." You do a Catholic prayer anyway to all those fellas from Rātana turn up." So it's about the sharing stuff as well. (PFG3)*

Participants discussed the challenges related to working across rural communities, and the difficulties and strategies used when addressing transport barriers for whānau seeking to access health and social services in local communities or urban areas, such as Whanganui, Palmerston North or Wellington. Participants reported that distance was a significant barrier to engaging with health and social services. Participants noted that these barriers were related to the cost of petrol, the lack of access to a vehicle, and the lack of when public transport was available. Participants noted that these cost factors further compounded the changes faced by whānau who may be seeking support for financial problems.

Participants also observed that transport was also a challenge for rural practitioners, however for different reasons. Travelling within and across rural areas was at times dangerous. Participants reported that practitioners were required to provide clinics and home-visits to service users and whānau in remote rural areas, and at times these roads may be dangerous due to rain or snow.

*Travel gets in the way; travel because you can't go to Taihape when it's snowing – the road is not safe. (PFG1)*

The challenges posed by road closures was reported by participants to reduce the responsiveness of services and at times effect the credibility of services due to practitioners not being able to deliver these services.

### **6.2.3 Rural practitioners: Insiders and visitors**

Participants reported that accessing health and social service practitioners to work in rural communities was a barrier to providing services to whānau. Recruitment of staff was identified as an ongoing challenge. Participants noted that practitioners from outside New

Zealand were moving to the area to access work, and these people were not necessarily the right fit for the type of work or the whānau they were employed to work with.

Several participants identified that practitioners from different cultures may be less likely to be motivated or able to engage with local cultures and groups. Participants perceived that these practitioners may be focused on the tasks of their job as opposed to the wellbeing of people or advancement of the community. They also believed that without the ability to engage with local cultures these outsiders do not access the knowledge that is important to enable them to do their jobs.

Practitioners noted that along with internationally sourced practitioners, rural services were often in the position of needing to employ practitioners that may not necessarily be the right fit for the service or whānau, due to the lack of people applying for the position and the necessity to fill the position to retain funding.

*And I think that can be barrier because some staff are employed to fill a number and not looking at the fit; that can be a real barrier. Some of our rural areas if there is not the right person in the job then it is just not going to work, but they are in the job because the need to fill the number. (PFG1)*

Participants noted that volunteers within the community provided a valuable and necessary resource for community health and social services. Participants identified that this was another example of a local rural solution to a challenging problem, a lack of funding for rural services.

Practitioners reported that different challenges and enablers of collaboration existed for practitioners that lived and worked in their community, and for those that lived outside of the area. This was noted even more so for people from other cultures or new immigrants. People who did not live or grow up in the local area identified being a ‘visitor’ as both a disadvantage and an advantage. Participants recognised that not being from the area meant they needed to find other ways to connect with people and to understand the local fabric of the community, whereas other participants mentioned being from outside the area and in some cases outside the culture (i.e., being non-Māori) allowed service users and their whānau a stronger sense of anonymity and confidentiality as these practitioners were perceived as much less likely to know the whānau or share their information with others that knew their whānau.

*That's probably where people like me, imports like me, have possibly a disadvantage. I don't know if it's a disadvantage or if it's just that we don't have that access thing. We have to find other ways. (PFG2)*

Practitioners who also lived outside of the area identified different perspectives on living and working locally. Participants noted that living and working locally could ‘open doors’ due to strong historical and cultural connections, whereas other participants observed that service users and their whānau would not want to engage with the practitioner because they lived locally. In this case there was more suspicion as to the level of confidentiality that would be in place.

*My mother or my koros, or the local kaumātua around here; I mean, I’m from here so that also makes a big difference as well. I went to Tirahia, you know, born and bred on the railway. So I mean that opens up the doors before you even get to the town. (PFG2)*

Participants who worked within local rural communities reported experiencing a lack of commitment from external organisations and practitioners, that is, services that were based in urban centres delivering in-reach health and social services. Participants reported an initial challenge in collaborating with external practitioners was the lack of face-to-face contact. Participants spoke of multiple contacts with practitioners they had never actually met. These practitioners were seen as ‘visitors’.

*I don’t know about that. They just come away, do their spiels, have a little chat and then they’re gone.... But the ones from outside, it’s sort of like they spend an hour or two here and then they’re gone. (PFG3)*

Several participants gave recent examples and similar examples occurring over a decade ago in which external specialist practitioners engaged with local rural services to address the occurrences of, and increased risk of suicide. Participants reported that during both periods there was a swift and intense intervention by urban centres, however there was a lack of commitment and a lack of follow-up. Participants reported that this left local practitioners feeling isolated and not being treated as a collaborative partner.

Participants mentioned that this lack of commitment was related to a range of issues, including lack of funding and a lack of passion for their work. Participants felt that external providers, including statutory services, were pressured by media attention to respond to issues, but felt that external providers were providing minimal practical support, or not spending necessary time to address a more complex issue.

When collaborating with statutory services, there was also an uneven balance on expectation and reciprocity. Participants recognised that they would be compelled to attend meetings related to the needs or priorities of statutory services, and follow-up on outcomes, whereas

statutory services did not need to attend or would not follow-up on the needs and priorities put forward by the local rural health and social service practitioners.

*I think unless the other half is running it they don't want to know... the government agencies will sit and talk with you but the expectation is that you do it, you know? You do everything. We'll sit there and we'll paint this picture but you fellas are going to get up and do it. But when we call, when the government agency calls for us to be present, we have to be. We have to present. But when we call they don't have to come. So when we identify well we need the police or we need CYFS there, you know, and we invite them in but they don't have to. (PFG3)*

Participants identified that developing interpersonal relationships with practitioners within these statutory services led to better outcomes as opposed to attempting service level relationships. Participants noted that by developing practitioner level relationships, the needs and priorities of local rural practitioners could be better expressed and received by statutory services.

#### **6.2.4 Summary of theme: Ko Apa whare rau: Collective community action starts with understanding of and engaging with the community**

In summary, shared goals were identified as an important foundational factor in engaging people in collective activity at both a whānau and community level. Being aware of the community groups, cultures and preferences within the community was argued to contribute to more locally relevant and responsive outcomes for practitioners, and for service users and their whānau. Changes in government priorities and funding were proposed to contribute both challenges and enablers of collaboration. On one hand some changes in funding and policy was argued to have contributed to competition between providers, while on the other, the introduction of Whānau Ora at a government level was proposed to have normalised and encouraged cross-sectoral collaboration.

As a researcher, it was interesting to note that changes in government policy and priorities acted as both enablers and challenges to collaboration for participants, however there was little or no comment on what enabled organisations to take hold of and take advantage of changes. There were some managers within the focus group. However perhaps this query has been better answered by the Key Community Member interviews in chapter four, as those participants reflected a larger number of CEOs and those working within politics.

The literature reviewed identified the importance of organisational competencies and resourcing in ensuring organisations could engage in larger collaborative ventures (Dougherty, 2013; Eppel, 2013; Ihimaera, 2007).

Community meetings were noted to provide an opportunity for practitioners to strengthen relationships with other practitioners and develop a better understanding of community structures, cultures, needs and preferences; whereas specialist focus meetings provided health and social service practitioners an opportunity to access advice and support from a range of sources to address practice-related challenges.

Local service hubs were identified as providing a way of coordinating in-reach specialist services at a local level services. Due to limited appointment slots for specialists in these service hubs, participants reported these specialist services were less responsive. Participants also noted that they perceived in-reach specialist practitioners as less committed to local community needs. In order to meet the diverse needs of rural whānau, rural practitioners were identified as requiring a broad set of knowledge and skills, however there are challenges accessing practitioners with these broad skills. Participants recognised it was also difficult to access practitioners with the cultural competencies necessary for working with rural Māori service users and whānau. Despite the concern over in-reach services, working and living in or being from the local area was sometimes noted to cause concerns for local service users regarding confidentiality, whereas for other service users this was noted to enhance collaboration. Providing home-visit services to rural whānau, and the need for rural service users to access urban based specialist services was identified as a significant barrier to collaboration. Due to the vast geography and climate in the southern Rangitīkei at times there are challenges to accessing service users and their whānau. It was argued that this can make practitioners appear unreliable. Whereas participants identified practical and financial challenges for service users and their whānau in accessing urban based services.

A gap in the literature appears to be the usefulness of in-reach specialist clinics in rural communities. There was differing views on the usefulness of these clinics. Some participants proposed that these hubs were an important central location, whereas other did not like the lack of availability and responsibility. There was support in the literature for the need to have knowledge of the local communities' resources, needs and culture (McLachlan, 2015; Howard, 2003; McLachlan et al., 2012; Taylor, Bessarab, Hunter & Thompson, 2013).

There was also strong support in the literature for the need for flexible, responsive and comprehensive care for service users with complex conditions and their whānau (Smith & Ovenden, 2007; Ministry of Health, 2010).

## **6.3 E kore e taka te parapara a ūna tūpuna, tukua iho ki a ia: Whānau centred practice to address intergenerational problems**

E kore e taka te parapara a ūna tūpuna, tukua iho ki a ia, “the qualities of their ancestors will not fail to be fulfilled, they must descend to them” (Williams, 1908, p18. In Mead and Grove, 2001,p34). One way this whakatauki has been proposed to mean is “Abilities and other qualities of importance are received from one’s ancestors and at the appropriate time will manifest themselves” (Mead and Grove, 2001, p. 34).

There is growing evidence in the literature that health and social problems can be intergenerational for many whānau. However this theme acknowledges that both problems and solutions can be found within whakapapa, through tikanga that has been passed through generations, and that collaboration must have strategies to tap into and nourish these strengths and abilities in order to address the chronic nature of intergenerational problems.

This themes also reflects the importance of understanding that professions, communities and organisations have an āhua (form) or culture of its own that needs to be identified, understood, utilised and in some cases addressed. This theme is reflected in three subthemes, ‘Substance use problems: Multiple factor that contribute to intergenerational transmission, ‘Culture with and across practitioner, organisation and community’, and ‘Delivering whānau centred and responsive services’.

### **6.3.1 Substance use problems: multiple factors that contribute to intergenerational transmission**

Participants reported that the collaborative practices within and across whānau were critical factors in whānau wellbeing. This includes collective whānau action towards wellbeing and decision-making regarding engaging with health and social services. Several participants acknowledged that intergenerational problems contributed to how severe a current problem may be, and also the likelihood that a whānau may seek help from services. Participants noted that other whānau attitudes and behaviours contributed to the decision-making process of whānau as to whether they would access whānau resources or engage with services.

Several participants observed that many of the barriers to service users and their whānau engaging with services were related to problems that were intergenerational. These intergenerational problems included attitudes, beliefs and practices related to substance use and cultural engagement and identity. Participants noted that to address the presenting problem, the practitioner and service user needed to identify the intergenerational pattern.

*Yes. Entrenched patterns that have just come along to the next generation, to the next generation, which is often a barrier because then you've got to find the link of how to get in to that prior step. (PFG2)*

Several participants discussed how many of these intergenerational problems for Māori were results of colonisation. Participants reported that these problems become cyclic and entrenched. Participants recognised that these intergenerational problems contributed to and reflected low-socioeconomic status, lack of opportunities, and disconnection from traditional lifestyles, practices and beliefs. These cyclic problems were noted by participants to result in substance use, abuse and violence. These were reported to be behaviours that reinforced the negative cyclic and entrenched problematic lifestyles.

Participants observed that addressing complex and interrelated intergenerational problems took time and expertise. Time, which was not reflected in current funding expectations. Expectations that are often related to interventions targeted over a number of weeks or months.

*You go in and that great grandmother had an issue with your great grandmother and there's some historical stuff that went on there and you've got to kind of break that down. I've come across that sort of thing. (PFG2)*

Several participants discussed how service users' self-esteem and self-efficacy were influenced by the intergenerational experiences of their whānau. This included the service user's belief as to whether they can overcome barriers. Participants also noted that even when given positive encouragement service users may discount this, as their intergenerational beliefs were stronger. Participants reported that low self-efficacy reduced the likelihood that service users would actively engage in collaborative work with health and social service practitioners, as they did not believe that they could change.

*It is kind of like when a person wants to stop doing something but because of the old stuff being normalised is that we have been told, "I can't, you can't, you won't, you don't." And so we grow up and we have that with us and it's like somebody says, "You're really good," and they go, "Oh, no I can't do that, so I won't." So it's kind of like it's those old stories that have come forward and the old story says, "You can't do that." (PFG1)*

Participants identified that for many service users and their whānau, substance use and related problems, including gambling were a normal part of their lifestyle. Several participants reported that when these issues were normalised within a whānau, they were less likely to identify it as a problem, or seek to engage with practitioners regarding these issues. Participants commented that even if a service user identified these issues as a potential

problem, whānau attitudes that normalise the problem reduced the likelihood that whānau will support their decision to engage with a practitioner. They also noted that whānau may be resistant to engaging with the practitioner to support the service user due to the substance use and related behaviours of the rest of the whānau.

Several participants highlighted that the easy availability of a range of substances contributed to the chronic nature of substance use for service users and their whānau. Participants observed the availability of methamphetamine and cannabis, and also the easy availability and acceptability of a range of legal substances and related problems, including synthetic cannabis, alcohol and gambling. Participants noted that the easy availability and normality of these problems within the community was working against the focus of health and social service practitioners supporting a Whānau Ora approach to wellbeing.

*And I think with the introduction into methamphetamine into New Zealand and our small communities that stuff is poison and it actually destroying especially small rural communities. You could write out a format of what you are going to see and it is typically your people that are probably middle class, people that are working and do have lives, have got a reasonable income because that shit is expensive. And people on benefits unless they sell themselves or they deal it or they do crime they are not going to get enough of it to be able to have a huge significant impact on their family structure and these little communities. You could write all that down and let's see if this is happening. You could go into a family, especially Child Youth & Family, and there is no talk of addiction or anything like that but there is a pattern that you are starting to notice – domestic violence, ill health, malnutrition, the kids are not going to school. That culture is a different culture. (PFG1)*

*I can think of somebody that I have been working with and it's like a norm for her to use the stuff that you used to buy from the dairy. But she talks about it like it's just the norm. Like, "Well I just take synthetic daily." "Oh okay!" And she's just "But that helps me and I feel good, it starts my day and makes me feel good." Some of our families see it like that; like "Why do I have to change, I'm okay. I feed my kids." So that's what you have to put up with. "You make it legal and then you take it away from us." "We were doing everything by the rules; you were the one that made it legal." (PFG1)*

Participants reported that many of their Māori service users and their whānau had experienced a significant separation from the culture, and in turn their identity. Practitioners identified that this had become a barrier to these service users and their whānau engaging with Māori providers as they felt uncomfortable and in some cases intimidated due to their lack of familiarity with Māori process.

*Because we are talking about a lot of our people are disconnected from their culture. So, to go in there and you know; kanohi ki te kanohi means nothing to*

*them because they've lost their...identity, and when you attempt to connect like that, sometimes some of the people are quite scared of that. They're quite intimidated by that and it makes them feel uncomfortable and they would prefer to have a tauwi. And that's sad. (PFG2)*

Participants acknowledged that service users and their whānau also presented at times with resistance to engaging with practitioners, or to address specific issues with practitioners. Participants reported that there were several contributing factors to resistance, including intoxication, the behaviour of the practitioner, the context of the collaboration, such as statutory intervention, a lack of motivation to change, and whānau being ‘burnt-out’ from a history of unsuccessfully supporting the service users to address their problems.

Participants reported that substance use directly affected the ability of the service user and their whānau to engage in collaboration with practitioners. Whānau attitudes towards substance use, and the attitude of practitioners toward substance use and toward people with substance use problems, contributed to poor engagement in collaboration with practitioners. These aspects are reflected by whānau not identifying substance use as a problem and the stigma and shame of substance use reducing engagement in collaboration.

Participants also recognised that this resistance could be seen as active sabotaging or placing roadblocks in place to make collaboration difficult.

*Sabotaging; they put tests out there all time. “I'm going to do this if you do that.”  
“Well I'm still going to do this...like a tester just to see.” (PFG1)*

Several participants reported that practitioners can increase resistance by their behaviours. A lack of partnership and whānau self-determination in collaboration was noted by participants to create resistance. Participants identified that resistance from service users and their whānau was influenced by what organisation the practitioner was from. More resistance was directed towards statutory agencies such as Child Youth and Family, probation or Police as opposed to health or non-governmental health and social services. Participants proposed that this was due to the different consequences of engaging with statutory services and the previous experiences that service users and whānau may have had with these services.

Participants recognised that despite resistance from service users and their whānau, practitioners could still enhance collaboration by ensuring that service users and their whānau were fully informed, that processes were transparent and that they were actively involved in decision making. Participants noted that sharing power often changed the ‘temperature’ of collaboration.

Participants observed that the source of motivation to seek help for substance use and related problems was a key factor in resistance. Participants noted that often service users were motivated by external factors such as employers to access support for substance use. Participants reported that external motivation led service users to try and provide clear urinalysis screens as opposed to actually changing their substance use and related habits or routines.

*I think that depends on people's motivation to go and seek help as well; whether they're pressured by whānau, employers these days with the random drug testing. I have seen a lot of people come through AOD services motivated by their employers. They don't actually want to change and they will try everything. They will buy the plush kits from the local places and they'll do everything possible to try and buck the system so they can carry on with their habit and still have a job because that's their income. They might be a good worker, sure they might be, and have a session when they get home, or they could have a session of the weekend and then go all week without it. And then they have a test and "Hello you're positive – BOOM!" Straight away, this is where you are going now – suspension. (PFG1)*

Participants highlighted that motivation was more effective when it was an internally produced process for service users, as opposed to an externally produced state. Participants discussed how practitioners needed to take their time in encouraging service users to identify their own motivation, vision and hope in order to self-determine their goals and engagement in collaboration.

Participants observed that whānau resistance to engaging in the treatment of service users, may not be related to a negative perspective of the practitioner or service, but due to the ongoing negative consequence on the whānau of the service users substance use and related behaviour. Practitioners termed this as whānau being 'burnt out' or 'bridges having been burned'.

*We always want families to be involved in the care of the person referred but when they have got an addiction of whatever sort it is really hard to get the families to want to help them because they are fed up...and they are burnt out. (PFG1)*

Several participants noted that impact of service users' substance use on their whānau may also reduce the likelihood that whānau will address the substance user's substance use. Whānau members presented as fearful as to what the outcome would be of bringing the issue up of their whānau member's substance use.

Participants acknowledged that due to normalization of substance use for some service user's and their whānau, some service users did not identify their substance use as a problem. In many cases, substance use was referred to as an important part of service users functioning and lifestyle. Participants noted that this reduced the likelihood that service users would seek support, or when offered, agree to engage with practitioners regarding substance use and related problems.

*It's my norm. I get up in the morning, I whip the knives on and I'm getting me through the day. I've heard that kōrero, "It gets me through the day." In the afternoon they'll go do it again and then, "Because I can't sleep." "If I don't have that I can't sleep." (PFG3)*

Practitioners also recognised that when working with a service user that used substances, their collaborative relationship was affected by the service users' substance use. Participants proposed that substance use impaired the service users' memory, which led to inconsistencies in the service user's ability to follow through with their agreed commitments.

Participants reported that there is a lot of stigma associated with substance use and addiction, and this reduced the likelihood that service users would bring the issue up with practitioners. One of the reasons provided by practitioners was that addiction was considered a mental health disorder.

Participants commented that even when practitioners brought up the issue, service users would deny substance use or problematic substance use. Participants noted that the behaviour and attitudes of practitioners towards the issue of substance use, influenced how open service users would be. Practitioners mentioned that some service users feared being criticized or judged, and this reduced the likelihood they would be honest about their substance use.

*So they'll tell the doctor what they want to hear...Because they don't want the doctor to get upset so they – Or tell them off. Because they growl a lot. They growl at our people, particularly our older people. Yes. So they won't tell them. (PFG3)*

### **6.3.2 Culture within and across practitioner, organisation and community**

The majority of participants noted that communities within the southern Rangitīkei incorporated a range of cultures, and that it is important for practitioners and services to be aware of and engage with these cultures. Participants gave examples of cultural groups within the area experiencing barriers to wellbeing due to having a lack of understanding of local cultures and local processes and expectations related to health and social services.

Several participants also observed that within the southern Rangitīkei there are also a large number of Māori living in the area who do not whakapapa to local iwi. Participants noted that this left these people struggling when cultural needs present, such as tangihanga (grieving and funeral process). Participants reported that community groups such as sports groups acted as whānui, and during times of needs, these groups would be relied upon for support. Participants recognised that this approach to caring for each other also occurred within their health or social service. Participants questioned whether this was a mainstream common practice, or a Māori approach.

Participants identified the importance of being aware of the different cultures of communities, practitioners and organisations. Participants reported that without understanding the cultures within rural communities, practitioners would struggle to engage with these practitioners and whānau in these communities.

*I think cultures is a really wide broad thing to talk about because you know you could bring the culture of the actual service and the kaupapa that they are bringing to the communities themselves, whether that's punitive or therapeutic. If you working with someone in the therapeutic aspect and someone from a punitive aspect comes along and they are trying to say this is how it is going to be and we are working from a "What do you see happening here?" that can be also be a culture as well. And from my experience with some of the little different rural communities and that their organisations have a culture of their own and that culture can be potentially a big input of one whānau that is working within an organisation; their kaupapa and their cultural beliefs for what they are doing could be potentially a huge barrier, which I have actually seen in some little rural communities; to try and actually have a good engagement with them. If you don't get on board with what their culture is and how they walk and their walk the door is going to be closed and it is going to be very hard and there is going to be barrier after barrier. (PFG1)*

Several participants also acknowledged that the culture of the whānau they worked with was an important aspect that influenced collaboration. Participants identified the importance of understanding and engaging with Māori, and building upon this relationship in linking service users and their whānau with other practitioners and services.

*It's easier to work with a Palangi. It is. But it's hard working with Māori because you have to understand how they work, how they think. And then you become the bridge between them and the services and while you're being a bridge you're actually building strong relationships with this – you know, with the other side, which is really cool. (PFG3)*

Several participants reported that the therapeutic approach or paradigm of an organisation is also an important part of an organisation's culture. Participants mentioned that organisations

with different therapeutic paradigms may also face a conflict of cultures. This is because the services delivered and practitioner's approaches to other practitioners and whānau will be aligned with that paradigm and their paradigm may conflict with that of the whānau and other potential collaborative partners (practitioners).

Participants identified that acknowledging and understanding one's own approach, assumptions and culture, and having skills in engaging with other practitioners and services from different therapeutic and ethnic cultures, as an important part in addressing potential conflict.

Several participants acknowledged experiencing significant organisational racism, where other mainstream practitioners, services and organisations devalued Māori perspectives and viewed Māori services and practitioners as inferior to mainstream practitioners and services. These aspects are reflected in two sub-themes: De-valuing Māori perspectives; and Māori services viewed as 'second best to mainstream providers.

A couple of participants reported that Māori practitioners were sought to attend meetings, however their perspectives were not heard or responded to. Participants mentioned that this was a barrier to effective collaborative relationships, and meant Māori practitioners and Māori in general were not active partners in some collective action.

Several participants identified that Māori practitioners and services, were viewed by others, as of less quality than other mainstream services. This included practitioners, services and, at times, service users and their whānau. Participants noted that mainstream services also received better funding and community and business sponsorship, which reinforced these perspectives.

*Well there is second best and not – if you're not European – if you're Māori you're seen as lesser than European or Pākehā. That's still quite – you get that a lot, like even within services that if it's a Māori service it's not as good as the – like [54.46] isn't as good as Plunket and yet they do the same thing. Sure, when I came out here. Oh yeah, when I came out here. When I was mental health in town and I hadn't come across that negativity towards to Māori providers and when I came out here there was very much you're the second cousins, you're the poor bro. (PFG2)*

The majority of participants also reported that mainstream practitioners, particularly specialist health practitioners devalued Māori health and social service practitioners. Participants recognised that mainstream practitioners questioned their qualifications and professionalism,

and that this was a barrier to the establishment of collaborative relationships, as they did not get treated as collaborative partners.

Practitioners reported that when engaging in collaboration with other practitioners and organisations for collective action, there were challenges when different practitioners or organisations had different priorities. Participants highlighted that for Māori, the priority of the collective action also had to align with their visions and goals, and have a direct benefit to Māori.

*It depends on what it is and if it is going to have enough. If it's going to have a positive influence for our people then there will a high level of engagement and participation. But if it is of absolutely no relevance to our goals, visions, goals, values and plan then we just might not go. (PFG1)*

Participants also commented that there were service delivery challenges when working collaboratively with other practitioners. Several practitioners mentioned that at times there were different perspectives of the current priority for the service user and their whānau. Participants observed that this was often an interprofessional issue, with health and social service practitioners having different perspectives of the primary problem or the contributing factors. This was noted by participants to be part of the culture of a profession, and a form of soloing.

*To them, we're just the Māori taxi service. What do you do? And we've tried and tried and tried to build that relationship but for whatever reason. (PFG3)*

The majority of practitioners reported that when engaging in collaboration with other practitioners focused on meeting the needs of service users and their whānau, that they perceived mainstream practitioners, particularly health professionals as holding a dominant perspective in collaboration on what should be done for service users and their whānau. Practitioners acknowledged feeling undervalued by mainstream health practitioners.

Participants also reported that the introduction of Whānau ora had led to more health practitioners starting to see the value of social service practitioners in removing some of the barriers to service users engaging with health services, and also an improved ability to address the social determinants of poor health. Participants noted this as an enabler of interdisciplinary collaboration.

One of the common barriers to interdisciplinary health and social service collaboration reported by participants was the different timeframes in place to address service user and

whānau needs. Participants recognised that the time allocated to address needs was different between services within and across health and social services. Participants noted that Māori health and social services preferred to address needs at a timeframe determined by attainment of desired outcome and the preferences of the service user and their whānau.

*But in working with iwi, when it comes to how long it will be there's no time frame. It's however long it takes the whānau to achieve it. Our partners that may be working from outside, externally, might not like that. But at the end of the day that's how we practice, is however long it's going to take you to do what you've decided you'd do, what you've chosen to do, that's fine. (PFG3)*

Participants identified lack of clarity in roles and lack of transparency in communication between practitioners, as barriers to effective collaboration, particularly the formation of trust between practitioners.

Despite the wide discussion of intergenerational problems associated with substance use within whānau, participants also identified that whanau often held solutions to substance use. Several participants identified that whānau, and in many cases, particularly rural whānau, have attitudes and behaviours that increase the likelihood that they can address issues within the wider whānau collective. Participants gave examples of rural whānau having a ‘can do’ attitude, and at times, participants reported that whānau and community groups were better able to respond to crises than statutory groups.

Participants mentioned that whānau were more likely to look at local solutions to problems and needs, as opposed to relying on statutory groups such as Work and Income. Participants termed this attitude and behaviour as part of whānau resilience.

### **6.3.3 Delivering whānau centred and responsive services to address substance use problems**

In order to address intergenerational problems such as substance use problems, participants noted that practitioners need to work with the whole whānau. Several participants reported that local knowledge of whānau and whānau structure allowed a deeper understanding of what and who is available within a community and within whānui (extended family). Participants mentioned the importance of participants looking beyond a western view of family and considering the support available in wider family structures. A key aspect of this was reported by participants to understand family structures and leadership.

Participants also observed that being whānau centred, also meant that the services were driven by Māori needs and preferences. Participants reported that this meant some activities were

focused on hapū and iwi priorities, and at times this drew criticism from the community. Some services or activities were also iwi funded, and therefore not open to criticism from others.

The majority of practitioners reported that it was important that practitioners had an understanding of Māori whānau structures and roles in order to effectively engage with whānau, and access and make use of the strengths and resources of the whānau.

*It makes your job easier knowing what's available and who's who in the community. Like it might not be specifically service orientated but it may be within a whānau who is the matriarch and who you can go to, to get something for somebody else within that whānau group, if you know what I mean. So it's not specifically service orientated but you've got to know your community. You've got to know who's who within the services, but within the community itself, who plays the pivotal roles. (PFG2)*

The majority of participants identified that an important aspect of engaging with service users and their whānau, was to ensure that service users and their whānau were leading the collective action, that they had a sense of self-determination, choice and control. Participants reported when service users felt in control of the collective action, that they were more engaged with practitioners in the collaborative process.

*Sometimes you're just educating; just giving them the information and knowledge for them to make their own decisions and which path they want to take; what is best for them. (PFG1)*

Participants discussed how providing intensive services *to* as opposed to *with* service users and their whānau had the potential to create dependency by the service user and their whānau on the practitioner and their services. Participants observed that it was important to consider issues of participant responsibilities, strengths and decision-making.

Participants reported that service users and their whānau had their own strengths and could identify their own solutions. Several participants recognised how service users and whānau developing their own solutions, from their own community contributed to the self-efficacy and resilience of the service users and their whānau. A resilience that was viewed as a unique rural strength.

*Which is how it should be. It's going back to days of old because within the community; and even with family whānau, they do have their own resources and their own networks that they can come to the whānau, as long as I guess, recognising that they – as a practitioner you always make sure that you are including that network when you are working with them. It is not just about*

*agency and service. It is about actually who is your extended whanau? Who are your friends? And involving them in the process, depending on the family and whānau. Because they have just as much access to resources in that, “Actually Uncle such and such has got a job for you.” That type of stuff. Hugely powerful, amazing stuff that they come up with themselves. (PFG2)*

Several participants identified that at times there needs to be a balance between service users and their whānau determining direction and statutory services who may also have priorities or requirements for service users to meet, particularly in cases of child welfare or probation.

*And when you get a justice or agency come and say they’re directed to do that, then that’s when they have to do it. But from where we – how we mahi, it’s all about the whānau that direct us. (PFG3)*

Participants discussed the importance of negotiation when there are competing priorities between the service user, their whānau and either statutory services or even with the health and social service practitioner. Participants mentioned that it was important to reassess goals and motivation across the establishment of the collaborative relationship and course of collective action.

Participants identified that it was important to also ensure that not only did service users have a sense of control, but that they also had shared responsibilities within the collaborative relationship and collective action. Participants noted that this shared control responsibility contributed to the service user’s sense of control in the relationship and across the collective action.

The majority of practitioners reported that in order to be whānau centred, practitioners and services needed to be flexible and responsive to the different needs of service users and their whānau. Participants acknowledged that at times the important issues for service users might not be the primary focus of the practitioner. The practitioner needed a broad set of skills, along with a willingness to be responsive in order to effectively engage with service users and their whānau with complex substance use and related issues.

Participants identified that contract based timeframes placed on practitioners service delivery, that is the number of sessions or weeks a practitioner can work with service users and their whānau, reduced the responsiveness and effectiveness of practitioners. Participants noted that these timeframes were not always based on funding and contracts but sometimes by the profession or theory the practitioner may be working from.

*I think it's a lot of – within our training we were given, depending what theorists we were following, and you understand sometimes we'd be given a practice model to run by and that would be up to seven weeks, if you're using that model and another one would be something else. It seems to be timeframes. (PFG3)*

Several participants identified that iwi health and social services were focused on responsive timeframes based on service users and whānau needs. Participants distinguished that short term contracts potentially contribute to the problems faced by service users and whānau, particularly if the presenting problems are complex and intergenerational. Participants commented that engaging the service user and then withdrawing can leave service users and their whānau in a vulnerable position and leave them less trusting of future engagement with practitioners.

Participants identified that limited timeframes placed an additional emphasis on collaboration between practitioners. Participants noted that if there was to be only a limited number of contacts, practitioners must effectively identify options that address service user and whānau concerns and also ensure that there is an effective community support system in place, so when the practitioner and service withdraw, progress is not lost.

Participants identified a range of challenges to engaging effectively with service users and their whānau regarding their substance use and related problems. Participants noted that practitioners had varying levels of understanding of substance use problems, including addiction, and may have either struggled to bring up the issue of substance use or struggled to know what to do about it when it was identified. Participants reported that this lack of knowledge and ability was related to a lack of service options addressing substance use and related problems in the area and a lack of training available. Such challenges included practitioners understanding substance use and related problems and the ability to identify and respond to substance use and related problems; and understanding the fabric and associated needs of different whānau.

The majority of participants acknowledged the importance of practitioners understanding addiction in order to effectively engage with service users and their whānau. A participant mentioned that some practitioners and whānau have negative perceptions of addiction and people with addictions. This participant reported that different services and even different practitioners within services can have different perceptions of what is the correct approach to addressing substance use and related problems. Several participants observed that this can cause confusion for service users and reduce the likelihood that service users will engage with services or practitioners.

Participants reported that practitioners within and across organisations can have different views on substance use and addressing substance use, such as the difference between abstinence or harm reduction. This meant the service offered to service users was more related to practitioners' beliefs as opposed to the service user's beliefs, preferences and needs.

*No we haven't. But we also I think have to deal with people and their judgements around approaches either incidents or harm reduction; so you might work with someone who says that abstinence or not at all or you could get someone else who says, "Okay we'll support you with harm reduction." It depends on who you get in Marton and what their approach is on any given day. (PFG1)*

A participant recognised that when a practitioner has a good understanding of substance use and related problems, service users are more likely to engage with the practitioner and be open about their substance use.

Several participants also identified that through lack of training they were less prepared for changes in service users' substance use or needs. Participants noted that this was a barrier to knowing what to look for and how to respond.

These participants reported that at times they did not have the skills or confidence to bring up the issue of a service user's substance use, and that this was a barrier to effective collaboration with that service user. Participants highlighted that without these skills or confidence they needed to bring in other practitioners, which was not always what service users or their whānau wanted.

Participants identified that when they do identify substance use as an issue, they have not had the training to sensitively bring the issue up. Participants acknowledged this as a barrier to addressing both the substance use and the associated problem that they may be focusing on, such as budgeting or health.

Several participants reported that a lack of training in identifying and bringing up the issue of substance use meant they needed service users to self-identify substance use as a concern before the practitioner could refer the service user to a specialist. Participants mentioned this was a barrier.

Practitioners identified that when substance use was identified while working with a service user, that the practitioner struggled with taking the next step with the service user, that is, how to address their substance use.

*... so we don't have a competent addictions workforce. We are working with Whānau Ora and then it gets to a situation like addiction where you need those specifics ... We are not specialised, we are not trained, so we don't have to have the "I need to get you someone else conversation," because in fairness to that family I don't have the skills and ability to help you through this part. I have to give you to someone else and that sucks sometimes, because you want to be able to deal with everything and anything but it isn't the reality. (PFG1)*

The majority of participants recognised that substance use and related problems were a symptom of other underlying issues and, despite not being trained in addiction, they wanted to look beyond the substance use and identify and address the underlying contributing factors such as socio-economic deprivation or intergenerational issues.

#### **6.3.4 Summary of theme: E kore e taka te parapara a ūna tūpuna, tukua iho ki a ia: Whānau centred practice to address intergenerational problems**

In summary, service user and whānau substance use problems were identified as an intergenerational issue, which in-turn contributes to the problems being more entrenched and difficult to address within collaboration. Whānau attitudes to collaboration were reported to be influenced by past personal or familial engagement with services, which was at times also intergenerational. Identifying and understanding this intergenerational pattern was noted to be important for broader concepts of wellbeing for Māori including cultural identity and engagement. Service user and whānau history of substance use was noted to influence their willingness and readiness to engage in collaboration with practitioners. Insight and motivation were identified as important foundational components to service users engaging in collaboration with practitioners. Stigma and judgemental attitudes towards substance users by practitioners were identified as reducing service users' engagement with services. Participants also identified a rural 'can do' attitude displayed by rural whānau and practitioners, which was argued to contribute to whānau resilience and more responsive local solutions to challenges and problems respectively.

As a researcher and clinician specialising in addiction, I was surprised to see the lack of whānau centred strategies for addressing what was evidently a well-known and shared concern, intergenerational substance use problems. It is difficult to see if this is about a lack of addiction specialists operating within the area, lack of training available or a general problem for workforce development in translating research and knowledge into practice. Whānau centred approaches to intergenerational complex issues presents as an important area of further study. There is some mention in the literature reviewed regarding the intergenerational nature of substance use and related problem such as mental health problems (Taylor, Bessarab, Hunter & Thompson, 2013; Marrone, 2007).

Participants identified the importance of being aware of the different cultures of communities, practitioners and organisations. These cultures included ethnicity, profession, therapeutic and philosophical views. Active engagement with community services and groups was proposed to increase access to locally relevant and responsive solutions to complex service user and whānau needs.

As an iwi member of Ngāti Apa and my associated experience within the southern Rangitīkei and Whanganui areas, I am aware of and understand some of the intricacies of the different cultures, ways of being, ways of acting and the associated expectations that come with these cultures. This includes within and between whānau, hapū and iwi, and also between Māori and non-Māori, including the large Samoan population that had migrated into the area to work in the different factories; the different iwi members that migrated to be with Rātana; and the nuances of rural pākehā farmers. This has taken quite some time to digest, so on reflecting on the likelihood that many health and social service practitioner's will not only be from another region, but also from another country leaves me wondering how someone is brought into a community and oriented to these issues in order to effectively engage with communities, other practitioners, whānau and service users. This is an area which warrants further study.

The priorities and perspective of practitioners, organisations and sectors was proposed to be a barrier to effective collaboration. Participants reported that Māori practitioner and organisation's views were not always valued within collective action, leading to unequal power relationships and poor engagement by Māori in collaborative action. Māori practitioners' skills and experience were also noted, by participants, to be devalued by specialist mainstream practitioners. This reduced Māori practitioners' ability to participate in collaborative service delivery for service users and their whanau.

There was strong support in the literature for these experiences, particularly 'Māori collaboration fatigue syndrome' (O'Leary, 2014), or 'consultation and collaboration fatigue' (Local Partnerships and Governance Research Group, 2005). These highlighted both the tokenism and isolatory nature of consultation processes with Māori.

Participants reported a series of practitioner behaviours and service processes that either enabled effective collaboration or acted as a barrier to the establishment of collaboration with service users and their whānau. These aspects included the tensions between the focus and priorities of the practitioners and the service they work for, and that of the service user and their whānau. Participants also noted that the flexibility and responsiveness of practitioners

and services enhanced collaboration, whereas time limited collaboration was proposed to be less responsive to service user and their whānau needs.

Participants recognized practical barriers to working with complex substance use and related problem presentations in service users and whānau. Practitioners have limited access to workforce development initiatives addressing substance use and related problems knowledge and skills, particularly screening and brief intervention, whereas time limited services can reduce the responsiveness and ability of practitioners to address complex intergenerational problems for whānau.

## **6.4 Taku rākau ka hē ki te marahea: The importance of applying collaborative practice, and addressing tensions and mistakes in collaborative ventures**

Taku rākau ka hē ki te marahea, “My weapon erred in the worst way.” (Williams 1971, In Mead and Grove, 2001). This whakatauki has been proposed to be one of the few which “permit the speaker to admit making a bad mistake. In this sense the error is attributed to choosing the wrong weapon, tool or tactic” (Mead and Grove, 2001, p. 356).

This theme reflects the experiences of practitioner’s personal qualities such as values, attitudes and priorities and how these impact on collaboration; alongside the strategies they use to enable collaboration and address barriers to collaboration and collective action. This theme is reflects by three subthemes, ‘Being a collaborative partner: values and attitudes’, ‘Organisational collaboration: taking opportunities for change’, and ‘Applying collaboration: collaborative practices that support collective action’.

### **6.4.1 Being a collaborative partner: Values and attitudes**

Participants identified the importance of practitioners’ attitudes toward collaboration and personal qualities that either enabled or acted as barriers to collaboration. Attitudes towards collaboration reflected positive attitudes that enhanced collaboration with service users and their whānau, and also siloed thinking that discouraged collaboration between practitioners within and across services and sectors. The personal qualities of practitioners were reported by participants to be important qualities that supported engagement with service users and their whānau, and also contributed to a high level of professionalism and quality practice.

Participants identified the importance of positive solution focused attitudes towards and within collective action. Participants reported that assertive and positive practitioner attitudes enabled collaborative relationships with service users and their whānau; whereas being self-

focused and having an attitude of ‘patch-protection’ produced barriers to effective interdisciplinary collaborative relationships.

Several participants acknowledged that assertiveness was an important aspect in working with service users and whānau with complex substance use and related problems. Participants described assertiveness as practitioners being persistent with service users, continuing to offer support and exploring issues that service users may have been resistant to in the past.

These participants reported that service users, whānau and practitioners in rural communities respond well to an assertive approach. Participants described people from rural communities as being honest and straight up. Participants gave examples of assertive practice with service users when they are resistant or hostile. Participants mentioned that an assertive approach required practitioners to take calculated risks in bringing up sensitive issues such as substance use and child welfare.

*Why do we persevere though? Like, really why? Because, you know, that's really what I guess he's asking. Because why would you bother? I mean you get the door slammed in your face ten times and tell you to eff off but you still go back.* (PFG3)

Participants also stated that it was important that practitioners were assertive with service users and other practitioners in order to encourage more comprehensive collaboration. Participants reported that some service users talk about having difficulty understanding some specialist practitioners and having difficulty advocating for their own needs. They often decline their health or social service practitioner accompanying them to these appointments, however through assertiveness from the practitioner both the service user and specialist practitioner become accustomed to more collaborative practice.

The majority of participants described the importance of practitioners having a positive ‘can-do’ attitude in collaborating with service users and their whānau. Participants observed that a can-do attitude provided encouragement to service users and also increased the likelihood that practitioners would be creative in meeting complex needs.

Participants commented that practitioners’ interests and priorities can be a barrier to their engagement in collaborative relationships with other practitioners. Participants reported that practitioners at times can focus on their professions or service’s priorities and limitations. Participants mentioned that practitioners’ self-interest contributed to poor outcomes for service users and whānau.

Several participants reported that at times self-interest could be related to the profession itself, which practitioners named siloed thinking. Participants reported that this siloed thinking was related to some professions thinking less of other professions, often considering them as para-professionals as opposed to partners in collaboration.

The majority of participants reported that health practitioners, particularly those based within general practices or the hospital, viewed social service practitioners as unimportant and in essence irrelevant, with participants describing a view of social service practitioners as ‘airy fairy’. Participants discussed that as Māori health practitioners, whether as Whānau Ora navigators or community health workers, they experienced being criticized and devalued by specialist practitioners, even challenged as to the legitimacy of their practice.

*Oh, you’re a community health worker. Well, what qualifications do you have for that? You know?... You’re just the iwi whatever. (PFG3)*

Participants reported that siloed thinking or professional egos led to both a devaluing of partner practitioners, but also led to ineffective collective action for service users and their whānau. Participants mentioned that practitioner ego can lead practitioners to focus their effort on proving their importance as opposed to focusing on a common or collective goal.

A few participants identified that funding was an aspect that contributed to siloed thinking and even competition between providers. Participants commented that competition between providers acted as a barrier to the development of collaborative relationships and reduced the likelihood that there will be collective action for service users, whānau or the community.

The majority of participants reported that the personal qualities of practitioners were a key determinant of engagement and maintenance of collaborative relationships between practitioners and service users and their whānau. Participants discussed the personal qualities of practitioners needing to include both a caring, empathetic and humble approach to service users and their whānau, and also a strong work ethic, with consistent and hardworking approaches to collective action.

*Work with a humble nature and do what you say. If you are going to be there or say you are going to be there at a certain time, because that’s just respect. If you say you are going to be there and you don’t turn up they go, “Eh?” You’ve taken five steps backwards instead of half a step forward. (PFG1)*

Participants identified that in order to engage with service users, their whānau and other practitioners, the practitioners themselves need to have good self-care and know their abilities and limitations well.

Several participants also mentioned that knowing your whakapapa was important for a practitioner to be well and to have the ability to engage in whakawhanaungatanga with service users, their whānau and other practitioners.

*I think it's about – because I know with myself it's always about whakapapa, and knowing who I am and what my role is before I can do anything else. Because if I don't know who I am and what I stand for, then I'm a bit wavery out there. And that's about whanaungatanga; and it's not about where you're at, at this situation. This is about who you are. "Oh, I'm from there." Ka pai. You know? And it's about that. So I think it's about whanaungatanga and knowing who you are first and foremost, even before your professionalism. A long way before your professionalism in fact. (PFG2)*

The majority of participants discussed the importance of active, respectful and patient listening in order to develop effective collaborative relationships with service users and their whānau. Participants reported that the process of listening with empathy was an important aspect in building trust and ensuring collaboration was responsive to service users' expressed priorities as opposed to practitioners' needs and priorities.

*And so it's going to actually involve then some listening that needs to take place. I think there needs to be a lot of time on your part as a professional to build that relationship with them. And I always find that if I'm sitting there and I'm listening and there is some empathy, but also it will be around, you know, here is a process that can be offered to you. It's not superficial. (PFG2)*

Several participants also reported that patience and humility in interactions with service users and their whānau were important qualities in practitioners that contributed to effective collaborative relationships. Participants acknowledged that this approach required time. If practitioners pushed service users or their whānau, collaborative relationships could be damaged.

Several participants reported that practitioners with a poor work ethic can act as barriers to effective collaboration with service users and their whānau. Participants reflected that poor work ethic can be seen as a lack of commitment by the participant to their work, to the collaboration and effectively to the service users and their whānau.

*Sometimes it can be lack of supervision, it can be also the staff members own work ethic can get in the way of that and their commitment to the job. (PFG1)*

Participants recognised that practitioners with a good work ethic, who were consistent and committed to collaboration were seen as building trust, security and respect with service users and their whānau.

Several participants acknowledged that it was also important that practitioners have aroha for the service users and whānau they work with. Participants described this as going the extra mile, to go beyond the limits of their profession or organisation to meet the needs and preferences of service users and their whānau. Participants also used the term passion to reflect going the extra mile and being committed to meeting the needs, preferences and aspirations of service users and their whānau.

*It's a passion. There's an underlying, and I don't know what your value base is around, but it must because – around something about wanting to make a difference with regards to young people and that's your passion, that's your drive and it's looking beyond. Because we know the mahi that you did; it's not a job. It's a calling, what we do. (PFG2)*

Several participants also described the importance of making a difference in their practice, as opposed to going through the motions in their practice with service users and their whānau. This was something which participants linked to their identity and role as Māori practitioners.

#### **6.4.2 Organisational collaboration: taking opportunities for change**

Participants reported that the ability to respond to government changes, priorities and policy developments was a core component of bringing people together for collaborative action, and in turn either contributed to enabling collaboration or becoming a barrier to collaboration.

The majority of participants observed that the way health and social service contracts were made available by government, had acted as a barrier to collaboration and collective action. Participants commented that the way contracting was done had led to competition between organisations, and the need for organisations to protect their professional space (roles, initiatives and geographical coverage). Participants also reported that

*... under this government it's set up almost to be – so you're vying for contracts and therefore you've got to be precious about your funding and therefore you've got to meet your outcomes. (PFG2)*

Several participants also reported that government priorities reflected within policy changes did not reflect practice. Participants noted that government funding was driving practice towards 'evidence based practice', which required specific outcomes. However, they observed

that in reality, outcomes for service users and their whānau engaging in health and social service practice in the community is dynamic and different for each service user and their whānau.

*Government is really pushed for evidence based and that's really difficult when you work in community providing social services. It's hard to evidence some of those changes. You can describe what you have seen, like this young person or this family is now able to get up. You have to prove now why they are living in poverty. (PFG1)*

The majority of participants recognised that the evolution of the Whānau Ora policy in the last 10 years had contributed philosophically and in practice. Participants noted that Whānau Ora had provided a compulsory drive for health and social services to come together. Despite the drive for collaboration across health and social services, participants observed that some G.P practices have not engaged as openly and willingly with social services.

*I think it's all collaborative practice and I guess the whole push with Whānau Ora made it compulsory for some places to actually sit and start talking. I have to admit, in the last six years, they might say there hasn't but there has been some really good progress around collaboration. Being able to talk and have forums where you can sit as a team and talk about things, which you didn't have before. I mean you still get the odd ones who don't want a bar of it and you still, you know, you try and get into a certain GP practice, you're still kicking in the door. (PFG2)*

A few participants identified that there was some confusion within and across some organisations between the philosophy of Whānau Ora, that is, the goals and mechanisms of Whānau Ora versus some of the funded initiatives that are incorporated within or come from government departments that administer or are guided by Whānau Ora. Participants observed that the fundamental changes brought about from Whānau Ora, was a more holistic view of wellbeing, and that this was more of a change to the way health services were delivered as opposed to social services.

#### **6.4.3 Applying collaboration: Collaborative practices that support collective action**

Participants reported a range of factors that led to conflict between practitioners who were in a collaborative relationship. These factors were related to the different perspectives and priorities of practitioners of their service, lack of honesty and transparency and lack of leadership. Participants highlighted that these issues were reduced when practitioners established clear roles, responsibilities and boundaries in collaborative relationships. Participants identified that if tensions did occur, there needed to be 'agreement to disagree' or active engagement by management to address issues between practitioners or organisations.

Several participants identified the importance of developing a clear direction for collective action. This direction was reported to involve the development of a plan with clear progress markers. Several participants also reported that practitioners required a set of attitudes and behaviours that reinforced a solution focused approach in collective action. Specific aspects highlighted were; a clear plan with progress markers, being accountable and consistent and, monitoring and following up on plans.

A few participants acknowledged that a barrier to collective action for service users and their whānau was poor planning, with meetings often lacking clear actionable steps.

*Although I think a lot of what happens is everybody comes together but they don't actually sit down and talk about, okay this is the kaupapa; what's the plan? ... They don't assign the specific roles to anybody. It's kind of like get together and big talk fest and then walk out, gone. (PFG3)*

Several participants also mentioned that along with an overall plan practitioners also need to identify specific goals for meetings. Participants recognised that often complex problems experienced by service users and their whānau require a clear, manageable and planned process. Participants reported that a clearly stepped out plan, with assigned responsibilities and roles contributed to increased trust and in turn engagement by service users and their whānau.

A participant discussed examples of developing progress markers in plans that provided clear feedback to service users about progress made, and in turn provided reinforcement for action taken and encouragement for the next steps in the plan.

*I think a lot of what happens is everybody comes together but they don't actually sit down and talk about, okay this is the kaupapa; what's the plan? Because we want to be – like there's no planned stage to it. There's like, okay in say four months' time we hope to have done this, this, this. And who does it? They don't assign the specific roles to anybody. It's kind of like get together and big talk fest and then walk out, gone. And then these fellas here are left to sort of think, okay we talked about this, and they said they wanted this and that, and the next thing, ah, who's going to do it? (PFG3)*

Several participants reported that it was important that practitioners acknowledge that collaboration is an ongoing process, beyond the creation of a plan. Participants mentioned that this required practitioners to follow through with their commitments to service user and whānau plans. Participants observed that this included practitioners commitments to the service users and their whānau and also and commitments to collaborating practitioners.

Several participants also identified that without following through on commitments, service users, whānau and other practitioners may not trust the practitioner or be willing to continue in collaboration with them.

*I think the main thing is if you say you're going to do something, you better make sure you do it, because they'll only allow you to do it once, then the door gets shut. So if they can't rely on you, and that's part of the relationship. (PFG3)*

Participants acknowledged that accountability is an important initial building block for collective action. They also reported that once practitioners saw the benefit of effective collaborative practice, practitioners were more motivated by the successful outcomes of collaboration as opposed to just not wanting to let their collaborative partners and service users and their whānau down.

A few participants reported that monitoring the plan in place was an important part of maintaining traction and focus on initial goals.

*Devising a plan, putting it all together and review meetings because those are the most important things. Because we can come up with the most fantabulous plan but if we don't monitor and make sure things are being ticked off, it'll start going down the gurgler again. (PFG2)*

A few participants also identified that some plans for service users are done hurriedly without the knowledge of the skills and abilities of partner services taken into consideration. Participants reported that unrealistic and hurriedly developed plans can place service users at risk of poor health outcomes. Participants commented that this was a significant issue for rural service users and their whānau that had difficulties accessing specialist services, particularly after hours and on the weekends.

Participants identified a series of key behaviours and processes that enabled the establishment of effective collaborative relationships with service users and their whānau. These behaviours and processes were proposed by participants to enable effective, trusting and responsive relationships between practitioner and service users and their whānau. Such behaviours included whanaungatanga, transparent consent, privacy and confidentiality, clear boundaries with whānau and professional boundaries reducing responsiveness.

Several participants identified developing engagement with service users and their whānau as the important first step in developing a collaborative relationship that can contribute to collective action. Participants mentioned that developing engagement required a focus on

personal relationship building and at times shared activities such as meals and getting to know each other.

*I think there are some things like I have worked with the real at risk young people and engagement is really important. There are ways that you can break down the barriers so that then we can engage them. Things like I focus on just getting to know them and going out for a feed; I will do that first before I even start the work with them. (PFG1)*

Several participants also noted that engagement could be made or broken at the initial meeting with the service user and their whānau. Participants reported the need to be culturally competent with greeting and making people feel comfortable.

Participants reported that by effective engaging with service users, and developing an aspirational framework for collaborative work, it was more likely service users would be willing to actively engage their whānau within the collaboration.

Several participants discussed the importance of whakawhanaungatanga (developing relationships) through whakapapa (genealogical relationships) as an important part of engagement for Māori practitioners, service users and whānau. Participants identified that Māori practitioners would often work very hard to identify whakapapa relationships between practitioner and service user and their whānau. Participants reported that this supported effective engagement for Māori.

*Whanaungatanga - knowing who I am. Knowing where and who they are, first and foremost. So that there can be some connection. You can guarantee right from anywhere. You know, if I dig deep enough. If I go home and say, you know, talk about whānau, not about what they're doing but, you know, the whānau or whatever, you can guarantee we'll connect somewhere. (PFG2)*

A few practitioners also stated that for some practitioners, faith was an interrelated aspect of whakapapa and contributed to the development of engagement with service users and their whānau. Participants mentioned that faith and religion was another example of shared histories and shared interests, which provided a platform for familiarity and shared experience upon which a relationship could be built. Practitioners also reported that beyond whakapapa, practitioners can also find shared interests or histories to develop engagement with service users and their whānau.

The majority of participants reported that having an open and clear discussion about consent and confidentiality and privacy of information was an important part of establishing clear and transparent collaborative practice.

Several participants also observed that there are some constraints within consent and confidentiality. In some organisations, they are given specific permission to access certain health or social information and communicate with practitioners or organisations associated with these areas. If an issue arises outside of this scope they are not permitted to pursue this issue or concern.

*For us, we are constrained by – we're only allowed to discuss the clients with anybody who has any financial dealings with them, which is theoretically the scope of our work. That's the box that we in. However, there's always more going on than money, and if you become aware that there may be issues in the family, there may be depression, there may be other things where you might want to bring in or to refer them on to another agency, then you can only do it with the client's permission. (PFG2)*

Participants identified the ability and importance of revisiting consent and confidentiality over the course of collective action, as over time practitioners, service users and their whānau potentially develop stronger relationships which may contribute to an increased likelihood service users and their whānau will consent to practitioners having broader access to or sharing of information with other practitioners. Also over the course of collective action service users, their whānau and practitioner may identify additional issues that require a reassessment of consent regarding accessing or sharing information.

Several participants reported that establishing boundaries with service users and their whānau was an important step in establishing effective collaborative relationships. Participants noted that these boundaries included each other's commitment to collaborative practice, such as meetings and communication.

Participants also mentioned that this discussion of boundaries also involved the discussion of potential need to break confidentiality agreements. Participants noted that keeping the focus of collaborative efforts on improving wellbeing or in some cases the safety of children was an important aspect of establishing clear boundaries and collaborative processes.

Several participants recognised that at times relationships with service users and their whānau became close and required clarification. Participants discussed how practitioners become an important part of the lives of service users and their whānau, and service users and their whānau view their practitioner as a friend or member of their extended whānau.

*The longer you're with a family the more inclusive you become and you have to state through the stages, actually clarify, "I'm still your health professional" you know, "I'm not your friend. I'm not your cousin. I'm not your aunty." You know? You have to keep that going throughout otherwise you can start to blur those*

*lines. Maybe not from your perspective as the professional, but from their perspective. Because you do get to really become involved with some of the family. (PFG2)*

Some practitioners identified that due to living and working in the same community, that at times they will be related to service users. Participants identified that this required practitioners to clarify their roles regarding when they were acting as a practitioner and when they were acting as a whānau member.

Despite the importance of establishing boundaries between practitioners and service users and their whānau, a few participants also identified that professional boundaries at times can reduce the ability of practitioners to be responsive to the needs of service users and their whānau.

*I think that's one of the negatives that I find, is that you're controlled by these so called boundaries, professional boundaries, and I know with me as a public health nurse, many they'll just check up on you all the time. "What are you doing that for? That's meant to be a social worker's thing." "So you're going to have another car parked in the driveway? Come on." "No, this is what you've got to do." Every week we have case study reviews and you get told there and then, "No, you can't do that. That's not your scope of practice". (PFG2)*

These participants identified that professional boundaries placed restrictions on what practitioners could and couldn't do. Participants observed that at times this led practitioners to need to advocate for the needs of whānau. It was noted that it was the practitioners' responsibility to address these issues. Participants mentioned that this made an already complex role more difficult.

Several participants also noted that professional boundaries placed limitations on Māori practitioners to effectively work in a way that was clinically and culturally congruent with themselves, the service user and their whānau. Practitioners reported that being employed as a Māori practitioner, to work with Māori was tokenism unless they were able to work in a clinically and culturally congruent manner.

The majority of practitioners also identified the importance of practitioners developing and communicating their individual and shared responsibilities and boundaries in order to engage in transparent collaboration with other practitioners and services. This incorporated being aware of the limitations and expectations of the sector and profession they work in, and being aware of these with each collaborative partner.

Several participants reported that practitioners also needed to become more aware of different roles, responsibilities and boundaries of other professions within their own service before engaging in collaboration with practitioners in other services.

Participants discussed the importance of identifying and directly addressing conflicts and challenges between practitioners. Participants identified that addressing interprofessional conflict improved the effectiveness of collective action for whānau.

*Because if there's something going on we need to – between us professionals I'm talking about – we need to sort that out too, so we can work in a better way for the whānau because if we're at loggerheads there well.... (PFG2)*

A few participants highlighted the importance of clearly understanding each other's kaupapa, that is, priorities, preferences and practices in order to effectively and sensitively engage with other services. Participants mentioned that this assisted in understanding each other's boundaries.

The majority of participants reported that leadership was an important aspect in the success of interdisciplinary and inter-sectoral collaboration. Participants noted that leadership could come from an individual or collective, and enabled collaboration by bringing groups together and providing direction and coordination.

*There's a lot behind them coming on board with some of it. And I'll go back to the suicides... That's when it all started. Four to five in Bulls, and after that we had John Wilson who was a fabulous Mayor, who brought everybody together. And that happened for two years in a row. In fact we did, we worked with whānau that were involved and the community as a whole. (PFG3)*

Participants identified that leadership involved maintaining the vision of whānau centred practice, ensuring collective actions was focused on service users and their whānau as opposed to practitioner or service priorities.

A few participants noted that practitioners prefer seeking support from known colleagues as opposed to approaching an unknown representative, profession or sector for advice or support. It was also noted that these relationships were stronger if established through face to face meetings than via telephone contact alone.

Several participants identified that informal contact with other practitioners was as important as formal meetings, as this maintained the strength of the relationship. Informal contact could be as simple as calling in for a coffee or inviting a practitioner or service for lunch.

*Coffee and lunch or, you know, if a service like Jigsaw is coming over here and we know they're coming over, we invite them in for a shared lunch, that kind of stuff.* (PFG2)

These same participants reported that collective action between practitioners is enhanced through a stronger level of interpersonal relationship. Although telephone and email contact was not as preferred as personal contact for maintaining relationships, email and telephone contact was still noted to be an important aspect of maintaining collaborative efforts for collective action.

*As in an email: Once you do know people and have relationships maintaining communication by email is still useful when you can't specifically rock up; even though you might be just seeing each other once every other month in person you can still maintain a relationship with them.* (PFG1)

Participants commented that engaging with other practitioners for formal or informal meetings, or collaborative meetings with whānau and other practitioners was a time-consuming task. The majority of participants noted that funding contracts focused on outputs by way of face-to-face contacts with whānau. This focus on outputs did not appreciate the value in ongoing collaborative contact targeted at preventative measures focused on minimising problems between practitioners and whānau.

Participants observed that different professions and sectors have different perspectives on the value of engaging in networking. Participants reported that the social work profession valued and encouraging networking and collaborative practice. Participants also reported that iwi non-governmental organisation services (NGOs) were also more likely to value and encourage networking and collaborative practice.

A benefit of maintaining collaborative relationships that was identified by a few practitioners was improving ability to access information that supports working with service users and their whānau, particularly in order to address risk. However, this work was mentioned by participants to be minimal, and by way of phone contact.

*I think that kind of stuff is. Like where it's sort of really client based, where that's part of your clinical assessment. So if you're ringing up other agencies that are working with the family and saying, "Hey, what's your view? Is there any risk here?" and you're incorporating it into your assessment, I think that's valued. But don't spend too much time on it.* (PFG2)

Several participants discussed that they were less likely to be motivated to or allowed to engage in collaboration with other services and practitioners if the focus of the meeting was

not regarding a shared service user or their whānau. Participants recognised that this reduced the likelihood they could provide advice or support to partner sectors relevant to their partner sector needs.

#### **6.4.4 Summary of theme: Taku rākau ka hē ki te maraea: The importance of applying collaborative practice, and addressing tensions and mistakes in collaborative ventures**

In summary, participants identified a range of practitioner qualities that were proposed to contribute to different aspects of collaboration with other practitioners within and across different health and social sectors; and with service users and their whānau when addressing substance use problems. Practitioner assertiveness was noted to be an important aspect of addressing complex and chronic intergenerational health and social problems. A positive ‘can-do’ attitude was reported to be important for encouraging hope and perseverance when addressing challenging problems. Good listening skills, empathy and patience was identified as important when engaging with service users and whānau experiencing complex and chronic health and social problems. Reliability, consistency, and a good work ethic were identified as an important aspect of integrity and professionalism. Participants noted that these qualities built trust with service users and their whānau.

As a practitioner specializing in addictions, it was evident that participants were aware of and prioritized interpersonal skills when engaging with service users and their whānau, and with other practitioners. These were evident within the focus groups, as participants, even if they did not know each other well, were respectful and encouraging. Despite not using the term Assertive Community Treatment (ACT), it was evident that participants were promoting a model used widely in other parts of the world, in both urban and rural communities to address complex problems. This highlights the pathway of evidence-based practice, which is based on what works. That is, locally grown and evolved services meeting the needs of the local population. This is an area for further study, particularly the elements of ACT that could strengthen the current local service delivery. Within the literature reviewed, the role of kaiawhina and Māori health workers were noted to be able to bridge the gap between mainstream clinical staff and Māori patients and their whānau through active outreach in whānau homes (National Health Committee, 2010).

In order to engage transparently and with confidence with service users and their whānau, participants identified that practitioners first need to be aware of their own whakapapa, skills and limitations. Practitioners than have a role in supporting service users and their whānau to develop their own assertiveness with practitioners, and at times practitioners have a role in

assertive advocacy for service users and their whānau when working with other practitioners and services. This was particularly important as participants identified that siloed thinking and patch protection was a common barrier to interprofessional collaborative relationships and practice.

There was no mention within the literature reviewed regarding the need for practitioners to reflect upon their own cultures, biases and practices. However this is likely a limitation of the breadth of the literature reviewed. These concepts are likely discussed within cultural competencies, particularly white privilege literature for non-Māori, tau-iwi practitioners who may view culture as something other people outside of the mainstream possess, some kind of artifact from the past. However, despite the likelihood cultural competencies and self-reflection may sit in other literature, the importance of cultural competencies within working with service users and their whānau are evident within the literature reviewed (Dougherty, 2013; Marrone, 2007), including when addressing substance use and related problems with indigenous populations (Taylor, Bessarab, Hunter & Thompson, 2013; Gray, Wilson, and Allsop et al., 2014). However, there was little in the way of explicit cross over of cultural competencies in literature regarding interprofessional collaboration. There was discussion within the literature reviewed regarding addressing cultural competencies with non-indigenous practitioners through training (Gibsin, Lisy, & Davy et al., 2015; Taylor, Bessarab, Hunter & Thompson, 2013). However, there was no mention of this occurring within the southern Rangītikei. This is an area of further development for services within the area, to address a series of problems identified within this theme and previous themes, particularly due to the large number of non-Māori specialist in-reach practitioners operating within the area.

Participants identified that collective action was supported by a clear plan with progress markers. Service users and their whānau were noted to need to be in control of collective action, and that practitioners needed to focus on the needs and aspirations of the service user and their whānau. This needs to be the central focus as opposed to service priorities and limitations. Practitioners can enhance service user and whānau engagement through options and encouragement; however, practitioners require cultural competence and understanding of whānau structures and roles to appropriately engage with Māori and access the resources and strengths of whānau. Practitioners need to be consistent with their engagement with service users and their whānau, and actively monitor and respond to the plan and needs of the service user and their whānau

Consent and confidentiality was highlighted as a significant barrier to collaboration with service users and their whānau. Service user and whānau willingness to provide consent to share and access information increases alongside the level of trust in the practitioner and the level of momentum in the collective action. Practitioners need to be open and honest about the limitations and processes involved in consent and confidentiality. Participants reported that at times they can actively limit their own ability to engage in effective collaboration with service users and their whānau due to poor understanding of consent and confidentiality or by establishing limiting boundaries based on overly stringent scopes of practice. Another boundary issue faced by rural Māori practitioners that live and work in the same area, and at times were related to service users and their whānau, was the need to continually reinforce boundaries regarding roles and acceptable behaviour with service users and whānau.

There was little in the way of discussion within the literature regarding the use of clear plans and active follow-up when working with service users and their whānau. However these processes were identified as an important issue of role clarification in interprofessional practice. These aspects were identified as important to be explicitly addressed within formal agreements between organisations (Taylor, Bessarab, Hunter & Thompson, 2013), along with issues such as privacy and confidentiality (Addiction and Mental Health Collaborative Project Steering Committee, 2014). The literature pointed out the importance of shared information and communication technologies (ICT) to support collaborative case management and communication across organisations (Mays, 2013; McKinlay, Gray and Pullon, 2013; Smith & Ovenden, 2007). However, this was not identified as currently happening by participants. This is an area of potential further study.

Informal and formal contacts were proposed to be an important part of maintaining collaborative relationships with other practitioners and groups. Maintaining collaborative relationships outside of service user focused contacts was proposed to be undervalued by organisations. This is proposed to be related to funding expectations around service-user contact as opposed to collaborative practice contacts.

Direct communication between practitioners to address challenges and conflicts was also proposed to strengthen collaborative relationships and engagement in collective action. Individual and collective leadership models were also proposed to be important in providing direction and coordination within collaboration and collective action.

As a researcher, I noted that several group participants had not previously met in person, however had communicated via email or phone call. It was evident that Māori practitioners preferred face-to-face informal contacts, and that relationships built upon these types of contacts built trust, and allowed for direct resolution of conflict when it did occur. Two aspects important for the fluid and flexible collaborative practice required within a rural area.

## **6.5 Chapter summary**

This chapter presented three key themes that emerged from participants' experiences of working with service users and their whānau; and in working collaboratively with practitioners from different professions and organisations. The three themes developed provided a context and insight into the diverse nature of working with service users and their whānau within and across rural communities. Those themes and associated subthemes were:

1. Ko Apa whare rau: Collective community action starts with understanding of and engaging with the community
  - communities engaging with resources, skills and solutions
  - multi-skilled and multifaceted service delivery in rural communities
  - rural practitioners, insiders and visitors.
2. E kore e taka te parapara a ūna tūpuna, tukua iho ki a ia: Whānau centred practice to address intergenerational problems.
  - substance use problems, multiple factor that contribute to intergenerational transmission
  - culture with and across practitioner, organisation and community
  - delivering whānau centred and responsive services to address substance use problems.
3. Taku rākau ka hē ki te maraheia: The importance of applying collaborative practice, and addressing tensions and mistakes in collaborative ventures
  - being a collaborative partner - values and attitudes
  - organisational collaboration - taking opportunities for change

- applying collaboration - collaborative practices that support collective action.

The results identified enablers for collective community action, including having common goals and being aware of the community groups, cultures and preferences within the community. Changes in government priorities and funding were proposed to have produced competition between organisations, whereas the introduction of Whānau Ora was proposed to have encouraged collaboration. Intergenerational problems, including substance use and past negative experiences with services were argued to reduce the willingness and ability of service users and their whānau to address their own issues and to engage in collaboration with services.

The development of motivation to change was identified as an enabler of engagement in collective whānau collaboration (service user and their whānau addressing concerns), and also engagement in collaboration with practitioners. The attitudes of rural whānau and practitioners were identified as important enablers and barriers to collaboration. Stigma and judgemental attitudes towards substance users by practitioners was noted to reduce service users' engagement with services. A 'can do' attitude by both rural whānau and practitioners was argued to contribute to enhanced whānau collective action and more responsive local solutions to complex problems.

Rurality was identified as posing a wide range of challenges to effective collaboration, particularly the delivery of services, and recruitment and retention of staff. Service hubs based in rural communities, staffed by in-reach travelling specialist clinicians, were identified as a common response to a lack of specialists in rural communities. These services were identified as having limited responsiveness to service user and whānau needs, and participants expressed some concern that in-reach clinicians lacked commitment to the rural communities.

Participants identified that it was difficult to recruit and retain staff with specialist clinical skills, cultural competencies and broad skills necessary to address complex health and social needs. When local staff were employed, participants reported that this, at times, enhanced collaboration with service users, however they also faced additional difficulties in establishing and maintaining boundaries when working with service users who were often also related to the practitioner. Access and transport was an additional barrier faced by rural service users, whānau and practitioners. Service users and their whānau have practical and financial challenges to accessing specialist services in main urban centres, whereas staff experienced challenges with adverse weather closing rural roads, making home visiting at times difficult.

Participants identified that siloed thinking and patch protection was a common barrier to interprofessional collaboration. Interagency collaborative practices required active engagement with community structures, cultures, needs and preferences, which could then be further enhanced by community and specialist focus meetings. This was proposed to increase access to locally relevant and responsive solutions to complex service user and whānau needs.

Informal and formal contacts between practitioners were identified as important, however these were not encouraged or acknowledged by funding contracts focused on service user contact. Māori practitioners were also reported to experience being de-valued in both organisational and practitioner level collaboration, contributing to unequal power relationships. Communication was identified as a core component within interagency collaboration, which was supported by individual and collective leadership models.

A range of personal practitioner qualities were also noted to enhance collaboration. This included: assertiveness, a positive ‘can-do’ attitude, listening skills, empathy, patience, reliability, consistency, a good work ethic, and being aware of their own whakapapa, skills and limitations.

Participants also identified the importance of enhancing the ability of whānau to advocate for their own needs. At times practitioners also needed to actively advocate for whānau when engaging with other practitioners and services. Limited access to workforce development initiatives addressing substance use and related problems knowledge and skills was noted. Specialist services working within strict timeframes with limited session available was proposed to be ineffective for complex intergenerational whānau problems.

A whānau centred approach was also identified as an enabler of collaboration. Effective whānau centred practice was noted to require a clear plan with progress markers, that was led by service users and their whānau, and actively followed up by practitioners. This was argued to be supported by the provision of options, encouragement and practitioner cultural competence and understanding of whānau structures and roles. The orientation of service users and whānau to privacy and consent issues was identified as an important step in reducing a range of potential barriers to service user and whānau engagement in collaboration.

The results identified several possible gaps within the literature. This may be a limitation of the present literature review, particularly as the present literature review was purposefully broad in nature in order to reflect a broad concept of collaboration. If not a gap in the literature these areas warrant further study and possible research. These include the

responsivity of the current specialist in-reach clinic based models; whānau centred models reflective of Maori approaches to addressing collective and intergenerational problems such as substance use and mental health problems.

Awareness of the history, make-up and preferences of different cultures, faith groups and communities within the southern Rangītikei was identified as a foundational step in enabling engagement in collaboration. However, there did not present as any particular training or induction for new staff coming into the area, or in fact, many of the practitioners from various professions currently working in the area. This presents as a practice gap in the area which warrants further study and support.

The participants rural Maori model of practice has some similarities to an Assertive Community Treatment model (ACT) used in other parts of New Zealand and internationally to address substance use and related problems. There may be benefits to looking at existing literature on ACT and identify what the current study can add to this, and what ACT literature could offer to strengthen the current locally developed models of practice. Another practice gap identified in the current study, was the use, or lack of, information and communication technologies (ICT) to address issues of access to professional support for service users and their whanau, and also for practitioners who are often working in isolation.

There is an existing gap within the literature regarding the role of cultural competencies and privilege and its relation to interprofessional practice. The findings of this study can offer a stronger insight to this issue.

Barriers to collaboration identified within this chapter can be summarised as:

- lack of responsivity of rural in-reach clinic based services
- lack of transport and/or finances for travel to access urban based specialist health and social services.
- recruiting health and social service professionals
- lack of specialist health services in rural communities
- lack of professionals, reducing the ability to gender or culture match.
- travel affected by rural roads and weather conditions (snow and floods).
- lack of ongoing commitment to communities by external agencies
- ongoing impacts of colonization on access to employment, services and own culture

- time-limited service options for complex problems
- service users and whānau having had negative experiences of collaboration
- low expectancies that collaborating with practitioners will contribute to improvements
- substance use and gambling normalised within the whānau
- availability of substances in the community
- service users and whānau disconnected from their culture
- service-user intoxication at appointments
- stigma and shame related to help seeking
- whānau ‘burn-out’ due to the impact of service user’s substance use on whānau
- Māori providers seen as second rate services
- Māori participation in collaboration not valued or appreciated
- lack of practitioner addiction knowledge and skills
- lack of valuing and recognizing the work and skills on Māori community outreach workers or Māori specialist clinicians such as nurses do.
- lack of organisational strength and resources to take hold of opportunities in policy and contract changes.

Following on from Chapters Four and Five, the enablers of collaboration for service users and their whānau will be presented below.

### **Enablers of Collaboration by Māori, for Māori and with Māori.**

- community, and health and social service hui
- kanohi kitea. Being seen - Engaging in community events
- understanding the historical and ongoing cultural fabric of communities
- understanding the strengths, skills and resources within communities
- multi-skilled staff
- practitioner cultural self-reflection and cultural competencies
- local health and social service hubs.
- service users and whānau self-determination
- practitioners negotiating needs, priorities, responsibilities and actions with service users and whānau.
- practitioners understanding the different forms of whānau
- philosophies underpinning the Whānau ora model.
- clarity in roles and communication
- positive, solution focused, can do attitude
- practitioner assertive engagement and follow-up

Chapter Seven will present the discussion section. This will include a discussion of the common and unique concepts, enablers and barriers of collaboration across the three participants groups and the relationship between these findings and current literature. The discussion section will also identify limitations of the study, reflect on the role of Kaupapa Māori Methodology across the study, and provide recommendations for further research and practice developments.

## **7 Discussion**

The purpose of the current study was to explore collaboration in the context of rural communities, for and with Māori with experience of substance use and related problems. Collaboration was deemed a priority focus because it has been argued to be a viable response to complex problems occurring within areas with limited service options (Hazel & Hawkeswood, 2016; Ministry of Health, 2010). Rurality presents one such context, with limited service options (particularly specialist health, substance use/addictions and mental health services), and also barriers for existing services to access rural residents, and equally for rural residents seeking help from existing services (Gibsin, Lisy, & Davy et al., 2015; Fraser, 2006; Marrone, 2007; McLachlan et al., 2012). The reason this rural area was chosen was because it represents a range of primarily Māori communities, with a long history of established innovative collaborative health service development and delivery; and that the researcher had whakapapa (genealogical relationships) with the local iwi. This allowed access and social accountability between the researcher to these Māori communities, and ensured the research process was undertaken within the parameters of local tikanga Māori (Māori practices), such as appropriate local karakia (blessings) and hui (meeting) processes.

This study provided the opportunity to identify Māori practice enablers of collaboration. A focus on Māori service users, whānau and communities experiences of substance use and related problems allowed for the identification of unique cultural experiences, strengths and strategies for engaging in collaboration. Finally a focus on substance use and related problems provided the platform for exploring collaboration within and between whānau, communities, health and social services for this population.

An earlier pilot study by the author (McLachlan et al., 2012) identified the importance of place (geographical area), history (between peoples, cultures and organisations), and connection (between peoples and place) in understanding the functioning of ongoing collaboration in a rural community. A case study design, guided by Kaupapa Māori Methodology provided the opportunity to explore a complex area of study within a bound system (a predominantly Māori rural community), utilising culturally congruent approaches and practice.

Three different participant stakeholder groups were selected in order to provide a broader interacting system view of collaboration in relation to place, history and connections, and the impact of rurality and substance use and related problems on collaboration. These stakeholder

groups were also selected in order to explore collaboration within and across levels of collaboration, including policy, organisational, practice, and service users and their whānau. These groups were: those involved in the initial forming of services (policy level), who also provided an understanding of collaboration across time; those engaged in interprofessional practice and collaborative practice with service users and their whānau (practice level), and; service users and whānau engaging in whānau level collaboration and engagement with a range of health and social practitioners (service user and whānau level).

Participants talked fluidly about collaboration, noting that collaboration took many forms and occurred at many levels. This included collaboration occurring for a single project or event, for a shared set of concerns, or on an ongoing basis focused on service users and their whānau. Irrespective of level of collaboration, participants also noted that collaboration was an interpersonal process occurring between people, even if the person is in a position of representing an organisation or sector. Despite these participant groups representing different levels of collaboration, study participants across participant groups reported an awareness and acknowledgement of the strengths, practices and challenges faced by the other participant groups (representing different levels of collaboration). As was noted for concepts of collaboration, there were similar challenges to collaboration experienced across all levels. Often the common root cause was seen as colonization and the intergenerational transmission of the associated attitudes, beliefs and practices within policy, government priorities, organisational goals and professional practice models. These attitudes, beliefs and practices were noted by service users and their whānau to discourage them from engaging in collaboration with practitioners and services, and contributed to mistrust and poor-quality relationships between service users, their whānau and the practitioners when they were engaged in collaboration.

Alongside these common intergenerational factors were also reported to be some of the key enablers of collaboration. Participants argued that tikanga Māori provided a vehicle by which relationships at a policy and organisational level could be developed, evolved and strengthened, and by which mainstream practitioners can better engage with Māori practitioners and organisations. It was also noted by participants to be the vehicle by which Māori and non-Māori practitioners could engage with communities, whānau and service users. Participants discussed how tikanga Māori reflected taonga tuku iho, those special gifts handed down from tūpuna (transmitted intergenerationally), as first principles or original teachings to guide behaviour and ensure wellbeing. Therefore, providing guidance on attitudes, beliefs and practices around both relationships and wellbeing.

The first results chapter, ‘Kia whakatōmuri te haere whakamua: Understanding the impact of past collective action and collaboration on present and future efforts’ provides many examples of Māori leaders, communities and organisations engaging in collective action that triggered collaboration across many decades. This included exemplars of Māori collaborative practices guided by Māori values. As an example, the initial development of one of the largest Māori health organisations in the region (Te Oranganui Māori Health Organisation), started with hui being held on marae across the region incorporating different marae, hapū, iwi and community groups. This reflects a collective co-production approach; Māori beliefs and practices around consultation, strengthening commitment by acknowledging and strengthening genealogical and geographical relationship (people, place and history); and stoking a collective vision.

From the exemplars provided in the initial development of services in the area, it was evident that participants faced a range of challenges which they described as occurring as somewhat of a ripple across time. The impacts of these initial conflicts were still felt and discussed, and similar beliefs, practices and conflicts continued to occur in ongoing collaborative efforts between Māori and non-Māori leaders, organisations and practitioners. The study findings showed that from the outset of service development in the area, different health priorities and philosophies between Māori and dominant non-Māori health system (policy and organisation level collaboration) meant Māori community needs and aspirations were not being met, and that Māori organisations needed to fight hard to enter the service delivery space in order to challenge this.

Participants reported that this formed one of the ‘sparks’ for collective Māori action. Findings from across participant groups also noted the continuing impacts of this initial power imbalance as Māori practitioners’ health and wellbeing philosophies and approaches were not being acknowledged or valued by mainstream practitioners, particularly those in the medical field. Service users and their whānau reported experiencing this power imbalance and dominance of non-Māori beliefs and practices through institutional and interpersonal racism in the way of limited opportunities for employment compared to non-Māori, being treated poorly by practitioners due to being Māori, and not having their cultural needs and preferences addressed within treatment.

Rurality and substance use and related problems were incorporated in this study to explore the impact of these on collaboration across the different levels of relationships and interaction that impact on collaborative health and social practice. These include policy level, organisational

level, practitioner level and whānau level. In relation to rurality, the barriers to collaboration reported by participants matched those identified within the literature, including geographical barriers to reaching whānau and a lack of access to specialist services, which further produced a cascade of problems.

However participants were also able to link these problems at a policy level to a strategic governmental and industry disinvestment in rural communities. Participants reported that the closure of rural hospitals and closure of other necessary services and industries contributed to not only reduced access to services but also limited opportunities to address socio-economic determinants of health. Findings showed that these challenges added further fuel to the initial spark of Māori collective action, motivating a desire for Māori organisational action to build capacity to enter the service delivery system. Findings also showed particular attitudes and practices held by people in rural areas in response to these challenges that acted as enablers of collaboration, these included innovative practices such as employing multi-skilled staff; a ‘can-do’ attitude to problems; and a focus on mobilising community resources to bridge gaps in employment and health and social service options.

The other main contextual factor, substance use and related problems, was an issue predominantly affecting the service user and in turn their whānau and community. Participants noted that substance use and related problems are particularly complex, posing challenges for service delivery, service access and collaborative relationships. Findings showed that substance use rarely occurred in isolation. The related problems were reported to include co-existing mental health problems, socio-economic barriers, and involvement of statutory services such as probation, CFYs and the police related to the service users’ substance use.

Service users and their whānau reported that substance use contributed to a reduced willingness and ability of the service users to address issues within the whānau; the willingness of whānau to help the service user; and the willingness to seek help from and engage in collaboration with practitioners. Due to the compounding nature of mental health and psycho-social problems on substance use, there was often an increased severity of both substance use and mental health problems that could not be addressed by local generalist health and social services or inflexible clinic based visiting practitioners.

The findings also identified that involvement by statutory services, and to a lesser extent health professionals had at times contributed to a worsening of substance use, co-existing mental health problems and socio-economic status and functioning. The findings in relation to

the impact of substance use and related problems, tied in closely with the concepts of peoples, place and history discussed earlier. Particularly as service users and their whānau reported that substance use and these related or co-existing problems were often intergenerational for their whānau, further adding complicated whānau attitudes around substance use being normal and accepted. Whānau members reported previous experiences with services such as not having their personal or cultural needs met, or having their children removed from their care, having ongoing effects. Often this led to the transmission of beliefs that engaging in collaboration with practitioners and services may not only be ineffective, but also potentially dangerous to the whānau system itself. Service users and whānau also identified that stigmatising attitudes by practitioners towards service users experiencing substance use problems also led to a reduced willingness by service users to engage in collaboration with services, and also to inflexible and ineffective approaches by practitioners.

As stated earlier, there are common challenges and enablers of collaboration within and across the different levels involved in collaboration. Participants also reported a range of enablers to collaboration and solutions to challenges that occurred at each level. These are presented below.

## **7.1 Enablers and Barriers to collaborative practice in the southern Rangitīkei**

At the end of each chapter, the themes of the chapter were summarised, and the barriers and enablers of collaboration were presented. Of note, participants from each group identified and discussed aspects of collaboration outside of their previous or current roles or direct experience. As an example, Key Community Members (KCM's) spoke not just about the development of policy, such as Whānau ora, they also discussed the challenges whānau in the southern Rangitīkei face day-to-day, such as lack of transport and lack of employment opportunities. At the opposite end of the spectrum of collaboration, service user's spoke about their awareness that small population numbers meant there was not the funding allocated to provide local specialised services. Not only did all groups discuss collaboration across different levels, they also spoke about the impact of experiences of collaboration across time, and how this influenced present attitudes and behaviour associated with collaboration. As an example, the impact of colonisation was discussed across all three participant groups. This awareness by participants of the continuum of collaboration, and the multiple levels or layers of collaboration highlights the importance of a contextual understanding of collaboration, one that acknowledges place, relationship and time.

As identified in the literature review, collaboration is often studied at one level, predominantly interprofessional collaboration, with very little discussion of the impact of that level of collaboration upon the next level(s). Basically considering only the observable and/or manipulable variables at hand, such as collaborative practice process e.g., different types of team meetings. The literature review also identified that present models of collaboration only acknowledged collaboration at the level of professional practice systems, such as between organisations or practitioners, often as a top-down view of collaboration. This view lacks attention to the relationship between practitioner and service users and their whānau, and even less so of service users own collaborative systems within their whānau (family and extended family), whānui (extended family and close non-familial relationships) and community. The type of collaboration and collective action reflected in the bottom-up paradigm promoted by the Whānau ora model. A model which argues that collaboration and service delivery should value and take direction from the experiences, needs, preferences and aspirations of service users and their whānau.

Those models of collaboration that did acknowledge more than one level of collaboration, such as Rose and Norwich (2014) and Kodner and Spreeuwenberg (2002), identified connectivity, alignment, and feedback loops, in which the actions of one level can and does impact the other and vice versa. Therefore, the different barriers and enablers presented within the results section will be discussed aligned to the associated levels of collaboration identified and discussed in the literature review, these being strategic collaboration, organisational collaboration, and practitioner collaboration (McLachlan, 2015; LaFond et al, 2002; Jansen, Bacal & Crengle, 2008; Gibsin, Lisy, & Davy et al., 2015); with the addition of a recommended whānau level collaboration (Whānau ora task force report, 2009; Addiction and Mental Health Collaborative Project Steering Committee, 2014).

The barriers and enablers to collaboration identified by the three participant groups will be synthesized and analysed according to each of the associated levels of collaboration identified in the literature review, with a particular focus on connectivity, alignment, overlap and feedback loops, that is, the way these barriers may relate and overlap (align and connect) and influence (feedback loops) other factors. Alignment and departure from existing literature will also be discussed. As discussed in the literature review and in the chapter summary of the first results chapter (Chapter four), a Kaupapa Māori approach calls for attention to identifying and promoting what can improve outcomes for Māori, a focus on solutions, or in this case enablers (Cram, 2001; Mahuika, 2008; and G. Smith, 1997). And as discussed earlier also, enablers are often a different side of the same coin, that is, at times the lack of an enabler can

be a barrier in itself (Hazel & Hawkeswood, 2016). Therefore both barriers and enablers to collaboration will be discussed together, showing both tension and similarities. The enablers of collaboration at each level will be bolded and italicised in-text. As at the end of this section, a contextual model of whānau centred rural collaborative practice will be presented. The bolded and italicised enablers of collaboration will be incorporated within the framework. The framework will present these enablers of collaboration within the levels of collaboration reflected by participants in the study; and also show the relationships and influence of enablers occurring at and between different levels of collaboration.

Systemic racism was identified as a significant barrier to effective collaboration at a strategic level. This systemic racism was reflected in patriarchal crown systems and priorities. Participants identified that health and social service contracts were aligned with Crown priorities and imperatives, not Iwi priorities or aspirations. Examples included, contracts that were focused on singular health issues, were focused on geographical boundaries not representative of iwi boundaries, or were time limited that did not allow practitioners or services to allocate sufficient time or resources to more realistic and complex whānau issues.

The literature reviewed identified that ongoing changes in policy priorities and contracting approaches used by the Crown in New Zealand have historically reduced whole-of-government or integrated approaches to service delivery (MSD, 2003; Widmer, 2011). Participants identified that service contracts needed to acknowledge the additional time and strategic focus of collaboration, whether between strategic bodies, such as iwi and the Crown, between organisations or between practitioners and practitioners and whanau - ***Policy and contracts acknowledging and supporting collaborative practice***. Participants across all three participant groups also identified a desire for integrated contracts that provided for whānau centred services - ***comprehensive, flexible and responsive services***. Participants identified the need for not only local ***rural service hubs***, with different profession working from one place, they also identified the reality that staff often had to be ***multi-skilled***, such as addressing physical health needs and social needs. Services offering a wider range of services were deemed more attractive to service users and their whānau, as they could engage in collective action with one service, however have multiple needs met. Participants identified service responsiveness in rural hubs as being able to drop-in and see practitioners without appointments, and also for practitioners to visit them and make phone contact with them at the home of the service user and their whānau. Practitioners also acknowledged the importance of being both receptive and showing ***Manaaki*** to service users, their whānau and other practitioners that called into their offices; however they also identified the importance of

***assertive follow-up***, whereby service users and their whanau were visited, and health and social needs were actively addressed. Practitioners acknowledged the multiple stressors and demands on service users and their whānau, and the need for practitioners to have a negotiated role in ensuring complex and often chronic issues are being addressed, and the service users and their whānau are engaging in their appointments and receiving the support and entitlements available and necessary.

Changes to Crown priorities, often led to changes in health and social service funding. Participants identified that the removal of crown initiatives such as Māori Development Organisations (MDOs) led to a loss of leadership and resources for Māori health and social service organisation. This loss of organisational support meant that not all Māori organisations were able to take hold of opportunities, whereas Crown provider and services were able to keep growing in strength through increased contracts, which increased services approaches delivered by and aligned with non-Māori, European beliefs and preferences.

Organisational support, particularly from Māori focused organisations, such as Te Puni Kokiri, was identified by participants as an enabler of collaboration and collective action – ***Māori health and social organisational development and support***. Organisational support was identified by participants as enabling Māori organisations to be in a position to respond to changes in strategic government direction, and to pursue Māori aspirations. Key community member participants provided several exemplars of collective collaborative development, such as the joint iwi initiative Te Oranganui Iwi Health Authority, which each rural iwi alongside the central urban iwi in Whanganui worked together to develop a strong sustainable central base, which in turn assisted rural health and social centres to develop and become independent. These groups also developed further collective leadership functions over time, which continue to maintain a common collective voice and role in decision making with the District Health Board, these being Hauora-a-Iwi and the associated Māori Health Outcomes Action Group (MHOAG).

Another enabler of Māori organisational development, was the parallel focus on ***Iwi organisational development*** and Iwi and/or Maori health and social service development. It was proposed that for Māori to influence the development of strategic development, that Iwi groups are well resourced and organised. The development and maintenance of ***Individual and Collective Leadership pathways*** was also identified by practitioners as enablers of collaboration between Māori organisations, Iwi and Māori and the Crown. Effective

leadership was identified as utilising their *whakapapa* to bind groups, and also address conflicts within and between groups.

Organisation support was identified in the literature as an important but often overlooked aspect of collective action. Effective resourcing was identified as important for allowing organisations to learn more about each other, including indigenous and non-indigenous organisations at the outset of a collective action initiative (Taylor, Bessarab, Hunter & Thompson, 2013), all the way through to maintenance of relationships and addressing conflicts within collaboration (Easterling, 2013; Taylor, Bessarab, Hunter & Thompson, 2013), and effective evaluation (Kania & Kramer, 2013).

Creating policy and practice that ensured Māori had not only a voice, but decision making roles within and on behalf of their own Iwi, Hapū and Whānau needs was identified across the three participant groups as an enabler to effective collaboration. This meant that Māori were in a position to design and guide the development and funding of services, through to being able to make decisions about their own health care, based on equitable and culturally appropriate options in their community. At the level of collaboration between practitioner, service user and whānau, it was proposed that an enabler to collaboration was practitioners having *the ability and attitude necessary to negotiate needs, priorities, responsibilities and actions with service users and whānau*. *The philosophies of the Whānau ora model* were proposed by participants to underpin this approach and should be consulted by all groups at a strategic level as an enabler of collaboration. This was proposed to support Maori to focus not only on deficits, but Iwi aspirations and more culturally responsive models of wellbeing

Having *a common vision, goal and unified message* was also identified as an important foundational cornerstone to collaboration and collective action. Participants reported that they were often invited or required to sit on collective groups as voice for Māori, when at times, the vision or goals did not align with Māori aspirations. Therefore one of the early issues to discuss in collaboration, is the vision and goals of the collaboration.

Participants identified that when engaging in collaboration with the crown, that the process lacked equal commitment from the crown, and that Māori did not have sufficient resource or support to engage in a collaborative process. Participants reported that they felt isolated, and that non-Māori expected more from them than they were able or mandated to give. Particularly as participants were often expected to be able to give opinions or make decisions for all Māori, or for specific Māori groups when they did not have the mandate to do so. Having *consistent equal representation from groups*, with the appropriate mandate to inform

and make decisions was noted to be an enabler of collaboration. It was also noted that it was important that these people were consistently attending collaborative meetings.

Participants also identified that when they did engage in collaboration with the Crown, at times the Crown did not follow through with their commitments, which in-turn caused damage to the mana and reputation of the Māori representative. This was proposed by participants to mean Māori participation in collaboration was not valued or appreciated, therefore Māori may be more hesitant to engage in collective action where they do not see benefit for Māori, or equality or equity in decision making.

The small number of studies that discuss collaboration between Crown and iwi health and social services also acknowledge that collaborative processes are often driven by government timeframes and priorities, which led to insufficient time and attention to relationships or joint negotiation (Kowhai consulting, 2008; McKenzie, Whiu & Matahaere et al., 2008). A range of terms were identified in the literature that reflected the tokenistic options available to Māori when engaging in collaboration, these included ‘Māori collaboration fatigue syndrome’ (O’Leary, 2014), ‘over collaboration’ (Knox, 2004) or ‘consultation and collaboration fatigue’ (Local Partnerships and Governance Research Group, 2005), by which Māori experienced their involvement in collaboration and collective action as just ‘ticking the box’ (O’Leary, 2014). The inappropriate approach to seeking, accessing and supporting Māori active participation in collaboration, as discussed by participants was best captured in the literature by the study by Trotman (2005), which the author cited an attitude of “any Māori will do” (Trotman, 2005, p. 33). The issue of Maori being expected to participate without mandate was also identified by Trotman (2005) and Kowhai Consultants (2008). Whereas the large study of collaboration between five iwi and the crown by Kowhai Consultants (2008), identified the importance of understanding the diversity amongst Māori in relation to mandate and the ability to participate in collaboration. Knox (2004) reinforced the importance of understanding the diversity amongst Māori organisation by stating that each group may require a different approach around engagement prior to collaboration. Despite the strong support for the experiences of the participants in the present study, much of the literature cited from the literature review was from grey literature, some of which was unpublished and accessed via the authors, including promising studies providing description and reflection on Māori co-production models (Kowhai Consultants, 2008). Therefore some of this information may not be easily or widely accessible to those interested in learning about effective collaboration between Māori and non-Māori groups. Enablers of future collective action

between crown and Maori organisation's will benefits from *co-production models - exemplars of Māori collective action* that demonstrate approaches that have worked.

In order for Crown organisations to effectively incorporate Māori idea and preferences within strategic development, it is important that *Iwi and Maori collective representation strategies are developed*. This incorporates understanding and responding appropriately to the different level of development each Māori hapu, iwi or Māori organisation is at, and its ability to engage in a collaborative process. Participants identified several challenges that Māori groups faced in gaining consensus. This included addressing issues of territorial responsibilities within and between iwi and other Maori groups. Some organisations may therefore need more support and time than others to process issues, gain consensus and deliver a response. The literature and participant feedback identified *active participation by Māori across the full spectrum of design, decision making, implementation and evaluation* within a collaborative relationship, as an enabler of effective collective action with Māori (Local Partnerships and Governance Research Group, 2005; Kōwhai Consulting Ltd, 2008).

Participants identified the same issues representing organisational collaboration (Between organisations) and between practitioners (Interprofessional collaboration). Participants identified strong alignment with systemic racism experiences listed above, including the loss of organisational support for Māori by Māori; inconsistent and low commitment from Crown representatives within collective action with Māori; lack of organisational strength and resources to take hold of opportunities in policy and contract changes; and Crown contracts aligned with Crown priorities and imperatives, not iwi priorities or aspirations. Participants identified that this lack of say in the design and delivery of services meant that Māori were unable to address their own need or priorities. As an example, participants identified time limited service delivery, and complex reporting and paper work systems as not aligning with Māori preferences for services.

Practitioners identified a range of issues related to rurality that affected the ability of Māori providers to effectively collaborate with and meet the needs of Māori service users and their whanau. This included difficulties recruiting health and social service professionals; a lack of specialist service options, particularly mental health and addiction. The lack of specialist services within rural services led to a 'hub and spoke' model of service delivery, where urban centres acted as the hub, and specialist services were delivered on a part-time clinic basis in different rural communities (spokes). Participants from both the Practitioner and the service

user and their whanau participant groups identified that this was not responsive to whānau, whose needs may occur on non-clinic timetables days.

There was strong support within the literature reviewed for the experiences reported by participants. These were well covered in the National Health Committee (2010) document ‘Rural health: challenges of distance, opportunities for innovation’, such as isolation, travel and geography as barriers. Studies also acknowledged the difficulties in recruiting specialist practitioners (Jansen, Bacal & Crengle, 2009; Wong & Nixon, 2016; McLachlan et al., 2012). The literature reviewed also identified the common occurrence of lack of access to specialist services (McLachlan et al., 2012; Fraser, 2006, Rameka, 2006; Jackson, Judd & Komiti et al., 2007). However, there was also literature reviewed that identified the importance of knowing the local community due to poverty in rural communities and high concentration of Māori in some regions, particularly traditional tribal regions, requiring more culturally attuned services (Fraser, 2006; Marrone, 2007).

All three participant groups identified the importance of services practitioners and service users and their whānau having *knowledge of historical and ongoing cultural fabric of communities* and *engaging with the local community, including local beliefs, customs and preferences*. As discussed earlier in this chapter, any strategic development that impacts upon a local Māori community, must engage with its representatives. This does not mean having any Māori voice on a panel, it means accessing and supporting local Māori representation. Practitioners, and by proxy their organisations were noted by participants to need to be seen by the community, so service users, their whānau and practitioners from other organisations knew who they were. *Attendance at community hui and specialist health and social service hui* were argued to enable interprofessional collaboration; whereas *attendance at local community and cultural events and celebrations* were proposed to enhance not only interprofessional collaboration but connection between community groups outside of health and social service, and whanau networks. In order for practitioners to engage with communities, participants across each group identified knowledge and understanding of the local community as an important enabler of collaboration. This knowledge and understanding was argued to relate to the historical and ongoing cultural fabric of communities; the strengths, skills and resources within communities; and connections with different cultural and faith groups within the community.

Maintaining relationships between practitioners was also identified as an enabler of collaboration. As stated earlier in this chapter, local rural Maori practitioners experience

external providers as infrequent visitors. Practitioners recommended utilising both *formal and informal types of contact to maintain relationships*, going beyond emails and phone calls, to calling in for a cup of tea.

Participants identified strategies to address transport barriers including *communicating with friends, whānau and community members* to identify when rides were available. Whereas practitioners identified that there were health and Work and Income New Zealand funds that services could access, particularly for service users to access specialist medical appointments in large urban centres. However, practitioners also identified that often they would work in with other work commitments and support service users and whānau to access appointments, and at times even grocery and other shopping at large urban centres. Practitioners *providing advocacy and support to service users and their whānau to address transport barriers* was identified as an enabler to collaboration between practitioners and service users and their whānau.

Practitioners representing organisations, engaging in collaboration with multiple organisations also felt that well-resourced Crown services did not follow-through with commitments within collective action. Participants provided examples, such as suicides occurring in the community, where multiple organisations would come out to the rural community and make promises, yet not follow-through or not maintain contact for long enough to effect change. Participants viewed this type of collaboration as for the media or government as opposed for whānau or the community.

Practitioners also identified that the difference in funding given to Māori organisations, along with the lack of understanding of Crown and other non-Māori practitioners and organisations of Māori beliefs and practices, led to Māori providers and practitioners being seen as second rate. The issue of Maori health workers not being recognized and valued within collaboration was also identified in a study by Holdaway (2003).

Practitioner identified the impact of restricted contracts on their ability to effectively meet the needs with whānau, therefore effecting their ability to collaborate with whānau for the purpose of collective whānau action. Practitioners identified that the lack of availability of health and social service practitioners in rural communities meant that there was not the ability to match service users with practitioners based on preferred gender or cultures. The issue of distance, terrain and transport was identified as a barrier by all three participant groups. The terrain and weather meant that those service users and whānau living in highly rural communities were at times difficult to get to. Whereas, some service users and their

whānau did not have a vehicle, or at times finances to drive or bus into specialist appointments in one of the three surrounding urban bases, Palmerston North, Whanganui and at times Wellington. This was particularly challenging for those that required specialist medical assistance.

Service users and their whānau identified service systems as a barrier to engaging in collaboration with practitioners, particularly ‘paper work’ such as forms required to enter service or meet eligibility for different service options. Service users and their whānau also identified a wide range of issues related to confidentiality. Participants noted that concerns about lack of confidentiality was a barrier to them engaging or engaging openly with practitioners. Participants also identified having whānau members working within services as a further concern. Practitioners and service users and their whānau identified whānau living and working in the same community as both a barrier and an enabler to collaboration. For some practitioner’s they felt this made engagement easier, whereas for some service users they felt that this made them avoid services due to fear of their whole family may find out about their issues. Practitioners recognized the importance of not only employing local people, but also encouraging and involving *local volunteers* as a way of increasing capacity of local services to engage and support whānau.

Confidentiality has been identified as a common barrier for service users (Goffin, 2014). The study by McLachlan et al., (2012) reported the term ‘kūpapa’ used by participants to represent the unique challenge faced by Māori who live and work in the communities where they are from. This position of kūpapa or ‘traitor’ was seen to not only impact on service user confidence, but also to contribute to added stress to the practitioner. Whereas, Taylor, Bessarab, Hunter and Thompson (2013) reported that mainstream practitioner’s often do not acknowledge the dual roles indigenous practitioners have in both clinical responsibilities to their organisation and practice along with cultural responsibilities to their communities.

All three participant groups identified the development of trust as an important foundation to collaboration and collective action. This trust is built upon and an outcome of a wide range of factors, attitudes and behaviours. Confidentiality is one of these factors. Addressing confidentiality and boundaries was proposed as an enabler of collaboration. This was proposed to occur not only between practitioners and service users and their whānau, but also between practitioners. This required *developing a shared understanding of confidentiality and privacy* between practitioners and between practitioners, service users and their whanau; *clarity of roles and responsibilities* between practitioners and between practitioners, service

users and their whānau; *and clear plans with service users and their whānau, addressing needs, priorities and aspirations*. In order to address the challenges of working and living within a small rural area, particularly for Māori who *whakapapa* to the area, practitioners proposed the importance of developing *clear whānau centred boundaries*, which were agreed upon between service users, whānau and practitioners.

Practitioners and service users and their whānau identified a wide range of skills and understandings that when lacking, impacted upon the ability of practitioners to engage in effective collaboration with service users and their whānau. This included a poor understanding of mental health issues and substance use as a health issue, and a lack of skills to address these issues once identified. As stated at the start of this section, a focus on ensuring service users and their whānau are in a position to make decisions for themselves, is a key aspect of initial engagement in collaboration and the ongoing maintenance of collective action. Practitioners recommended that *focusing on service user and their whānau needs, strengths and priorities* enabled this approach, whereas practitioners with a positive, solution focused, can do attitude was identified by participants as an enabler of collaboration, particularly when addressing complex problems.

Service users and their whānau also identified the downward flow of systemic racism. They identified practitioners lacking cultural competencies as a barrier to collaboration. Participants gave examples of requesting and being denied cultural process within engagement with practitioners, however service users and their whānau identified when this was provided, by Māori or non-Māori staff with advanced cultural competencies, that engagement and collaboration was enhanced.

All three participant groups identified the importance of *tikanga Māori in guiding collaboration and addressing differences – tinorangatiratanga, whakawhanaungatanga, kanohi kitea and manaakitanga*. This was identified as another foundational building block for collaboration and collective action across all level; and also pathways to wellbeing. Key Community Members (KCM) participants identified that *whakapapa (genealogical ties)* could be accessed, at an iwi, waka or even historical interaction basis in order to form, strengthen or address conflict within collaboration within and between Iwi and other Māori groups (organisations, faith groups and Maori who did not whakapapa to an area) - *affirming generational bonds between peoples, place and history*. Connections between peoples and the land was also important, such as the way the local awa (rivers) connected different iwi groupings, and even Māori and non-Māori.

KCM and Practitioner participants also identified tikanga associated with meeting, establishing relationships and ***whakapapa*** (***whakawhanaungatanga***), hosting (***Manaakitanga***) and addressing tensions were important for guiding the safe, respectful and appropriate development of collective action between Māori and between Māori and non-Māori. Practitioners identified that the ability to facilitate whanaungatanga between themselves and service users and their whānau as an important foundational step in developing a collaborative relationship with whānau Māori.

In order for this level of care to be available, service users and their whānau identified that it was important that there were ***Māori health and social services available***, and both Maori and non-Māori services had ***Māori staff available***. Access to Māori staff was identified by participants to reduce barriers to engaging in collaboration, particularly when engaging with statutory services, such as child welfare or probation services. Service users, their whānau and practitioners identified the importance of ***cultural competencies*** in order to provide the tikanga associated with both collaboration and pathways to wellbeing. Practitioners identified that it was important for practitioners to reflect on their own cultures, and how this impacts on themselves, and their engagement with other practitioners (Māori and non-Māori) and with service users and their whānau. Practitioners identified that several aspects were important when considering cultural competencies, these included understanding the different forms that whānau may take for service users (whakapapa and kaupapa whānau); knowledge of the local geography and the history of these such as the mountains and rivers, and how the different hapū and iwi connect to these.

Cultural competence has been identified as an important skill and attitude in engaging with Māori and other indigenous populations (Dougherty, 2013; Marrone, 2007), including knowledge of spiritual and health beliefs (Marrone, 2007), of colonisation (Bessarab, Hunter & Thompson, 2013), and the cultural history of the area and its peoples (Bessarab, Hunter & Thompson, 2013; Dougherty, 2013; McLachlan et al., 2012; McLachlan, 2015).

Service users and their whānau also reported further downstream impacts of systemic racism, including direct discrimination and racism by staff and statutory service systems. They reported that often services and practitioners did not care about their needs, or did not provide access to service options or entitlements due to their culture, substance use history or affiliations with gangs. Racism towards service users have been identified within the literature as barriers to collaboration (Jansen, Bacal & Crengle, 2009; Rameka, 2006). This racism was

identified as contributing to poor health outcomes including mental health and substance use problems (Marrone, 2007).

Service users and their whānau identified barriers to their ability to collectively address issues as whānau; and also barriers that affected their ability to engage with practitioners in collaboration. Service users and their whānau identified substance use and gambling as normalised within the whānau. Participant's also identified that substance use, and positive beliefs about substance use as a coping strategy for distress was an intergenerational problem for whānau. Participants identified *addressing intergenerational values, beliefs and practices that conflict with traditional whānau/whānui values, beliefs and practices* as an important aspect of 'breaking the cycle'. One example provided by a large whānau that were interviewed, was the role of learning whakapapa and tikanga Māori as an anchoring force in bringing the whānau together for a positive outcome.

Further attitudinal barriers reduced the likelihood that whānau would seek to address these issues or seek help externally from services. The impact of intoxication on service users was argued to reduce their ability to engage with practitioners and make their appointments, whereas, whānau reported being 'burnt-out' by the behaviour associated with intoxication and a substance use lifestyle. Stigma associated with substance use, mental health problems and appearing 'weak' was noted by service users and practitioners to reduce the likelihood that people will seek help within and outside of the whānau system. Practitioners identified that the availability of legal and illegal substances in the community was also a barrier to help-seeking. This availability was proposed to contribute to the normalisation of substance use and work as a barrier to those that may want to change. This normalisation of substance use was identified within the pilot study for the present research by McLachlan et al. (2012).

Service user and their whānau participants identified a range of strategies that enabled them to engage in collective action within the whānau and community, and where necessary with practitioners from services. Participants identified the importance of *whānau hui* to discuss issues, plan and approach and at times to review what has happened and how any engagement with practitioners has been going, particularly when engaging with statutory services. *Whānau and community advocacy and support* were identified as important. For service users this was not limited to family. Service users may use an aunty for an advocate or may use a local minister or neighbour. Service users also identified neighbours and faith leaders as whānau, people that were available to them and cared for them. Particularly for isolated

service users and whānau, *connecting with neighbours, community and faith leaders for support* was noted as an enabler of whānau collective action.

There were mixed views on whānau members becoming involved with service user's issues or engagement with services. Some participants viewed it as helpful that they could invite whānau to attend appointments when they wanted, and some service users identified it as helpful when *Whānau and friends directly bringing up their concerns with whānau*, such as their substance use or mental health. This included *encouraging help-seeking*. However, there were strong views from service users that they had responsibility to reflect on their own needs, the harm to self and the harm occurring to others. Personal motivation to change and to engage in collaboration, whether within the whānau or with services was seen as an important enabler of collective action - *Self-reflection regarding needs and impacts of substance use*. Alongside this personal motivation, was a commitment to *self-care*. Service users identified that it was important that they managed to schedule down-time amongst at times, multiple agency appointments, by doing things such as gardening. Having a personal diary was also proposed to assist in managing multiple demands and maintaining wellbeing.

Service users, their whānau, practitioners and key community member participants reported that low access to employment contributed to considerable poverty, and that this was an issue or rurality, and also a downstream impact of colonisation, where Māori in their own rohe (area), and those from outside, lacked access to familial lands, support and even culture. The barrier of transportation discussed earlier further compounded this, as seeking and maintaining employment in urban areas required a car, finances and additional travel time; Whereas being dislocated from one's culture was identified as a barrier to service users accessing traditional pathways to wellbeing and healing within the whānau and through hapū and iwi systems.

Service users and their whānau, along with practitioners identified that previous negative experiences of collaboration for service users and their whānau reduced the likelihood that they would engage in collaboration with practitioners, and if they did engage, that they would have low expectations of positive outcomes. Whānau participants reported that this had been an intergenerational issue, where parents had experienced negative outcomes from collaboration with practitioners, particularly from statutory services, and that their children were now engaging with these same services. These experiences reflect a common barrier identified across all three groups, which was the whakapapa of relationships, the negative experiences from the past that continue to affect groups, organisations, whānau and individuals. Whether this is colonisation, past conflict between iwi or past competitive

contracting between organisations, *addressing historical experiences and conflicts, and the attitudes, beliefs and practices that stem from these* has been identified as an entry point to new relationships and collaborative efforts for collective action. The influence of past negative experiences of collaboration for Maori, including intergenerational experiences was identified in research by Jansen, Bacal and Crengle (2009) and McLachlan et al. (2012).

### **7.1.1 Contextual model of whānau centred collaborative practice**

The current findings extend the literature by providing demarcations between previously overlapping levels of professional practice collaboration, such as the different attitudes and behaviour applied by practitioners when engaging with other practitioners (interprofessional practice) and practitioners' attitudes and beliefs when engaging with service users and their whānau (practice level collaboration). The findings also support a whānau collaborative system, in which the service user and whānau engage as a whānau unit to address problems, and engage wider community members, resources and opportunities as a first port of call when seeking support. These community members can be seen as sitting within a broader whānau whānau system. The term whānau is utilised within the southern Rangitīkei, and in other parts of New Zealand to represent service users, clients or patients, as from a Māori perspective, the individual is a whānau member and should be referred to as such. In this model, the term 'whānau whānui' is used to represent the family and social unit to whom the individual belongs. The term whānui is a modifier which extends or broadens the concept of whānau to be inclusive of non kin or kaupapa whānau, such as friends, neighbours and community members. When referring to the present study participants, the terms service user and whānau will continue to be used.

This broader community collaborative system has been overlooked within the models of collaboration identified in the literature review, with most focusing solely in a 'top-down' professional practice system. Therefore, a conceptual model (Figure 6) has been developed from the findings that illustrate the different collaborative systems, the different levels of collaboration within each system and the relationship between levels; and then the relationship between the two systems.

The contextual model of whānau centred rural collaborative practice (Figure 6) contains two collaborative systems, the whānau-centred collaborative system (in green), and the professional practice collaborative system (in blue). Within each level of collaboration in both collaborative systems, enablers to collaborative practice, sourced from the findings are presented.

Within the whānau-centred collaborative system are three levels, whānau, whanau whānui and iwi/hapū/community. Within the model the term whānau is used to represent “service users”. The term ‘service users’ was used within the study to represent those who had experienced substance use and related problems and accessed services. As presented in the model though, individuals may access their needs from within the whānau-centred collaborative system, and not engage with the professional practice collaborative system.

The second collaborative system is the professional practice collaborative system. There are four levels of collaboration within this system: strategic, organisational, interprofessional and practitioner. Strategic level collaboration reflects government strategy and policy that impacts a range of factors including funding and planning priorities and expectations. Organisational level collaboration reflects collaboration between different organisations within or across health and the social sector. Organisational collaboration follows directly from strategic development, that is, strategic level enablers also apply to organisational level collaboration when organisations are engaging in collaboration for collective action (at a strategic level). However, within the present model, enablers of collaboration between professional health and social service systems and whanau whānui are promoted. Within Figure 6, issues of service type are also included to reflect the role organisations and their services have in collaboration with whānau and whānau whānau. As discussed earlier, interprofessional and practitioner level collaborations have different foci (the other professional and the whānau and whānau/whānui respectively).

Both collaborative systems are encased by whakapapa. The term whakapapa can be seen as layering (papa being a layer or whenua) and whaka (to action). Whakapapa is also commonly used to reflect historical relationships, particularly genealogy, and for Māori the connection between people, between people and the land, and people and migration (waka). Therefore the concept of whakapapa is used in this model to reflect the overarching findings related to peoples, place and history and the relationship between these. Whakapapa is represented in the model by the border of kowhaiwhai (traditional visual narrative pattern) which both frames and flows through every aspect of the model.

Whakapapa reflects both the transmission of intergenerational knowledge and values that enhance collaboration and wellbeing and also those that can act as barriers to collaboration and wellbeing. The vertical arrows between the levels of both collaborative systems reflect the nature of this view of whakapapa permeating each level, represented by the systemic influence of these attitudes and behaviours across every level of collaboration.

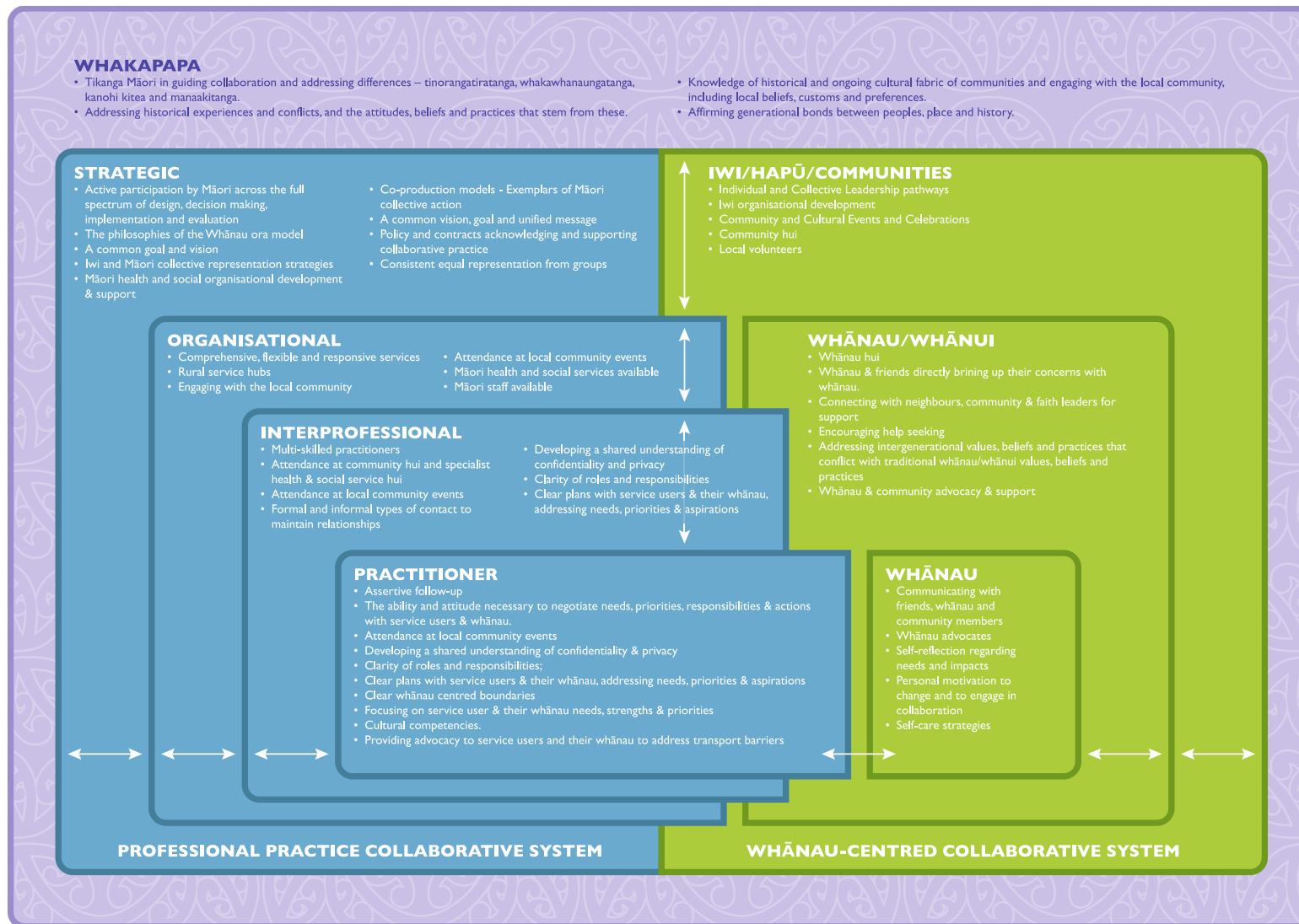


Figure 6: Contextual model of whānau centred rural collaborative practice

The concept of whakapapa also incorporates values, beliefs and practices that enhance collaboration. Interviews revealed knowledge of and engagement in whakapapa (genealogical relationships, both past and present) and traditional values, beliefs and practices increased access to traditional healing and relational practises that enhance collective and individual wellbeing. Addressing intergenerational beliefs and practices that do not align with/create conflict with these was identified as an important process for addressing complex intergenerational problems, such as substance use, violence and mental health problems.

Knowledge of traditional local beliefs, customs and preferences, along with local leadership structures, whānau and processes was noted by participants to enhance the ability of Māori whānau and practitioners to affirm generational bonds between peoples, place and history; and also for non-Māori practitioners and organisations to engage in collaborative relationships with Māori whānau, practitioners and organisations.

The two collaborative systems within this whakapapa can be seen interacting within Figure 6. This image reflects the reality of attending to both rurality and work with whānau. The model represents the professional practice collaborative system moving level by level into the whānau collaborative system. The organisation engaging within the community; the interprofessional practice level engaging with whanau whānui therefore creating a broader concept of interprofessional practice (including whānau); and then the practitioner engaging directly with the whānau. This movement into the whānau system reflects the findings that rural Māori service users and their whānau prefer home-based outreach services that engage the community and whanau whānui. This does not prevent the movement of whānau and whanau whānui into the professional practice collaborative systems to engage with practitioners and services. Therefore this model could be presented in many different ways.

## **7.2 Relationship with existing literature**

There were a wide range of factors in common between the results produced in this present study and those identified within the narrative literature review that formed the background of the present study. These included challenges and enablers occurring across many of the different collaborative levels presented within the whānau centred contextual model of collaboration (Figure 6). As an example, many of the practical and attitudinal barriers to collaboration associated with rurality in the literature were supported by the present results, as were barriers associated with substance use and related problems. However of note, the present study contributed a more specific cultural understanding of barriers and enablers of collaboration for rural Māori service users and their whānau, such as the benefits of having

local Māori practitioners employed within services, along with the challenges of boundaries and affiliations for staff living and working in these communities. Also the present results identified the need to take a broader intergenerational view of the development of problems, challenges to collaboration and also potential guidance for developing relationships within collaboration and for the purposes of healing. Substance use and related problems were identified as intergenerational issues, which were often compounded by health and psychosocial problems. Participants noted that at times these problems were made worse by ineffective or inappropriate interventions by practitioners. Healing was also framed as connected to intergenerational teachings stemming from whakapapa. Participants identified that whakapapa, colonisation, marginalisation and migration impacted on the transmission of this knowledge and these skills.

As discussed in the literature review, models of collaboration developed internationally have incorporated little to no concepts or recommendations relevant to culture. Martin-Rodriguez, Marie-Dominique and D'Amour et al. (2005) proposed that culture was one of several key systemic determinants of successful collaboration, however culture was poorly described and was not incorporated across all aspects of collaboration. Likewise, Hazel and Hawkeswood (2016) proposed culture as one of six common collaborative elements, however the description of culture was focused more on organisational or project culture, with very little description or discussion of the role of ethnic or indigenous cultures. From what little is available nationally, this has not been evolved or made more widely available across research or practice sectors. Exemplars of collaborative processes with iwi Māori and Māori organisations at times sit in sectors outside of health and social practice, such as the work on fresh water management by Robb, Harmsworth and Awatere (2015).

Rose and Norwich (2014) proposed a comprehensive contextual framework of collaboration, which accounted for collaboration across levels, i.e., individual, group, context, and policy levels (Figure 1). These contexts and the factors within these contexts are argued to interact and influence each other through various feedback loops. The model accounts for several of the practical and personal aspects of collaboration identified by participants of this study, including policies and structures; the purpose of collaborative action; roles and responsibilities; leadership and management structures; shared/differing concepts and knowledge; kinds of joint activities; and personal and professional skills. However, as the contextual model by Rose and Norwich (2014) was focused on professional practice, it was unable to address issues relating to whānau, whānau whānui or community level collaboration, that is, the ability of whānau and whānau whānui to work as a collective to

identify issues and mobilise resources from within the whānau whānui and broader community. Without the acknowledgment of a whānau-centred collaborative system, collaboration within the health and social service sector presents as an action ‘done to’ whānau, as opposed to enabling whānau and whānau whānui to better address their own issues. This potentially contributes to whānau needing to re-access service in the future, as their collective self-care competencies have not necessarily been developed or strengthened through the process of engagement with practitioners and services.

Despite the model by Rose and Norwich (2014) incorporating the history and experience of past collaborative relationships at the group and individual level within their model, it was evident that this view was somewhat limited. The present research identified the importance of whakapapa at all levels of collaboration, including the history of policy development and change influencing the context of collaboration, the expectations of collaborative practice and the relationships between organisations on an ongoing basis. As discussed, these historical factors were seen as permeating what was designed and delivered to whānau and their whānau whānui. The relationship between iwi Māori and the Crown, built on a background of colonisation, can be seen in the experience of Māori whānau, whānau whānui and practitioners, including:

- marginalisation
- mistrust
- discrimination
- racism
- lack of, or inappropriate allocation of services
- poor service design, flexibility and comprehensiveness
- lack of knowledge and application of Māori cultural beliefs and practices
- lack of acknowledgement, valuing or inclusion of Māori practitioners in collaborative practice
- lack of equal representation, mandate and commitment from crown within collaboration.

The importance of acknowledging and addressing the ‘colonial footprint’ is evident in this study and supports earlier work in New Zealand by Knox (2004), Trotman (2005) and

Kōwhai Consulting Ltd (2008), and also work in Australia by Taylor, Bessarab, Hunter and Thompson (2013) and Gray, Wilson, Allsop et al. (2014).

This study found several similarities with the recent Australian research on collaboration between Aboriginal substance use treatment services and non-Aboriginal services (Taylor, Bessarab, Hunter & Thompson, 2013; Gray, Wilson, & Allsop et al., 2014). These studies identified the impact of colonisation on all levels of collaboration (funding, power differential and orientation of practice). However, these studies did not incorporate the experiences of service users or their whānau, and despite the acknowledgement of historical issues, there was little in the way of direct research of these issues. Also, culture appeared to be referenced as a barrier to collaboration by way of the intergenerational trauma associated with colonisation. However within the present study culture is seen equally as an enabler of both collaboration and healing.

The present study also aligns with New Zealand literature, which focused on collaboration as a core component of community-level non-governmental social service delivery (Ball & Thornley, 2015; Hazel & Hawkeswood, 2016; Knox, 2004; Local Partnerships and Governance Research Group, 2005; National Health Committee, 2010; Widmer, 2011). However, the present study proposes that a collaborative model, which focuses on community as an independent collaborative system (as within the whānau-centred collaborative system), is a core partner of the professional practice systems. It is felt that the combination of both systems is vital for strengthening the other and meeting the complex health and social needs of whānau and whānau whānui.

### **7.3 Enhancing health and social service collaboration in rural New Zealand: The way forward**

As discussed earlier, collaboration takes many forms, serves many functions and occurs at many levels. Despite the differences, there are important learnings to be taken from this study, which can be applied directly to collaborative practice, build upon existing literature, and can provide the foundation for future research. When considering the application of the proposed contextual model of whānau centred collaborative practice (Figure 6), there are two distinct approaches to discuss. The first is how the different enablers of collaboration are best applied in order to effect change in the health and social service sectors. The second is understanding Māori values and approaches to collaboration, and how these may apply to collaboration at different levels

### **7.3.1 The application of the contextual model of whānau centred collaborative practice**

When considering how to apply the factors identified as enhancing collaboration (enablers) or addressing challenges to collaboration as represented within the proposed contextual model of whānau centred collaborative practice (Figure 6), there are several potential avenues to ensure these are in a position to effect change in the health and social service sectors. An initial practical step for effective collaboration with iwi and Māori organisations would be providing guidelines at a policy and organisational level, based on the model. This would include training in understanding and addressing the whakapapa of people and organisations to people, place and the kaupapa (topic of the collaboration). This allows for discussion of historical barriers and relationships, which can both, reduce barriers and enhance collective action - applying the ‘whakapapa level’ from the ‘Contextual model of whānau centred collaborative practice’ to collaborative practice and collective action.

Formal agreements between organisations provide the opportunities to discuss and clarify values, relationships, roles and commitments. Agreements between Crown organisations and Māori health and social service organisations should also address issues of equity. Funding should have a dual focus on strengthening the capacity and capabilities of Māori organisations to address their own priorities and continue to be key partners in the health and social service sectors.

Funding agencies can expect organisations to demonstrate the establishment of formal agreements with both health and social services and community organisations and to develop shared care agreements and service user pathways. This approach acknowledges the likelihood that service users experiencing substance use and related problems, and their whānau access multiple agencies, and their journey within and through these services should be planned for and monitored.

However, as discussed, collaboration is primarily a relationship approach, therefore both formal and informal mechanisms should be in place to enable collaboration between organisations and practitioners.

At the level of interprofessional and practitioner collaboration, training workshops can be provided to reinforce the importance of both whakapapa and attitudes, beliefs and practices that enhance collaboration with Māori whānau, whānau whānui and practitioners. Further digestible pieces of academic writing (journal articles) can also be written based on the study data and model, which contribute to both national and international literature, and also to the

health and social sector workforce through professional training programmes in Universities and Institutes of Technology.

It is also important to recognise the tensions of living and working in small rural communities, and of Māori practitioner's at times holding overlapping roles and responsibilities to and with service users, whānau, the organisation, iwi and faith groups. More work is required that enables Māori organisations and practitioners to discuss and develop guidelines around ethical practice unique to Māori. At a whānau and whanau whānui level, two approaches could be made. Firstly, the importance of practitioners and interprofessional practice acknowledging and valuing the role of whānau and community can be applied to professional training programmes and community workshops. Secondly, guidelines of effective collaboration for whānau and their whanau whānui can provide personal exemplars of success, address issues of stigma and encourage help seeking. This type of guide can provide suggestions around helpful strategies to support self-care and how whanau whānui as a collective can address complex substance use and related problems. This type of self-help guide could also make recommendations for effectively and safely engaging in collaboration with practitioners and services. This could include discussion from a whānau and whanau whānui perspective around privacy and confidentiality.

#### **7.3.1.1 Applying the whakapapa level of collaborative practice**

The concept of whakapapa presented in the contextual model of whānau centred collaborative practice (Figure 6), and discussed within the results sections, reflects a Māori approach to relationships. The whakapapa level of contextual collaboration is an overarching layer of collaboration that acknowledges the connections of people, place and time. Addressing this overarching level of collaboration therefore requires further discussion.

Applying the concepts within the whakapapa level requires taking a longitudinal approach to understanding relationships between peoples, place and history. Also of importance is identifying people, places or events that bind people together, or addressing intergenerational health and socio-economic problems affecting whānau.

As identified by study participants, and reflected in the model, tikanga Māori (Māori practices) is proposed to be a guiding and healing process, which has been transmitted across time through whānau. Tikanga Māori, in its many forms, whether it is welcoming people onto a marae, or conducting a whānau hui, reflect the values, roles and expectations within relationships between people, relationships to the present concern, and the aspirations for the

future. In essence providing a culturally congruent way to engage with other individuals and groups.

Therefore, whether engaging with a Māori collective group, such as an iwi or Māori health organisation or engaging with a service user and their whānau, it is of vital importance that tikanga Māori is followed, and at a level guided by the Māori individual or group being engaged, that is, responding to the multiple realities of Māori identities. As noted in the literature review, and the key findings of this study, engaging with Māori requires both a focus on values and process. In understanding and valuing the role of whakapapa and tikanga, those engaging in collaboration with Māori will be in a better place to develop strong working relationships with Māori.

Eppel, Gill, Lips and Ryan (2008) warned that attempts to define or lay ‘steps to success’ in relation to collaboration would be ineffective or the “death of an initiative” (Eppel et al., 2008, p. 12). However, in relation to engaging with iwi Māori or Māori organisations, this study identified a series of very important steps that at each stage (parts of the process) reflected and incorporated key Māori values and processes.

Each step including the value, process and implications are represented below in Table 1. The cultural concepts (reflected as values) will be listed on the left-hand column, followed by the process and practices necessary to apply these customs in collaborative practice. This may include enablers identified within the results section and/or from the literature review. Finally, the implications of this will be identified. This may include addressing either or both barriers to collaboration and/or enacting enablers to collaboration with and between Māori organisations, practitioners and whānau.

Table 2 - Whakapapa level collaboration: Applying tikanga Māori in collaborative relationships

Māori concept	Process	Implications
Tino rangatiratanga <i>Self determination</i>	<p>Māori actively involved in service design, delivery and evaluation.</p> <p>Focus on iwi aspirations, whānau ora (family wellbeing), and equity in health and social service delivery and wellbeing outcomes.</p> <p>The development of common vision, goals and unified message to guide collaborative efforts.</p>	<p>At a service use and whanau level, collaboration is focused on their aspirations, and service negotiate roles that support whānau leadership.</p> <p>At a strategic and/or organisational level, this insures that Māori aspirations are at the forefront, Māori are actively engaged, and committed to collaboration.</p>
Kanohi ki te kanohi, rangatira ki te rangatira <i>Face to face, leader to leader</i>	<p>Having key representatives and decision makers consistently at the table.</p> <p>Ensuring equal representation at collaborative meetings, including those mandated to inform and make decisions.</p> <p>Ensuring iwi and Māori organisations have the support and resource to develop strategies and provide input and engage in decision making within collaboration.</p>	<p>Having the right people, whether this is the practitioner or CEO attending face-to-face meetings.</p> <p>This ensures both sides are contributing equal commitment and respect.</p> <p>This acknowledges the status and mana of those present.</p> <p>This also increases the likelihood that decisions can be made and momentum continued.</p>
Whakapapa <i>History, genealogy, and past and present connections</i>	<p>Knowledge of historical and ongoing cultural fabric of communities and engaging with the local communities including local beliefs, customs and preferences</p> <p>Addressing historical experiences and conflicts, and the attitudes, beliefs and practices that stem from these.</p> <p>Addressing intergenerational values, beliefs and practices that conflict with traditional whānau values, beliefs and practices</p> <p>Ahu, Hoare and Stephens (2010) discuss a three-stage process within conflict resolution utilised by Māori, incorporating take (issues), utu (compensation) and ea (harmony or balance). This highlights the importance of naming, processing and negotiating when past hara (offences) that have</p>	<p>At a service user and their whānau, and strategic and organisational level, barriers to collaboration based on previous engagement and historical events can be addressed.</p> <p>This may include ongoing down-stream systemic and interpersonal issues such as stigma, racism, colonisation and intergenerational trauma.</p> <p>Preferences and processes for moving forward can be discussed.</p>

Māori concept	Process	Implications
	occurred.	
Whakawhanaungatanga <i>Establishing effective relationships</i>	Relationship processes incorporate tikanga Māori.  Affirming generational bonds between peoples, place and history.	Relationships are strengthened, commitment from both sides is reflected in relationships built through process and over time.
Manaaki <i>Hospitality</i>	Maintaining relationships through formal and informal contact.	Opportunity to host and be hosted to show hospitality and respect and nourish interpersonal relationships.  Ongoing contact can also occur at both hui and over the telephone and email. Contact is therefore both relationship and task centred.  Collaborative relationships are maintained through strong interpersonal relationships.
Tika me te pono <i>Doing the right thing and being honest.</i>	Having clear plans which identify roles, responsibility and process.  Following through with commitments	Issues such as privacy and confidentiality are discussed.  Collaborating partners clarify their roles and responsibility and commitment to vision, process and plan.

Therefore, as outlined in Table 1, engaging in collaboration with Māori stakeholders, whether whānau or organisational representatives, involves addressing any existing relational barriers that have been influenced by people, experiences or events over time. From this, it is then important to ensure that the right people are consistently at the table in order to develop collaboration at the right level. As part of this process, tikanga Māori guides the development of meaningful relationships, co-developed with a common vision and unified message that aligns with Māori needs, philosophies and aspirations. This foundational work can be supported and reinforced by developing clear roles, responsibilities and commitment vision, process and plans. This is also done through both informal and formal methods of contact between groups, particularly between key decision makers in establishing and maintaining collaboration. These approaches can be planned for and resourced at the start of a high-level project between iwi and the Crown, or between a practitioner and whānau.

## **7.4 Limitations and Strengths**

One of the primary limitations of the present study relates to the inability of the researcher to confirm the presence of or severity of substance use problems or disorders in the service user participant population. Participants were only required to self-identify having had experienced a substance use problem. The fact that most participants who responded to recruitment advertising did so via local health and social services as opposed to an alcohol and drug service was due to the fact that there were no established alcohol and drug services in the communities under study. There was a DHB outpatient clinic in one of the urban hubs (Marton) and an in-reach alcohol and drug clinician held a clinic there two days per week. However, despite advertising for participants at this service hub, no participants responded to recruitment advertising from this location.

Another limitation of the present study was the coverage of health and social services within the practitioner participant focus groups. There were several services, which were unable to send a participant to one of the three focus groups, or declined the invitation to participate. Of note was the lack of participation by medical specialists from the general health clinics; the Department of Corrections and Police; Work and Income, and the in-reach alcohol and drug practitioner. These different representatives reflect a lack of representation in the present study of several services having a role in responding to alcohol and drug problems and on whānau accessing alcohol and drug services. Probation services (Department of Corrections) often require whānau with court conditions related to substance use offending to access alcohol and drug services. Therefore participant feedback on working with whānau using substances and in working collaboratively with other services would have added important information to the present study. A large number of participants reported past access to alcohol and drug services that were facilitated by the Department of Corrections. The primary health care sector is another level of care that engages in screening, brief interventions and in facilitating access to services for this group. As noted in the results participants had noted having substance use identified via their GP, but not being supported to access services to address this problem. Accessing participants from this group was identified as a challenge in the pilot health and social service practitioner focus group study (McLachlan et al., 2012).

In order to address the problem of poor engagement in collaborative research by the general practice sector, the researcher made a presentation at the 2012 New Zealand Rural General Practice Network conference in Queenstown, and published an article in the Rural General Practice Network News online magazine (New Zealand Rural General Practice Network,

2012). The researcher also made contact with the WPHO to discuss strategies for accessing practitioner participants from the local general practices, and made direct phone contact with administrators or nurse practitioners at both general practices, along with personalized letters to doctors at both of the general practices working within the area. Accessing this population in future research may require more personalized individual approaches, as opposed to focus groups. This may include on-site interviews, telephone interviews, or online surveys.

Within the study, the majority of participants also identified being currently engaged with Work and Income, and that at times issues of alcohol and drug use were discussed, such as accessing a sickness benefit related to a substance use problem or due to drug testing relevant to seeking work. Work and Income participation in the focus groups may have identified current difficulties in pathways to alcohol and drug services that could be addressed in the recommendations of this study. As Work and Income is a government department, future research wanting access to representation may require higher-level contact with regional or national managers in order for participants to have permission to participate.

This study presented many areas of strength. The first being that this study focused on a hard to access population, that is 1) Māori; 2) Māori with histories of substance use and related problems; and 3) their whānau. Taking a Kaupapa Māori research approach in the present study enhanced the likelihood that practitioners and organisations within the area promoted the recruitment process in locations and at situations where potential study participants were. This was done in two ways, and discussed in detail in Chapter Three (methods chapter). Initially the researcher engaged in a wide range of hui (meetings and presentations) to present the whakapapa of the researcher and the intent of the study. This strengthened ‘insider’ status and whanaungatanga (quality of relationships) between the researcher, community and Māori health and social service workers. Following this, the author facilitated a community workshop for Māori health and social service workers, delivering education on screening for alcohol and drug problems and brief interventions. This increased the ability and knowledge base of participants to identify potential participants with substance use problems.

Very little information is available on the experiences of Māori with substance use and related problems within treatment, and even less for those with substance use and related problems that do not access services. Despite the lack of objective support for the presence of substance use problems, participants identified a wide range of health, family, social and legal problems related to their substance use. These may provide some support that the participants group did include participants with a substance use problem, and for some, these may have been severe.

These problems included loss of relationships, familial conflict, incarceration, hospitalization, family and professionals expressing concern over their substance use, and removal of children from their care by child welfare services due to their substance use.

Despite the service user population not representing a population engaged in current treatment, the participant population did represent a vulnerable population, that being rural Māori experiencing substance use problems that are not accessing treatment. The experiences of this population may be of significance for planning and funding of services in order to increase the accessibility of services. The experience of a non-treatment accessing population may also reflect the strengths and resilience of rural Māori whānau. Reporting the experiences of this population may assist other whānau in understanding how whānau/whānui as a collective can respond in a helpful way to substance use and related problems. The lack of objective support for participants having a substance use problem could be addressed in future studies by introducing screening measures to confirm the likelihood of a substance use disorder, and the severity of the substance use disorder.

Another area of strength within this study was the comprehensive approach taken to a complex area. The study drew on data from a wide range of sources in order to assist in understanding collaboration in the health and social sector. The study then accessed three stakeholder groups representing different levels within health and social service collaboration. This approach allowed collaboration to be looked at across experiences, settings and time. This showed to be particularly important when understanding enablers and barriers to collaboration for Māori organisations, practitioner's, service users and their whānau. It was also particularly important in understanding the different impact other areas of collaboration have on either enabling or providing barriers to collaboration. As an example, if two government-funding agencies agree of an integrated reporting format (policy level collaboration), practitioners spend less time reporting and have more time available to engage with whānau (Practitioner level collaboration). This highlights the importance of initiatives in acknowledging and addressing collaboration across all levels.

## **7.5      Further research required**

This study provided a broad interacting contextual perspective of collaboration with and for rural Māori with substance use and related problems. As noted in the literature review, the majority of practice-focused literature attends to interprofessional collaboration, however this does not address cross cultural collaboration nor collaboration between a range of organisations and/or professions, including:

- Community non-governmental organisation (NGO) practitioners
- Iwi based health and social service practitioners
- Primary health care, particularly medical practices
- Statutory health and social service practitioners from services (e.g., Vulnerable Children’s Department, Department of Corrections or Work and Income)
- Tertiary level health and social service providers (e.g., DHB provider arm services and primary health care services).

When considering further research required, it must be acknowledged that chapter summaries identified areas of practice need, research, and potential gaps in the literature. As stated in the first results chapter summary, the potential gaps in the research may be a limitation in the present literature review. The narrative literature review covered a wide range of different levels of collaboration, therefore the identified gaps may have been beyond the scope of the present literature review.

This study was not an evaluative study, however it is important to acknowledge that service users, their whānau, practitioners and key community members did identify some common areas of concern related to service delivery. This included the model of care based on in-reach specialist services; the high rates of youth suicide and related impact of lack of employment and training, and recreation and entertainment for rangatahi (young people) in the area.

Another practice need was possibly a lack of material available for service users and their whānau regarding confidentiality, and privacy; working with multiple agencies, particularly statutory agencies; what options are and should be available; and examples of helpful whānau practices for discussing and responding to complex and at times sensitive whanau issues.

In order to build on the findings of the present study, there would also be benefit for developing an induction training program for new staff (and some current staff) delivering services into the southern Rangitīkei, particularly for new staff, internationally recruited staff and Maori from other iwi. This would include training on the history of the area, cultures, faith, practice and beliefs.

It is important that the above practice issues are fed back to key stakeholders of the study by the author, including iwi, the Whanganui District Health Board and the Rangitīkei District Council.

In relation to further study of collaboration with and for rural Māori with substance use and related problems at a strategic level, a practical next step is to take a more focused approach to areas of collaboration with less literature available and more need. One of these areas is the development of models of care in DHBs. There are currently no widely accepted rural models of care, developed for engaging Māori with substance use and related problems. This could include building upon the early co-development literature by Kōwhai Consulting Ltd (2008) within an actual project. This would allow a clearer description and evaluation of a process guiding collaboration and collective action at a policy and organisational level within rural communities.

In relation to practitioner and interprofessional practice, there is also a lack of nationally or culturally validated measures of collaborative practice between practitioners, nor are there widely accepted measures of whānau and whanau whānui experiences of collaborative practice. This is an important area, particularly with the national drive for enhanced collaborative and integrated practice. It is important there are mechanisms for identifying a) Is this working (e.g., contributing to whānau and whanau whānui outcomes)?; and b) what is the whānau and their whanau whānui experience of their care journey?

In relation to gaps in the literature, it was evident that there was a lack of published and critiqued successful exemplars of Māori collaboration and collective action which could be used to inform and guide Māori collective action at an organisational level. It is intended that the present study provides both exemplars and the processes that underpinned the development and maintenance of these exemplars through the contextual model of whānau centred collaborative practice, and discussion of services mentioned in the present study such as Te Kotuku Hauora Limited and Te Oranganui Iwi Health Authority.

It would be beneficial to review current literature on Assertive Community Treatment (ACT) model used in other parts of New Zealand and internationally to address substance use and related problems, particularly complex and chronic mental health concerns. There are many similarities to the ACT model and the assertive outreach cited as preferential to service users and their whānau in the present study.

Recent ACT literature has identified benefits to its application within rural communities (Schroder, 2018; LeFebvre, Dare, Farrell & Cuddeback, 2018), and have also identified benefits to the combination of ACT and telehealth (Swanson & Trestman, 2018). The literature identified telehealth as a recommendation for addressing several of the cited rurality related barriers, such as responsivity of specialist services and difficulties with transport,

however the use of telehealth was not mentioned by participants in the present study. This warrants further research and updating, particularly an updated look at the usability and interface between, whānau, rural health and social services and their access to specialist urban practitioners, such as psychiatrists via telehealth options.

The ACT model has a strong evidence base, however less is known about its efficacy for rural Māori and other indigenous populations. It would be beneficial to services and potentially service users and their whānau to identify learnings from the ACT model that can support rural Māori practice, and likewise what the present study could offer the ACT literature and practice nationally and internationally, particularly when working with indigenous populations.

Finally, the issue of intergenerational substance use and related problems was a strong theme in the present study however there is very little literature available within clinically oriented practice literature in addressing intergenerational issues with service users, their whanau or hapū and iwi. This area warrants further study.

## **7.6 Conclusion**

Collaboration is an interpersonal process, supported and guided by both values and process. For Māori service users, whānau and practitioners, this involves viewing collaboration as a relationship, occurring across time and built through interactions that allow the enacting and reciprocation of Māori values, including: Tino rangatiratanga (self-determination); kanohi ki te kanohi, rangatira ki te rangatira (face to face, leader to leader); whakapapa (history, genealogy, and past and present connections); whakawhanaungatanga (establishing effective relationships); manaaki (hospitality); and tika me te pono (doing the right thing and being honest).

In order to engage with Māori stakeholders in their communities, whether engaging with local Māori whānau, practitioners, or community groups, a practitioner must engage in a process of learning the whakapapa of the peoples, history and place before entering into relationships within and working from this area. Solutions to intergenerational problems such as substance use and related problems require the ‘colonial footprint’ and its associated beliefs, attitudes and practices to be challenged and addressed at every level.

Māori health inequities will not be addressed if whānau and whanau whānui continue to experience ineffective, poorly integrated, culturally inappropriate, and at times dangerous,

interventions. The professional practice system must seek to actively engage with and strengthen the existing whānau collaborative system; address issues of whakapapa alongside presenting needs and aspirations; and support the application of culturally congruent interventions in order to intervene in the intergenerational cycle of negative health and social service experiences.

In essence, the ‘colonial footprint’ must be overlayed with ‘relational footprints’.

## **Manawa Mai**

Manawa mai ai te putanga o te ariki

Manawa mai ai te putanga o te tauira

Ka eke ki a Rangi e tū nei

Ka eke ki a Rangitāhuahua

Tēnei te whatu kei au kei te kaunga tapu

Te mauri tū te whiwhianuku

Tu te whiwhiarangi

Kei te whiwhia i waho, kei te rawea i waho

Puritia mai i waho, tawhia mai waho

Tēnā te mauri ka whakapiki, tēnā te mauri ka whakaekē

Ko te mauri o tēnei ariki, ko te mauri o tēnei tauira

This karakia was gifted to me by a kaumātua (tribal elder) from Ngāti Apa to use in this research. This karakia is often used to settle things and to ensure that what is being placed in front of people remains. Versions of this karakia can be found in White (1889).

## References

- Adams, R., Smart, P., & Huff, A. (2017). Shades of Grey: Guidelines for working with the Grey Literature in Systematic Reviews for Management and Organizational Studies. *International Journal of Management Reviews*, 19, 432-454.
- Addiction and Mental Health Collaborative Project Steering Committee. (2014). *Collaboration for addiction and mental health care: Best advice*. Ottawa, ON: Canadian Centre on Substance Abuse.
- Ahu, T., Hoare, R., & Stephens, M. (2011) Utu: Finding a balance for the legal Māori dictionary. *Victoria University of Wellington Law Review*, 42(2), 201-220.
- Alexander, J., Pollack, H., Nahra, T., Wells, R., & Lemak, C. (2007). Case management and client access to health and social services in outpatient substance abuse treatment. *Journal of Behavioral Health Research*, 34(3), 221-236.
- Ash, C. (2012). *Marton Connections community response model forum*. Unpublished. Marton: Rangitīkei District Council
- Attia, Mariam and Edge, Julian (2017) Be(com)ing a reflexive researcher: a developmental approach to research methodology. *Open Review of Educational Research*, 4 (1). pp. 33-45.
- Ball, J., & Thornley, L. (2015). *Effective community-level change: what makes community-level initiatives effective and how can central government best support them?* Wellington: Policy Evaluation and Research Unit.
- Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, 113(4), 544-559.
- Berryman, M., & Bateman, S. (2008) Claiming space and restoring harmony within hui Whakatika. IN: Levy, M., Nikora, L.W., Masters-Watere, B., Rua, M.R., Waitoki, W. (2008). *Claiming Spaces: Proceedings of the 2007 National Māori and Pacific Psychologies Symposium, 23-24 November, Hamilton*. Hamilton: Māori and Psychology Research Unit.
- Biringer, E., Hartveit, M., Sundfør, B., Ruud, T., & Borg, M. (2017). Continuity of care as experienced by mental health service users - a qualitative study. *BMC health services research*, 17(1), 763.
- Bishop, R. (1996). *Whakawhānaungatanga: collaborative research stories*. Palmerston North: Dunmore Press Ltd.
- Bishop, R. (1999). Kaupapa Maori research: An indigenous approach to creating knowledge. In Robertson, N. (Ed). *Maori and psychology: Research and practice. Proceedings of*

*a symposium sponsored by the Maori & Psychology Research Unit, Department of Psychology*, University of Waikato, Hamilton, Thursday 26th August 1999 (pp.1-6). Hamilton, New Zealand: Māori and Psychology Research Unit, University of Waikato.

- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- Brooks, J., McCluskey, S., Turley, E., & King, N. (2014). The Utility of Template Analysis in Qualitative Psychology Research. *Qualitative research in psychology*, 12(2), 202-222.
- Buetow, S. (2004). New Zealand Māori quality improvement in health care: lessons from an ideal type. *International Journal for Quality in Health Care*, 16(5), 417-422.
- Butterfoss, F. (2007). Coalitions and Partnerships in Community Health. USA: Jossey-Bass.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.
- Cram, F. (2001). Rangahau Maori: Tona tika, tono pono – the validity and integrity of Maori research. In M. Tolich (Ed.). *Research ethics in Aotearoa New Zealand* (pp. 35-52). Auckland: Reed Publishing Ltd.
- Cram, F., & Kennedy, V. (2010). Researching with whānau collectives. *MAI Review*, 3, 1-12.
- Craig & Courtney (2004). The Potential of Partnership: Key Learnings and way forward. Based on Waitakere City experiences. Waitakere: Waitakere City Council and Local Partnership and Governance Research Group.
- Cunningham, C., Stevenson, B., & Tassell, N. (2005). *Analysis of the characteristics of whānau in Aotearoa*. Wellington: Ministry of Education.
- Department of Correction (2015). Trends in the Offender Population 2014/2015. Wellington: Department of Corrections.
- Dougherty, A. (2013). *Psychological consultation and collaboration in school and community settings*. United Kingdom: Brooks/Coles.
- Ducharme, L., Mello, H., Roman, P., Knudsen, H., & Johnson., J. (2007). Service delivery in substance abuse treatment: reexamining “comprehensive” care. *The Journal of Behavioral Health Services & Research*, 34(2), 121–136.
- Durie, M. (1994). *Whaiora: Maori health development*. Auckland, New Zealand: Oxford University Press.
- Durie, M (1998). *Whaiora Māori Health Development* (2nd edition). Auckland: Oxford University Press.
- Durie, M. (2003). Keynote address: Is there a distinctive Māori psychology? In Nikora, L.W., Levy, M., Masters, B., Waitoki, W., Te Awekotuku, N., & Etheredge, R.J.M. (Eds).

- (2003). The Proceedings of the National Māori Graduates of Psychology Symposium 2002: Making a difference. Proceedings of a symposium hosted by the Māori & Psychology Research Unit at the University of Waikato, Hamilton, 29-30 November 2002 (pp.19-25). Hamilton, New Zealand: Māori and Psychology Research Unit, University of Waikato.
- Dyall, L., Bridgman, G., Bidois, A., Gurney, H., Hawira, J., Tangitu, P., & Huata, W. (1999). Māori outcomes: expectations of mental health services. *Social Policy Journal of New Zealand*, 12.
- Easterling, D. (2013). Getting to collective impact: how funders can contribute over the life course of the work. *The Foundation Review*, 2(7), 65-83.
- Edinburgh Alcohol and Drug Partnership (2013). Care Pathway for children and young people who misuse drugs and alcohol: Recommendations and Action Plan. Scotland: Barnardo's charitable Trust.
- Edwards, R., & Holland, J. (2013). *What is qualitative interviewing?* London: Bloomsbury Publishing.
- Eketone, A. (2008). Theoretical underpinnings of Kaupapa Māori directed practice. *MAI Review*, 1.
- Elo, S. and Kyngas, H. (2007) The Qualitative Content Analysis Process. *Journal of Advanced Nursing*, 62, 107-115.
- Eppel, E. (2013). *Collaborative governance: framing New Zealand practice*. Wellington: School of Government Victoria University of Wellington.
- Eppel, E., Gill, D., Lips, M., & Ryan, B. (2008). *Better connected services for Kiwis: A discussion document for managers and front line staff on better joining up the horizontal and the vertical*. Wellington: Institute of Policy Studies, School of Government, Victoria University of Wellington.
- Fitzgerald, J., & Galyer, K., (2007). *Family inclusion in mental health services: A child and youth focus*. Unpublished report for the Mental Commission, Wellington, New Zealand.
- Fraser, J. (2006). *Rural Health: A Literature Review for the National Health Committee*. Wellington: Victoria University of Wellington.
- Freeman, T. (2006). 'Best practice' in focus group research: making sense of different views. *Journal of Advanced Nursing*, 56(5), 491-497.
- Fredheim, T., Danbolt, L., Haaver, O, Kjonsberg, K., & Lien, L. ?, (2011). Collaboration between general practitioners and mental health care professionals: a qualitative study. International. *Journal of Mental Health Systems*, S(13),1-13.

- Gibbs, M. (2001). Toward a strategy for undertaking cross-cultural collaborative research. *Society and Natural Resources*, 14, 673-687.
- Gibsin, O., Lisy, K., Davy, C., Aromataris, E., Kite, E., Lockwood, C., Riitano, D., McBride, K., & Brown, A. (2015). Enablers and barriers to the implementation of primary health care interventions for indigenous people with chronic diseases: a systematic review. *Implementation Science*, 10(71), 1-11.
- Glaser, B., & Strauss, A. (1967). *Discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine.
- Goffin, A. (2014). *Farmers' Mental Health: A review of the literature*. Wellington: Accident Compensation Corporation.
- Gray, D., Wilson, M., Allsop, S., Saggers, S., Wilkes, E., & Ober, C. (2014). Barriers and enablers to the provision of alcohol treatment among Aboriginal Australian: A thematic review of five research projects. *Drug and Alcohol Review*, 33(5), 482-90.
- Guba, E., & Lincoln, Y. (1989). *Fourth generation evaluation*. Newbury Park: Sage.
- Harmsworth, G. (2005). *Good practice guidelines for working with tangata whenua and Māori organisations. consolidating our learning*. Palmerston North: Landcare Research.
- Harmsworth, G., Awatere, S., & Robb, M. (2016). Indigenous Māori values and perspectives to inform freshwater management in Aotearoa-New Zealand. *Ecology and Society*, 21(4), 9.
- Hatch, J. (2002). *Doing qualitative research in education settings*. Albany, NY: SUNY Press.
- Hazel, J., & Hawkeswood, J. (2016). *Barriers to collaboration within the community service sector; an exploration*. Auckland: The Incubate Group.
- Henare, M. (1988) *Standards and foundations of Maori society*. In Royal Commission on Social Policy (eds) *Nga Tikanga me Nga Ritenga o te Ao Marama*, 3. Wellington: Royal Commission on Social Policy.
- Holdaway, M. (2003). *Mental health in primary care*. Palmerston North, New Zealand: Te Rau Matatini, Massey University.
- Howard, D. (2003). Culturally competent treatment of African American clients among a national sample of outpatient substance abuse treatment units. *Journal of Substance Abuse Treatment*, 24, 89–102.
- Huata, P (1997). *Powhiri poutama*. Te Ngaru Learning Systems.
- Hudson, M., Milne, M., Reynolds, P., Russell, K., & Smith, B. (2010). *Te Ara Tika. Guidelines for Māori research ethics: A framework for researchers and ethics committee members*. Wellington: Health Research Council of New Zealand.

- Huriwai, T. (2002). Re-enculturation: culturally congruent interventions for Māori with alcohol and drug-use-associated problems in New Zealand. *Substance Use and Misuse*, 37 (8-10). p1259-1268.
- Huriwai T, Armstrong D, Huata P, Kingi J, Robertson P. (2001) ?Whanaungatanga: A process in the Treatment of Māori with alcohol and drug problems. *Substance Use and Misuse*; 36(8), 1033-1052.
- Ihimaera, L.V (2007). Whakarato Whānau Ora – Whānau wellbeing is central to Māori wellbeing. Palmerston North: Te Rau Matatini.
- Imafuku, R., Kataoka, R., Ogura, H., Enokida, M., & Osakabe, K. (2018). What did first-year students experience during their interprofessional education? A qualitative analysis of e-portfolios. *Journal of Interprofessional Care*, 32(3), 358-366.
- Jackson, H., Judd, F., Komiti, A., Fraser, C., Murray, G., Robins, G., Pattison, P. & Wearing, A. (2007). Mental health problems in rural contexts: what are the barriers to seeking help from professional providers? *Australian Psychologist*, 42(2), 147-160.
- Jansen P., Bacal K., Crengle S. (2009). *He Ritenga Whakaaro: Māori experiences of health services*. Auckland: Mauri Ora Associates.
- Jones, R., Crengle, S., & McCreanor, T. (2006). How Tikanga guides and protects the research process: insights from the Hauora Tane Project. *New Zealand Journal of Social Policy*, 29, 60-77.
- Jones, B., Ingham, T., Davies, C., Cram, F. (2010). Whānau Tuatahi: Māori community partnership research using a Kaupapa Māori methodology. *MAI Review*, 3.
- Kania, J., & Kramer, M. (2013). Embracing Emergence: How Collective Impact Addresses Complexity. *Stanford Social Innovation Review*, January, 1-7.
- Kennedy, V. & Cram, F. (2010). Ethics of researching with whānau collectives. *MAI Review*, December, Issue 3, Article 2.
- King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London: Sage.
- Kingi, T. K. R. (2006). *The Treaty of Waitangi and Māori Health. A Paper Presented at the Te Mata o te Tau Lunchtime Lecture Series*. Wellington, Massey University.
- Kodner, D., & Spreeuwenberg, C. (2002). Integrated care: meaning, logic, applications, and implications – a discussion paper. *International Journal of Integrated Care*, 2(14), 1-6.
- Kowhai Consulting Ltd. (2008). *Co-production approach process evaluation*. Unpublished. Hamilton: Kowhai Consulting Ltd.
- Krauss, S. E. (2005). Research Paradigms and Meaning Making: A Primer. *The Qualitative Report*, 10(4). 758-770.

- Knox, W. (2004), 'Waitakere City Māori Community Research Report', <http://www.lpg.org.nz>.
- Lacey, C., Huria, T., Beckert, L., Gilles, M., & Pitama, S. (2011). The Hui Process: a framework to enhance the doctor-patient relationship with Māori. *The New Zealand Medical Journal*, 124 (1347).
- LaFond, A. K., Brown, L. & Macintyre, K. (2002). Mapping capacity in the health sector: a conceptual framework. *International Journal of Health Planning and Management*, 17, 3-22.
- Leavy, P. (2011). *Oral history: Understanding qualitative research*. New York, NY: Oxford University Press.
- Lee, H. C., Arora, V., Brown, T., & Lyndon, A. (2016). Thematic analysis of barriers and facilitators to implementation of neonatal resuscitation guideline changes. *Journal of perinatology : official journal of the California Perinatal Association*, 37(3), 249-253.
- Local Partnerships and Governance Research Group. (2005). *Balancing Means and Ends. Key messages for central government from the 'Strengthening Communities through Local Partnerships' Research Project*. Auckland: Local Partnerships and Governance Group, Auckland University.
- Lu, C., & Shulman, S. (2008). Rigor and flexibility in computer-based qualitative research: Introducing the coding analysis toolkit. *International Journal of Multiple Research Approaches*, 2(1), 105-117.
- Mahuika, R. (2008). Kaupapa Maori theory is critical and anti-colonial. *MAI Review*, 3(4) .1-16.
- Marrone, S. (2007). Understanding barriers to health care: a review of disparities in health care services among indigenous populations. *International Journal of Circumpolar Health*, 66(3), 188-198.
- Marsden, M. (2003). *The Woven Universe. Selected Writing Rev Māori Marsden*. Masterton: The estate of Rev Māori Marsden.
- Marsh, J., Cao, D, Guerro, E., & Shin, H. (2009). Need-service matching in substance abuse treatment: racial/ethnic differences. *Evaluation and Programme Planning*, 32(1), 43-51.
- Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research (5th ed.)*. Thousand Oaks, CA: Sage.
- Martin-Rodriguez, L., Beaulieu, M., D'Amour, D., & Ferrada-Videla (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care*, 19(1), 132-147.

- Mauriora Ki Te Ao - Living Universe Limited (2010). *Whānau Ora Integrated Services Delivery*. Wellington: Ministry of Health.
- May, T. (2010). *Social research: Issues, methods and process*. Maidenhead: McGraw-Hill Education.
- Mays, N. (2013). *Reorienting the New Zealand health care system to meet the challenges of long-term conditions in a fiscally constrained environment*. Wellington: Victoria University of Wellington and New Zealand Treasury Conference.
- McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2017). Understanding collaboration in general practice: a qualitative study, *Family Practice*, 34(5), 621–626.
- McKenzie, D., Whiu, T.A., Matahaere-Atariki, D., Goldsmith, K., & Te Puni Kōkiri (2008). Co-production in a Māori context. *Social Policy Journal of New Zealand*, 33.
- McKinlay, E., Gray, B., Pullon, S. (2013). Interdisciplinary collaboration: working in teams for patient care. Chapter 16 in *Cole's medical practice in New Zealand*, 12<sup>th</sup> edition. Medical Council of New Zealand, Wellington.
- McLachlan, A (2011) *Barriers and Enablers of effective collaboration with and for rural Māori with substance use and related problems: A presentation of research findings of collaboration across services for those working in the Huntly Rohe*. Unpublished technical report. University of Otago. New Zealand.
- McLachlan, A., Hungerford, R., Schroder, R., & Adamson, S. (2012). Practitioners' experiences of collaboration, working with and for rural Maori. *The Australian Community Psychologist*, 24(1). 52-63.
- McLachlan, A. (2015). *Waikato Youth Alcohol and Other Drug Model of Care*. Commissioned report for the Waikato DHB Youth AOD Project Implementation Team, July 2015. ISBN 1877296-27-9
- Mead, H. (2003). *Tikanga Māori: Living by Māori values*. Wellington, New Zealand: Huia Publishers.
- Mead, H., & Grove, N. (2001). *Ngā pēpeha a ngā tīpuna: The sayings of the ancestors*. Wellington: Victoria University Press.
- Mental Health Commission (2012). *National Indicators 2012: Measuring mental health and addiction in New Zealand*. Wellington: Mental Health Commission.
- MidCentral District Health Board and Whanganui District Health Board (2015). *Health Needs Assessment 2015*.
- Mika, C. (2010). A chance for ontology. *MAI Review*, 2, 1-3.
- Miles, M & Huberman, A. (1994). *Qualitative data analysis (2nd ed.)*. Thousand Oaks, CA: Sage.

- Ministry of Education (2009). *Te Aho Arataki Marau – Kura Auraki mō te Ako i Te Reo Māori Curriculum Guidelines for Teaching and Learning Te Reo Māori in English-medium Schools: Years 1–13*. Wellington: Learning Media Limited.
- Ministry of Health. (2010). *Service Delivery for People with Co-existing Mental Health and Addiction Problems: Integrated Solutions*. Wellington: Ministry of Health.
- Ministry of Health. (2012). *Mātātuhi Tuawhenua: Health of Rural Māori 2012*. Wellington: Ministry of Health.
- Ministry of Health. (2014). *Annual Update of Key Results 2013/14: New Zealand Health Survey*. Wellington: Ministry of Health.
- Ministry of Social Development (2003). *Mosaics: Whakaahua Papariki. Key Findings and Good Practice Guide for Regional Co-ordination and Integrated Service Delivery*. Wellington: MSD.
- Mitchell, J., & Mitira, T.H. (1972). *Takitimu A History of Ngati Kahungunu*. Wellington: Reed Publishing
- Moewaka-Barnes, H. (2000). Kaupapa maori: explaining the ordinary. *Pacific Health Dialog*, 7(1), 13-16.
- National Health Committee. (2010). *Rural health: challenges of distance, opportunities for innovation*. Wellington: National Health Committee
- Nepe, T. M. (1991). *Te Toi huarewa tipuna. Kaupapa Maori an educational intervention system*. Unpublished master's thesis, The University of Auckland, Auckland, New Zealand.
- New Zealand Rural General Practice Network (2012). Survey looks at substance use and related problems. *Network News*, 20, p6. Retrieved from: [www.rgpn.org.nz](http://www.rgpn.org.nz).
- Nowell, L., Norris, J., White, E., & Moules, N. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. *International Journal of Qualitative Methods*, 16 (1), 1-13.
- O'Leary, R. (2014). *Collaborative Governance in New Zealand: Important Choices Ahead*. Wellington: Fulbright New Zealand.
- Paino, M., Aletraris, L., & Roman, P. (2016). The relationship between client characteristics and wraparound services in substance use disorder treatment centers. *Journal of Studies on Alcohol and Drugs*, 77(1), 160-169
- Patton, M. (2002). *Qualitative research & evaluation methods (3rd ed.)*. Thousand Oaks, CA: Sage.
- Penny, P. (2013). *Collaborative Practice: A grounded Theory of connecting in community collaboration*. PhD Thesis. Auckland: Auckland University of Technology.

- Pere, R. (1984). Te Oranga o te Whanau: The health of the family. In K. Whakahaere (Ed.), *Hui Whakaoranga: Maori Health Planning Workshop Proceedings, Hoani Waititi Marae, Auckland, 19-22 March 1984*. Wellington: Department of Health.
- Pihama, L., F. Cram & S. Walker (2002) "Creating methodological space: A literature review of Kaupapa Māori research" *Canadian Journal of Native Education*, 26(1), 30–43.
- Pipi, K., Cram, F., Hawke, R., Hawke, S., Huriwai, TeM., Mataki, T., Milne, M., Morgan, K., Tuhaka, H. & Tuuta, T. (2004). A research ethic for studying Māori and iwi provider success. *Journal of Social Policy of New Zealand - He Puna Whakaaro*, 23, 141-153.
- Pohatu, T. (2005), *Āta: Growing Respectful Relationships*. Retrieved from <http://www.kaupapamaori.com>
- Pringle, J., Emptage, N., & Hubbard, R. (2006). Unmet needs for comprehensive services in outpatient addiction treatment. *Journal of Substance Abuse Treatment*, 30, 183–189.
- Pautasso, M. (2013) Ten Simple Rules for Writing a Literature Review. *PLoS Computer Biology*, 9(7), 1-4.
- Pope, C., Ziebland, S., & Mays, N. (2006). Analysing qualitative data. In: Pope C, Mays N (eds) Qualitative Research in Health Care. Oxford, Blackwell, pp 63–81.
- QSR International. (2013). *NVivo 10: Getting started*. Victoria, Australia: QSR International.
- Ramage, C., Bir, J., Towns, A., Vague, R., Cargo, T., & Niumata-Faleafa, M. (2005). *Stocktake of Child and Adolescent Mental Health Services in New Zealand*. Auckland, NZ: The Werry Centre for Child & Adolescent Mental Health Workforce Development, University of Auckland.
- Rameka, R. (2006). *He Arakanahi ki te Oranga: Report of Health Research Council Rangahau Hauora Award*, Te Rōpū Rangahau Hauora a Eru Pōmare.
- Rangitīkei District Council (2010). Long Term Council Community Plan Review 2008-09 and 2009-10. Unpublished. Marton: Rangitīkei District Council.
- Rangitīkei District Council (2011). *Rangitīkei community profile: for the community response model forum*. Rangitīkei: Rangitīkei District Council.
- Ritchie, J. (1992). *Becoming bicultural*. Wellington, New Zealand: Huia Publishers
- Robb, M., Harmsworth, G., & Awatere, S. (2015). *Māori values and perspectives to inform collaborative processes and planning for freshwater management*. Wellington: Ministry of Business and Innovation.
- Rose, J., & Norwich, B. (2014). Collective commitment and collective efficacy: a theoretical model for understanding the motivational dynamics of dilemma resolution in inter-professional work. *Cambridge Journal of Education*, 44(1), 59-74.

- Royal Commission on Social Policy (1988). *The April Report*, Volumes I to IV. Wellington: The Royal Commission on Social Policy.
- Ryan, A. (2006) *Post-Positivist Approaches to Research*. In: Researching and Writing your thesis: a guide for postgraduate students. MACE: Maynooth Adult and Community Education, 12-26.
- Saldana, J. (2013). The coding manual for qualitative researchers (2nd ed.). London: Sage.
- Savic, M., Grynevych, A., Best, D., Hunter, B., & Lubman, D. (2014). *Strategies to improve integrated care for agencies working with people with AOD problems*. Victoria: Turning Point.
- Schadewaldt, V., McInnes, E., Hiller, J., & Gardner, A. (2016). Experiences of nurse practitioners and medical practitioners working in collaborative practice models in primary healthcare in Australia – a multiple case study using mixed methods. *BMC Family*, 17(99).
- Simons, H. (2009). *Case study research in practice*. London: Sage
- Smith, C. (2007). *Tikeitia Oku Waewae! Maori Community Work in the Rangitikei*. Whanganui: Te Atawhai o Te Ao.
- Smith, G. H. (1997). *The development of Kaupapa Maori: Theory and Praxis*, Unpublished doctoral thesis. University of Auckland, Auckland.
- Smith, L. (1999). *Decolonising Methodologies*. Dunedin: University of Otago Press.
- Smith, J., & Ovenden, C. (2007). Developing integrated primary and community health services: what can we learn from the research evidence? Victoria University of Wellington: Health Services Research
- Spoonley, P. (1995). The challenges of post-colonialism. *Sites*, 30, 48-69.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA, US: Sage Publications, Inc.
- Taskforce on Whānau-Centred Initiatives. (2010). *Whānau Ora: Report of the taskforce on Whānau-centred initiatives*. Wellington, New Zealand: Taskforce on Whānau-centred initiatives.
- Taylor, K., Bessarab, D., Hunter, L., & Thompson, S. (2013). Aboriginal-mainstream partnerships: exploring the challenges and enhancers of a collaborative service arrangement for Aboriginal clients with substance use issues. *BMC Health Services Research*, 13(12).
- Taylor, K., & Thompson, S. (2011). Closing the (service) gap: exploring partnerships between Aboriginal and mainstream health services. *Australian Health Review*, 35, 297-308.

- Te Karu, L., Bryant, L., & Elley, R. (2013). Maori experiences and perceptions of gout and its treatment: A kaupapa Maori qualitative study. *Journal of Primary Health Care*, 5(3), 214–222.
- Thomas, D. (2003). *A general inductive approach for qualitative data analysis*. Auckland, New Zealand. School of Population Health, University of Auckland.
- Thomas, D. (2006). A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation*, 27(2), 237–246.
- Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology* 2008, 8(45). 1-10.
- Thomas, P., & Cowie, B. (2004). *The state of the Rangitīkei environment*. Marton: Rangitīkei District Council.
- Te Awekotuku, N. (1991). *He tikanga whakaaro: Research ethics in the Maori community: A discussion paper*. Manatu Maori: Wellington.
- Tolich, M., & Davidson, C. (1999). *Starting fieldwork: An introduction to qualitative research in New Zealand*. Melbourne: Oxford University Press.
- Trotman, R. (2005). Balancing Means and Ends - Key Messages for Central Government from the “Strengthening Communities through Local Partnerships” Research Project. Auckland: University of Auckland Local Partnerships and Governance Research Group.
- Tucker, L. (2012). *Service users' views of collaborative care: A descriptive exploratory study*. Unpublished master's thesis. Auckland: Auckland University of Technology.
- Turiana, T (2010). *Te Oranganui Iwi Health Authority (TOIHA) Hui-a-Tau Whanau Ora Practitioner Graduation Speech* (Friday 8 October). Retrieved from: <http://pacific.scoop.co.nz/2010/10/whanau-ora-practitioner-graduation/>
- Vanderstoep, S., & Johnston, D. (2008). *Research methods for everyday life: Blending qualitative and quantitative approaches*. USA: John Wiley & Sons Inc.
- Waa, A., Holibar, F., & Spinola, C. (1998). *Programme Evaluation: An Introductory Guide for Health Promotion*. Auckland: University of Auckland.
- Walker, S., Eketone, A., & Gibbs, A. (2006). An exploration of kaupapa Maori research, its principles, processes and applications. *International Journal of Social Research Methodology*, 9(4), 331–344.
- Walker, T., Signal, L., Russel, M., & Tuhiwai-Ruru, R. (2008). The road we travel: Māori experiences of cancer. *New Zealand Medical Journal*, 121(1279), 27- 35.

- Wevers, S (2011). *Recognizing Rangatiratanga: Sharing Power with Māori through Co-management*. University of Otago. A dissertation submitted in partial fulfilment of the requirements of the degree of Bachelor of Laws (Honours).
- White, J. (1889). *Ko Ngā Tātai Kōrero Whakapapa a Te Māori Me Ngā Karakia O Nehe Volume 4 of The Ancient History of the Maori: His Mythology and Traditions*. California: G. Didsbury, Government Printer.
- Whittemore, R., & Knafl, K. (2005), The integrative review: updated methodology. *Journal of Advanced Nursing*, 52, 546–553.
- Widmer, S. (2011). *Keeping well: A review of enablers and barriers to collaboration in population health in the Wellington region*. Wellington: Regional Public Health.
- Williams, A. & Irurita, V. (1998). Therapeutically conducive relationships between nurses and patients: An important component of quality nursing care. *Australian Journal of Advanced Nursing*, 16, 36–44.
- Wolf, M. (1990). *China notes: Engendering anthropology*. In: R. Sanjek (Ed.), Field notes (pp. 343–355). Ithaca, NY: Cornell University Press.
- Woodside, A. (2010). *Case study research: Theory, methods and practice*. Bradford: Emerald Group Publishing.
- Wong, D., & Nixon, G. (2016). The Rural Medical Generalist Workforce: The Royal New Zealand College of General Practitioners' 2014 workforce survey results. *Journal of Primary Health Care*, 8(3), 196-203.
- Yin, R. K. (2012). *Applications of case study research (3rd ed.)*. Washington DC: SAGE Publications, Inc.

# Appendix A - District Health Board Clinical governance team letter of support



*Heads Road  
Private Bag 3003  
Whanganui 4540  
New Zealand*

Dr Andre McLachlan  
Pai Ake Solutions Ltd  
21 Commerce Street, Hamilton  
PO Box 5631  
Frankton

[andre@pajake.co.nz](mailto:andre@pajake.co.nz)

Tena koe Andre

Thank you for taking the time to present your research project to the Whanganui District Health Board's Clinical Board meeting in February.

The Clinical Board has agreed and recommended that they approve and endorse your research proposal and that you have access to WDHB clinical personnel during your research, particularly participant recruitment and for data collection purposes.

The clinical board asks that you report to the board on your research findings as your research progresses; and that you seek further endorsement/approval for additional areas in your research if required from the board.

Please feel free to contact me anytime you are down in the area.

Nga mihi

Gilbert Taurua  
Director Māori Health  
Whanganui District Health

Cc Dr John Rivers, Chief Medical Officer (Chair, Clinical Board)

*"Better health and independence"  
"He hauora pai ake, he rangatira"*

Maori Health Services, Wanganui Hospital, Heads Road  
Telephone (06) 348 3083

## **Appendix B – Evaluation of Screening and Brief Intervention - Te Kotuku Hauora o Rangitīkei Iwi service staff team**

### **Workshop Evaluation: Community Based Screening and Brief interventions for Alcohol and Drug problems**

#### **1. Introduction to Report.**

This evaluation is the summary of data collected from the 19 participants at the free training day on 18<sup>th</sup> June 2012. This workshop was hosted by Te Kotuku Hauora, and held at the Rangitīkei Health Centre Blackwell Street, Marton (Paanui attached to appendices, page 6 of this summary). The workshop was facilitated by Andre McLachlan, Registered Clinical Psychologist from Pai Ake Solutions Limited, and catered for lunch, morning and afternoon tea by Graze Out Caterers. This was funded by the HRC Māori PhD Research Tikanga Allowance of the facilitator.

The workshop was delivered to respond to the need for training on Screening and intervening with whānau experiencing alcohol and drug problems in the Rangitīkei. Staff at Te Kotuku Hauora Limited identified a lack of specific Alcohol and drug services in the Rangitīkei, and the need to upskill local practitioners.

This evaluation is completed by the workshop facilitator for the purposes of evaluating the suitability of workshop material and presentation, and to recommend ongoing training needs and delivery format for practitioners working within the Rangitīkei (The evaluation form is attached in the appendices, page 7 of this summary).

#### **2. Report structure.**

The first section of this evaluation will describe the demographics of participants, including ethnicity, current role/title, and highest qualification. This data was collected in order to evaluate the suitability of the workshop for practitioners of different culture and ethnicity, levels of qualification and area of practice. The second section will summarize participants rating of course delivery and content, whereas the final section will summarize participant's responses to two questions a) Anything that could be added to the workshop content or delivery that could improve the workshop? and b) What did you learn today that you are most likely to try? Following this the evaluation will be summarized and recommendations made.

#### **3. Participant Demographics**

10 participants identified as Māori, One participant Māori / Cook Island, and eight that identified as New Zealand European.

Participants came from Te Kotuku Hauora Ltd, Ngati Rangi Community Health Centre, Te Puke Karanga Hauora, Supporting Families in Mental Illness, Otaihape Māori Komiti, Te

Atawhai o Te Ao Independent Māori Research Unit, Marton Counselling Centre, Whanganui District Health Board Public Health Unit, and the Anglican Parish of Rangitīkei.

The current role of participant's including researchers (2), counsellors (3), priests (2), social worker (1), administration (1), rural mental health/ mental health support worker (2), public health nurse (1) and the largest group whose role/job title included Whānau ora kaimahi, Kaitoko whānau kaimahi, whānau support worker, and family whānau co-ordinator (7)

Participant's qualification appeared in three general categories. These were Degree, Diploma and Certificate Level qualification. Six participants held degrees covering a wide range of areas including ICT, Bachelor in Theology, Degree in Education, BA (Social Science), Bachelor of Social Work and Bachelor of Nursing. One participant has two degrees, whereas another also identified a Diploma in Counselling. Three participants held Diploma level qualifications, these were Diploma in Hauora Māori, Diploma in counselling and one completing a Social Work Degree. Those participants reporting certificate level and below were the largest group (7 participants). One participant identified Bursary Māori as their highest qualification and another identified Mauri Ora as their highest qualification. Five participants identified having a Certificate in Mental Health.

#### **4. Participants rating of course delivery and content.**

Participants completed a table that rated factors related to presenter, presentation, and material. This was rated 1 (Poor), 2 (O.K.), 3 (Good) and 4 (Great). Participant's ratings are summarized below for each question.

	1	2	3	4
Expertise of the presenter.			5% (1)	95% (18)
Presentation techniques of the presenter			5% (1)	95% (18)
Your learning experience			26% (5)	74% (14)
Usefulness of handouts or other "take aways."			11% (2)	89% (17)
How was the relevance of the workshop to your role?		5% (1)	21% (4)	74% (14)
How would you rate the appropriateness of new tools accessed in the workshop to your work?		5% (1)	21% (4)	74% (14)
How would you rate the appropriateness of new skills presented in the workshop to your work?			26% (5)	74% (14)
Hosting of the workshop: Setting and Refreshments (if provided)			21% (4)	79% (15)

#### **5. Participant's comments.**

## **Anything that could be added to the workshop content or delivery that could improve the workshop?**

The Majority of comments under this question were positive comments about the workshop in general, such as: “Awesome presentations: excellent interaction with movies, activities, scales”; “Thank you so much for delivering an excellent workshop”; “Really enjoyed the day, Andre was Fantastic”; “Everything excellent!!”; “Kia Mau te Wehi” “excellent presenter keeps you awake, alive and firm”; “Great Presentation, thank you”

Two comments related to hosting of the workshop: “the seats were quite uncomfortable which made sitting and listening hard due to back pain”, and “Please provide water”. Three participants commented on the facilitation of the workshop: “No workshop was probably rushed but that is due to time restraint”, “handing out notes before the presentation”, and “More slide show (Two participants)”. One participant commented on additional content “How to engage with those in denial”.

## **What did you learn today that you are most likely to try?**

The responses to this question are presented in six themes. These are: addressing the issue, micro-counselling skills, Motivational Interviewing and Change, Screening tools, Confirmation, and Learning more and passing on the knowledge.

Addressing the issue. This reflected those participants that were talking about applying their new skills, potentially in an area that they would not have gone with whānau. These included:

“Learn to try”, “To work with more clients with A or D issues rather than refer to supposed A&D specialist counselor”, “Helping people to make changes. Just being able to be “Straight up” about what I see i.e., drug use etc”, “Approach the ‘Elephant in the room” (referring to substance use in the whānau).

Micro-counselling skills. Participants commented on the helpfulness of basic counseling skills, commonly referred to as micro-counselling skills. “Great reminders about open questions etc”, “Questions leading into conversation, all open ended questions”, and “how to approach clients with sensitive information. Looking at the affects of drug and alcohol dependency...”

Motivational Interviewing and Change. Several participants identified Motivational Interviewing and discussions about the process of change as a helpful skill-based outcome from the workshop. These included: “Reinforced the need to appeal to peoples need to change through sound counselling methods i.e., Motivational interviewing as a pro-active way to help others rather than lecturing is telling you what to do and why”, “Manipulate talk content in order to get to end objective in a non-lecturing way”, “Motivation, reflection listening”, “Scale, using questions and change strategies”, and “How to implement strategies, help people see where they are at-recognition, understand people”.

Screening Tools. Three participants specifically noted “Screening Tools” as skill that they are most likely to try following the workshop.

Confirmation. Two participants reflected how the workshop confirmed the way they practice, this may reflect their level of training and/or experience, “*Confirmation of how I work in my practice i.e., as a counselor*”, and “*Thoroughly enjoyed today, Today reinforced the way I work. Awesome*”.

Learning more and passing on the knowledge. One participant identified their desire to do further up study, and pass on what they had learnt, “*Continue learning and pass on knowledge learned utilise audit forms, learn more-degree in rotorua 2013*”, whereas another commented on passing on these skills to their own whānau, “*...Excellent tools to have and use in my own whānau in regards to alcohol*”.

## 6. Summary and Recommendations.

A maximum number of 20 participants places were offered (advertised) for the workshop, although 24 participants registered to attend. The 19 participants who attended were predominantly Māori, working in whānau contact roles, and with diploma level qualifications and below. The most common qualification was a certificate in mental health. The participants predominantly came from Māori organizations.

The vast majority of participants rated the expertise and presentation of the workshop facilitator as ‘Great’ (95%). The majority of participants also rated the usefulness of handouts as ‘Great’ (89%).

In relation to relevance and applicability of the workshop to participants role, three areas were explored, these were 1) relevance of the workshop to their role; 2) appropriateness of new tools accessed in the workshop to their work, and 3) appropriateness of new skills presented in the workshop to their work. 14 of the 19 participants (74%) rated all three areas as ‘Great’. Those that rated these areas lower were working in either administrative or Pastoral roles.

The vast majority of Participants written comments were positive about the day as a whole. When commenting on what skills they would most likely try it was clear the Motivational Interviewing was seen as helpful and achievable for this largely outreach/whānau contact workforce. Secondly the use of screening tools was noted as another skill participants were most likely to apply. Using an informal audit of participants at the beginning of the workshop, it was clear that approximately 90% of participants were not using screening tools of any sort. The practice of using these tools as both a conversation starter and a decision maker (need for further assessment) assisted in bridging the confidence and skill gap around screening. During the workshop several participants queried around mental health screening tools, and following the workshop three participants specifically emailed the facilitator for links to mental health screening tools. Three other participants emailed seeking advice on further training options for those with Mental Health Certificates, and advice around scholarships. These participants were emailed a scholarship brochure and links to Kaupapa Māori specific diploma and degree level studies.

Based on the delivery of the workshop, the evaluation and participants comments and email queries, I would suggest developing a training calendar for rural community outreach workers, particularly for Kaupapa Māori organizations, and targeting practitioners with Diploma level and below qualifications.

The training calendar could offer training on Motivational Interviewing, Screening and responding to Mental Health issues (and possibly general health issues), and workforce development (tertiary training and scholarships). It would be helpful if a local agency coordinated and evaluated this initiative. This initiative is particularly important as local workers in rural communities are often the first port of call for whānau, therefore these practitioners need a high level of screening skills. They also need the skills to motivate whānau to address these issues, and to motivate whānau to engage with tertiary services to address these issues, that may or may not be available in their communities.

Workshop facilitator and Evaluator

A handwritten signature in black ink, appearing to read "Andre McLachlan".

Andre McLachlan  
Clinical Psychologist / Clinical Co-ordinator  
PGDip ClinPsych; PGDipHealthSci (Dist)  
Registered Clinical Psychologist (NZPB)  
Registered Alcohol and Drug Practitioner (DAPAANZ)

# **Community Based Screening and Brief interventions for Alcohol and Drug problems**

People who engage with whānau in the community, either as whānau support workers or health care workers often identify that alcohol or drug use may be a problem for the whānau they are working with.

In this workshop participants will be introduced understanding, identifying and addressing alcohol and drug use within community work. This involves:

1. **Understanding:** Alcohol and drug use problems, principles of change, and principles of harm reduction as they relate to alcohol and drug use for whānau
2. **Identifying:** Asking the right questions. Raising the topic of alcohol and drug related harm in a way that increases engagement. Introduction to the use of common screening tools
3. **Addressing alcohol and drug use:**
  - Strategies for exploring current and potential alcohol and drug related harms for whānau.
  - Increasing engagement and motivation to change
  - Creating plans for reducing use, reducing risks and increasing safety
  - Resources for supporting community based interventions

This workshop will be interactive, with small group activities and case studies.

The workshop will be held:

**Date:** Wednesday 18<sup>th</sup> July 2012

**Time:** 9:00 a.m. to 4:00pm

**Location:** Rangitīkei Health Centre  
Blackwell Street, Marton.

**Numbers:** Max of 20 participants

**Costs:** No charge

## ***Facilitator***

Andre David McLachlan  
PGDip ClinPsych; PGDip Health Sciences (Dist);  
DAPAANZ Member and registered practitioner.

Andre is a Clinical Psychologist, and the Clinical coordinator at Pai Ake Solutions Ltd, a Kaupapa Māori co-existing disorders assertive outreach service in the Waikato. He is of Ngāti Apa descent and has worked within the mental health and addiction field over the past 20 years, having developed a number of services for young people and families. Andre has also been an expert reviewer and panel member on a range of national and international working groups including the United Nations Office on Drugs and Crime (UNODC). Andre is currently a reference group member in the Māori Health Professional/Clinical Development Reference Group at Te Rau Matatini, the National Māori Health workforce centre, and is passionate about creative and innovative approaches to working with whānau.

**Community Based Screening and Brief interventions for Alcohol and Drug problems**

## Workshop Evaluation form

Tēnā Koe, please take some time to complete this evaluation form. It is important that we learn from your experience of the workshop so that we can improve it for people that we deliver this to in the future.

**Information about you:** This information is to help identify the types of people that this workshop best suits. It will not be used to identify you.

**Ethnicity** (i.e., Māori, NZ European, South African etc...):

---

**Current role/title** (i.e., social worker, whānau support worker, counselor etc..):

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**Highest qualification** (i.e., certificate in mental health, diploma in counseling, nursing degree etc,,):

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Please circle the number that best reflects your thoughts and experience of the question related to the workshop

Poor	O.K.	Good	Great	1	2	3	4
Expertise of the presenter.				1	2	3	4
Presentation techniques of the presenter				1	2	3	4
Your learning experience				1	2	3	4
Usefulness of handouts or other “take aways.”				1	2	3	4
How was the relevance of the workshop to your role?				1	2	3	4
How would you rate the appropriateness of new tools accessed in the workshop to your work?				1	2	3	4
How would you rate the appropriateness of new skills presented in the workshop to your work?				1	2	3	4

Hosting of the workshop: Setting and Refreshments (if provided)      **1**      **2**      **3**      **4**

Anything that could be added to the workshop content or delivery that could improve the workshop?

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What did you learn today that you are most likely to try?

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**Thank you for taking time to complete this evaluation!**

## **Appendix C – Participant Information Sheets**

### **Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

#### **INFORMATION SHEET FOR KEY INFORMANT PARTICIPANTS**

Tena Koe,

Nga mihi mahana ki a koe mō to tautoko mai ki tenei kaupapa.

My name is Andre McLachlan and I am undertaking a PhD research project about the development of health services for Māori by Māori in the Rangitīkei. You have been recommended to me as a person with specific knowledge of the Rangitīkei communities, and involvement in the development of important health initiatives in the area.

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

#### **What is the Aim of the Project?**

I will be conducting approximately 10 key interviews with people such as yourself, with the goal of documenting the social fabric of the Rangitīkei, highlighting collaborative efforts in developing services for Māori by Māori, and discussing the barriers and enablers to the development of these services.

The findings of these interviews will form part of the PhD project, and also journal publications discussing collaboration with and for Māori with substance use and related problems. This part of the study will be followed by interviews with current service users and their whānau using multiple services, and focus groups with practitioners from a cross-section of health and social services delivering services across the Rangitīkei.

#### **What will Participants be asked to do?**

Should you agree to take part in this project, you will be asked to participate in an interview with the primary researcher. This would take approximately two hours of your time. I could conduct this interview at a place of your choosing, such as your home or workplace, or I could arrange a suitable location. I am also flexible to meet you at a time that works around your commitments.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

#### **What Data or Information will be Collected and What Use will be Made of it?**

Interviews will be audio taped to assist gathering participants' comments. A researcher will also take notes during the interview to assist in understanding the information gathered.

Information about you and your roles within the Rangitīkei will be gathered on a participant demographic form.

Participants will be given the choice of having specific interview topics, such as exemplars of successful outcomes digitally video recorded. Participants will also be given the opportunity to share photographs of key events or people involved in these exemplars of successful outcomes. These are to contribute to a digital Video) describing the development of successful initiatives by Māori for Māori in the Rangitīkei.

Information gathered during the interview will be analysed for common themes and experiences. Comments that accurately reflect these themes may be used as quotes and linked to the person that made these comments. In cases that this happens the original person that made the comments will be contacted for permission.

Transcripts of your interview will only be accessible by the research staff and their supervisors at Otago University.

This primary (student) researcher is supported with funding by the way of a Health Research Council scholarship.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for **at least 10 years** in secure storage. Any personal information held on the participants, such as contact details and audio tapes may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published and the resulting doctoral thesis will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

On the Consent Form you will be given options regarding your anonymity. Please be aware that every effort will be undertaken to preserve your anonymity. Your names will not be used and where necessary, certain identifying characteristics may be altered. However, with your consent, there are some cases where it would be preferable to attribute contributions made to individual participants. It is absolutely up to you which of these options you prefer.

As participants, you will be provided with transcripts of the interviews in the two weeks following the interview. You have the right to correct or withdraw information within two weeks of receiving the transcripts. Any direct quotes will be checked with you for accuracy and consent to include in the study.

This project involves an open-questioning technique. The general line of questioning includes: What were the key achievements in services for Māori by Māori in the Rangitīkei; What are the health and social needs of whānau in the Rangitīkei; What if any are the impacts of rurality and substance use on service engagement and delivery in the Rangitīkei.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

**Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

### What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Andre McLachlan [Student Researcher]	and/or	Simon Adamson [Supervisor]
P.O. Box 5172, Frankton Hamilton, Waikato 3242		Department of Psychological Medicine, Christchurch. Otago University
		Department of Psychological Medicine, Christchurch. Otago University
Telephone Number: 027 676 8922		University Telephone Number: 04 364-0480
Email Address: <a href="mailto:andre@piake.co.nz">andre@piake.co.nz</a>		Email Address <a href="mailto:simon.adamson@otago.ac.nz">simon.adamson@otago.ac.nz</a>

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.



## **Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

### **INFORMATION SHEET FOR SERVICE USER AND THEIR WHĀNAU**

Tena Koe,

Nga mihi mahana ki a koe mō to tautoko mai ki tenei kaupapa.

My name is Andre McLachlan and I am undertaking a PhD research project about how whānau with substance use and other health and social concerns work with service providers.

I am interested in meeting with individuals and where possible their whānau to discuss their experiences of working with these agencies. This is done to identify effective whānau practices that can be shared with other whānau; and to inform service providers about the difficulties in working with multiple agencies; and what is helpful when working with whānau that have several other agencies involved.

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to take part. If you do decide to take part we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

#### **What is the Aim of the Project?**

I am looking at interviewing Māori currently accessing services in the Rangitīkei. I will be interviewing individuals and with permission, their whānau.

The findings of these interviews will form part of a PhD project, and also journal publications discussing collaboration with and for Māori with substance use and related problems.

#### **What Type of Participants are being sought?**

Participants are sought that are:

- Māori
- 18 years of age or older
- Currently involved with two or more health or social agencies; and
- Identify that they have a problem with alcohol and/or drug use

If you agree to participate, we would like to interview you with your whānau. Whānau participants can be anyone that you consider to part of your whānau and/or support network. Whānau participants must be 18 years of age or older.

#### **What will Participants be Asked to Do?**

Should you agree to take part in this project, you will be asked to attend one interview with the primary researcher, and an assistant researcher. The interview will take approximately

one hour of your time. I could conduct this interview at a place of your choosing, such as your home or workplace, or I could arrange a suitable location. I am also flexible to meet you at a time that works around your commitments.

This interview will involve discussing how you respond to multiple health and social challenges as a whānau, your experiences of working with multiple agencies, and the impact of substance use problems and living rurally on addressing your health and social needs.

Each participant (including whānau members) will receive a koha of a \$30 warehouse or supermarket voucher. This is to a maximum of \$100 per group. This will be gifted after each interview in recognition of your time and involvement.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

### **What Data or Information will be collected and What Use will be made of it?**

Interviews will be audio taped to assist gathering you and your whānau's comments. A researcher will also take notes during the interview to assist in understanding the information gathered.

We will also ask you to complete a form that asks some specific questions about you and/or your whānau involvement with services, and issues and challenges faced by you and your whānau.

The information you share with me during the interview will be analysed for common themes and experiences. Comments that accurately reflect these themes may be used as quotes and linked to the person that made these comments. In cases that this happens the original person that made the comments will be contacted for permission.

A written record of your interview will only be accessible by the research staff and their supervisors at Otago University.

This primary (student) researcher is supported with funding by the way of a Health Research Council scholarship.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for **at least 10 years** in secure storage. Any personal information held on the participants, such as contact details and audio tapes may be destroyed at the completion of the research.

On the Consent Form you will be given options regarding your anonymity. Please be aware that every effort will be undertaken to preserve your anonymity. Your names will not be used and where necessary, certain identifying characteristics may be altered. However, with your consent, there are some cases where it would be preferable to attribute contributions made to individual participants. It is absolutely up to you which of these options you prefer.

As participants, you will be provided with a written record of the interviews in the two weeks following the interview. You have the right to correct or withdraw information within two weeks of receiving the transcripts. Any direct quotes will be checked with you for accuracy and consent to include in the study.

During the interview you have the right to choose if you wish to answer or not answer any particular question(s) and you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

### **Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

### **What if Participants have any Questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Andre McLachlan [*Student Researcher*] and/or Simon Adamson [*Supervisor*]

P.O. Box 5172, Frankton  
Hamilton, Waikato 3242

Department of Psychological Medicine,  
Christchurch. Otago University

Telephone Number: 027 559 7609  
Email Address: [dahub@xtra.co.nz](mailto:dahub@xtra.co.nz)

University Telephone Number: 04 364-0480  
Email Address [simon.adamson@otago.ac.nz](mailto:simon.adamson@otago.ac.nz)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.



## **Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

### **INFORMATION SHEET FOR PRACTITIONER PARTICIPANTS**

Tena Koe,

Nga mihi mahana ki a koe mō to tautoko mai ki tenei kaupapa.

My name is Andre McLachlan and I am undertaking a PhD research project about how whānau with substance use and other health and social challenges work with service providers.

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to take part. If you do decide to take part we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

#### **What is the Aim of the Project?**

This research project aims to gather information about service collaboration from key social service and health providers working with adults with substance use problems in the Rangitīkei.

The information sought relates to what is deemed collaboration, what are barriers to collaboration between services and what are the enablers of effective collaboration.

This research will complement other research areas within the PhD such as identifying the development of services for Māori by Māori in the Rangitīkei; and service user and their whānau experience of working with multiple agencies.

#### **What Type of Participants are being sought?**

Participants are required that work as paid or volunteer staff members of health and/or social services that work directly with adults 18 years and older that live in the Rangitīkei.

Participants identified by local iwi social service staff as providing services to adults with substance use problems are invited to attend a focus group

Key stakeholders including focus group participants, and their colleagues and management will be invited to attend a presentation of key themes of the focus groups. Participants will also be provided with copies of any articles that are published based on these key themes.

#### **What will Participants be Asked to Do?**

Should you agree to take part in this project, you will be asked to a focus group of approximately 10-12 members that also work with whānau that live in the Rangitīkei.

Focus groups will take approximately 1.5 hours

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

### **What Data or Information will be Collected and What Use will be Made of it?**

Focus groups will be audio taped to assist gathering participants' comments. A researcher will also take notes during the focus group to assist in understanding the information gathered. Information about you, your role and experience in the Rangitīkei will be collected on a demographic form.

Information gathered during the focus groups will be analysed for common themes and experiences. Comments that accurately reflect these themes may be used as quotes and linked to the profession of the person that made these comments. In cases that this happens the original person that made the comments will be contacted for permission.

A written record of focus groups will only be accessible by the focus group participants and research staff and their supervisors at Otago University.

This primary (student) researcher is supported with funding by the way of a Health Research Council scholarship.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for **at least 10 years** in secure storage. Any personal information held on the participants, such as contact details and audio tapes may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The results of the project may be published and the resulting doctoral thesis will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve your anonymity.

On the Consent Form you will be given options regarding your anonymity. Please be aware that every effort will be undertaken to preserve your anonymity. Your names will not be used and where necessary, certain identifying characteristics may be altered. However, with your consent, there are some cases where it would be preferable to attribute contributions made to individual participants. It is absolutely up to you which of these options you prefer.

As participants, you will be provided with a written record of the focus group within two weeks following the focus group. You have the right to correct or withdraw information within two weeks of receiving the transcripts. Any direct quotes will be checked with the participant for accuracy and consent to include in the study.

Focus group participants will be invited to a presentation of key themes of the study and provided with a copy of final publications.

This project involves an open-questioning technique. The general line of questioning includes What is collaboration?; What are the common collaborative practices for agencies and practitioners delivering services in the Rangitīkei?; How does rurality impact the delivery of services in the Rangitīkei?; How does rurality affect collaborative practice with other agencies? How does substance use problems impact on working with whānau in the Rangitīkei? What are the barriers to collaboration in the Rangitīkei? What are the enablers of

collaboration in the Rangitīkei? What is needed to improve collaboration with whānau? What is needed to improve collaboration between services?

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind.

### **Can Participants Change their Mind and Withdraw from the Project?**

You may withdraw from participation in the project at any time and without any disadvantage to yourself of any kind.

### **What if Participants have any Questions?**

If you have any questions about our project, either now or in the future, please feel free to contact either:-

Andre McLachlan <i>[Student and/or Researcher]</i>	Simon Adamson <i>[Supervisor]</i>
P.O. Box 5172, Frankton Hamilton, Waikato 3242	Department of Psychological Medicine, Christchurch. Otago University
Telephone Number: 027 559 7609	University Telephone Number: 04 364-0480
Email Address: <a href="mailto:dahub@xtra.co.nz">dahub@xtra.co.nz</a>	Email Address <a href="mailto:simon.adamson@otago.ac.nz">simon.adamson@otago.ac.nz</a>

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.



## **Appendix D – Participant Consent Forms**

### **Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

#### **CONSENT FORM FOR COMMUNITY KEY INFORMANT PARTICIPANTS**

Tena Koe,

This consent form provides written documentation of your consent to be involved in sharing your information and matauranga with the researcher for this research project.

Please read and indicate consent by placing a tick in the appropriate box and signing this consent form.

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. I understand that my identity will not be disclosed without my approval and that I can indicate this below;
4. I understand that I will be audiotaped. I understand that I may ask that the tape be stopped at any time during the interview;
5. Personal identifying information and data obtained as a result of the research will be retained for **at least 10 years** in secure storage. Any personal information held on the participants, such as contact details and digital audio and videotapes may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.
6. This project involves an open-questioning technique. The general line of questioning includes: What were the key achievements in services for Māori by Māori in the Rangitīkei; What are the health and social needs of whānau in the Rangitīkei; What, if any, are the impacts of rurality and substance use on service engagement and delivery in the Rangitīkei.
7. In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind;
8. The PhD student (primary researcher) is supported by a scholarship provided by the Health research Council;

9. The results of the project may be published and the resulting doctoral thesis will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity should I choose to remain anonymous;

10. I, as the participant (please tick which options you prefer):

a) agree to being named

OR:

b) remain anonymous

c) like a copy of my interview transcript sent to me

Name: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Telephone Contact: \_\_\_\_\_

Email: \_\_\_\_\_

I agree to take part in this project.

..... (Signature of participant) .....

(Date)

### Researcher Name and Contact

Andre McLachlan [*Student Researcher*] and/or Simon Adamson [*Supervisor*]

P.O. Box 5172, Frankton  
Hamilton, Waikato 3242

Department of Psychological Medicine,  
Christchurch. Otago University  
Department of Psychological Medicine,  
Christchurch. Otago University

Telephone Number: 027 676 8922

University Telephone Number: 04 364-0480

Email Address: [andre@paiake.co.nz](mailto:andre@paiake.co.nz)

Email Address: [simon.adamson@otago.ac.nz](mailto:simon.adamson@otago.ac.nz)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.



[12/198]  
[23/07/2012]

**Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

**CONSENT FORM FOR SERVICE USER AND THEIR WHĀNAU**

Tena Koe,

This consent form provides a written documentation of your consent to be involved in sharing your information and matauranga with the researcher for this research project.

Please read and indicate consent by placing a tick in the appropriate box and signing this consent form.

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. I understand that my identity will not be disclosed without my approval and that I can indicate this below;
4. I understand that I will be audio-taped. I understand that I may ask that the tape be stopped at any time during the interview;
5. Personal identifying information and data obtained as a result of the research will be retained for **at least 10 years** in secure storage. Any personal information held on the participants, such as contact details and audio tapes may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.
6. This project involves an open-questioning technique. We will talk about how your whānau responds to multiple health and social challenges? What types of support you access from your whānau? What types of support you access from your community? What strategies you and your whānau use to work with different agencies? The challenges your whānau faces when working with several agencies? How substance use affects how you access or receive support from your community and service providers? And how living in a rural community affects how you access or receive support from your community and service providers?
7. In the event that you feel unsure or uncomfortable with a question(s) you have the right to refuse to answer any particular question(s) and also to withdraw from the project at any stage without any disadvantage to yourself of any kind;
8. The results of the project may be published but every attempt will be made to preserve my anonymity should I choose to remain anonymous;
9. I, as the participant:

- a) agree to being named
- b) remain anonymous
- c) like a copy of my interview transcript sent to me

Name: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Telephone Contact: \_\_\_\_\_

Email: \_\_\_\_\_

I agree to take part in this project, and maintaining the confidentiality of the information shared in the Whānau interview

..... (Signature of participant) ..... (Date)

Researcher Name and Contact

Andre McLachlan [*Student Researcher*] and/or Simon Adamson [*Supervisor*]

P.O. Box 5172, Frankton  
Hamilton, Waikato 3242

Department of Psychological Medicine,  
Christchurch. Otago University

Telephone Number: 027 676 8922

University Telephone Number: 03 364-0480

Email Address: [andre@paiake.co.nz](mailto:andre@paiake.co.nz)

Email Address [simon.adamson@otago.ac.nz](mailto:simon.adamson@otago.ac.nz)

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

## **Barriers and Enablers of effective service delivery with and for Māori with substance use problems in Rural Communities**

### **CONSENT FORM FOR PRACTITIONER PARTICIPANTS**

Tena Koe,

This consent form provides written documentation of your consent to be involved in sharing your information and matauranga with the researcher for this research project.

Please read and indicate consent by placing a tick in the appropriate box and signing this consent form.

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:-

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project at any time without any disadvantage;
3. I understand that my identity will not be disclosed without my approval and that I can indicate this below;
4. I understand that I will be audio-taped. I understand that I may ask that the tape be stopped at any time during the interview;
5. Personal identifying information and data obtained as a result of the research will be retained for **at least 10 years** in secure storage. Any personal information held on the participants, such as contact details and audio tapes may be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.
6. This project involves an open-questioning technique. The general line of questioning includes What is collaboration?; What are the common collaborative practices for agencies and practitioners delivering services in the Rangitīkei?; How does rurality impact the delivery of services in the Rangitīkei?; How does rurality affect collaborative practice with other agencies? How does substance use problems impact on working with whānau in the Rangitīkei? What are the barriers to collaboration in the Rangitīkei? Prompts can you give me an example? What are the enablers of collaboration in the Rangitīkei? What is needed to improve collaboration with whānau? What is needed to improve collaboration between services?
7. In the event that the line of questioning does develop in such a way that you feel unsure or uncomfortable you are reminded of your right to refuse to answer any particular question(s) and also that you may withdraw from the project at any stage without any disadvantage to yourself of any kind;

8. The Phd student (primary researcher) is supported by a scholarship provided by the Health research Council.;
9. The results of the project may be published and the resulting doctoral thesis will be available in the University of Otago Library (Dunedin, New Zealand) but every attempt will be made to preserve my anonymity should I choose to remain anonymous;

10. I, as the participant (please tick which options you prefer):

- a) agree to being named  OR:  
 b) remain anonymous   
 c) like a copy of my interview transcript sent to me

Name: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Telephone Contact: \_\_\_\_\_

Email: \_\_\_\_\_

I agree to take part in this project, and maintaining the confidentiality of the information shared in the focus group interview:

.....  
 (Signature of participant)

.....  
 (Date)

Researcher Name and Contact

Andre McLachlan [Student and/or Researcher] P.O. Box 5172, Frankton Hamilton, Waikato 3242	Simon Adamson [Supervisor] Department of Psychological Medicine, Christchurch. Otago University Department of Psychological Medicine, Christchurch. Otago University
Telephone Number: 027 559 7609	University Telephone Number: 04 364-0480
Email Address: <a href="mailto:dahub@xtra.co.nz">dahub@xtra.co.nz</a>	Email Address <a href="mailto:simon.adamson@otago.ac.nz">simon.adamson@otago.ac.nz</a>

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

## **Appendix E – Participant Recruitment Fliers**

### **RESEARCH PARTICIPANTS NEEDED**

*Would you and your whānau (family) be willing to discuss your experiences of working with several different agencies at the same time?*

*Would you and your whānau be willing to discuss how you respond to substance use and related problems?*

#### **What is this study about?**

This study is aimed at exploring Whānau experiences coping with adversity and working with multiple agencies, when a Whānau member has substance use problem and other health or social difficulties.

#### **Who is the Researcher?**

Tena Koe, my name is Andre McLachlan, I am a psychologist working in addictions in the Waikato. I whakapapa to Ngāti Apa and Ngāti Kauae in the Rangitīkei. I am excited to be completing a PHD research project through Otago University and returning to undertake study to help shape service delivery for whānau experiencing multiple challenges.

#### **Who can participate in the study?**

Participants are required to be 18 years and older, Māori, live in the Rangitīkei area, self-identify as experiencing an alcohol or drug problem, and be involved with two or more social or health agencies.

#### **What will I be asked to do?**

As a participant in this study, you would be asked to participate in a series of four interviews with yourself and those you identify as whānau. These interviews will take approximately two hours each.

Whānau participants can be anyone that the individual considers part of their whānau. Whānau participants must be 18 years of age or older.

In appreciation for your time, at each interview you will receive a \$30 warehouse or supermarket voucher for your time to a maximum of \$100 worth of vouchers per Whānau group.

If you would like to know more about this study, please contact the researcher by phone, text or email at the contacts below.

**Andre McLachlan**, Otago University PhD Candidate  
Telephone Number: 027 676 8922  
Email Address: [andre@paiake.co.nz](mailto:andre@paiake.co.nz)

This project has been reviewed and approved by the University of Otago Human Ethics Committee

*Would you be willing to explore how services work collaboratively with whānau who are experiencing substance use and other health and social challenges in the Rangitīkei?*

*Would you be willing to explore how health and social service agencies work collaboratively together when working with these Whānau?*

Reference Number: 12/198  
23 July 2012

## RESEARCH PARTICIPANTS NEEDED

### **What is this study about?**

This study is aimed at exploring the barriers and enablers to collaboration between health and social services, and between services and whānau.

### **Who is the Researcher?**

Tena Koe, my name is Andre McLachlan, I am a psychologist working in addictions in the Waikato. I whakapapa to Ngāti Apa and Ngāti Kauae in the Rangitīkei. I am excited to be completing a PHD research project through Otago University and returning to undertake study to help shape service delivery for whānau experiencing multiple challenges.

### **Who can participate in the study?**

Participants are required to be 18 years and older, working in a paid or voluntary capacity in a health or social service that is delivering services to whānau that live in the Rangitīkei.

### **What will I be asked to do?**

As a participant in this study, you would be asked to participate in a series of two focus group interviews with other health and social service providers that are delivering services to whānau that live in the Rangitīkei. These focus group interviews will take approximately two hours each.

In appreciation for your time a morning or afternoon tea will be provided following each focus group interview.

If you would like to know more about this study, please contact the researcher by phone, text or email at the contacts below.

**Andre McLachlan**, Otago University PhD Candidate  
**Telephone Number:** 027 676 8922  
**Email Address:** andre@paiake.co.nz

This project has been reviewed and approved by the University of Otago Human Ethics Committee

## Appendix F – Semi-structured Interview Guides

### Interview Schedule

#### Community key informants from the Rangitīkei communities:

Question	Prompts
1. How did Māori health services develop in Rangitīkei?	<ul style="list-style-type: none"> <li>• How did these come about?</li> <li>• Who were the key people?</li> <li>• What has helped these collaborative relationships happen? Policy change, people or events?</li> <li>• What were the barriers to this?</li> <li>• What enabled this to happen (how were barriers overcome)?</li> <li>• What do you consider were the key principles that guided people in this collaboration?</li> <li>• What were the key achievements in services for Māori by Māori in the Rangitīkei?</li> <li>• What do you think the outcomes for whānau have been from the development of these services?</li> <li>• What do you think the outcomes for the community have been from the development of these services?</li> </ul>
2. As a rural area, what are the specific incidents or challenges that have drawn all community services together?	<ul style="list-style-type: none"> <li>• What happened?</li> <li>• What enabled this collaboration to happen? (key principles and practices)</li> <li>• Who were the key people / Agencies?</li> <li>• What were the specific challenges to collaboration</li> <li>• What were the outcomes?</li> <li>• How do you think this impacted on the community?</li> </ul>

#### Service users and their whānau

Question	Prompts
1. How do you / does your whānau respond to multiple health and social challenges?	<ul style="list-style-type: none"> <li>• What do you and/or your whānau do to help cope during tough times?</li> <li>• What works / what doesn't?</li> <li>• What types of support you access from your whānau?</li> <li>• What types of support do you access from your community?</li> <li>• What works / what doesn't?</li> <li>• What agencies are you/your whānau currently involved with? What types of things did you do there? How long; how often do/did you see them; how effective has this been for you/your whānau?</li> <li>• Other than agency involvement, how do you access or receive support during times of need. Such as family, friends or faith; tell me how this works; give me an</li> </ul>

	example of this.
2. Tell me about your experiences of working with multiple agencies at one time	<ul style="list-style-type: none"> <li>● Is anything challenging about working with multiple agencies at one time?</li> <li>● Is anything helpful about working with multiple agencies at one time?</li> <li>● What strategies you and your whānau use to work with different agencies?</li> <li>● How do the different members of your whānau experience the involvement of these agencies? Prompt such as children, koroua/kuia.</li> <li>● Tell me what it was like working with different agencies in the past. Prompt: What worked? What was different between then and now?</li> <li>● What has helped these collaborative relationships happen? Policy change, people or events?</li> <li>● What were the key principles that guided these helpful working relationships? These collaborative practices?</li> <li>● Tell me about any strategies or things that you do in your whānau to keep you and your whānau safe when working with different agencies. Such as what you will or will not share; any agreements you make within the whānau about this; or any agreements you make with agencies about what you will or will not discuss.</li> <li>● How do these strategies differ across the different agencies? Why is that?</li> <li>● Tell me about what you and/or your whānau do to help you develop and manage relationships with these different agencies. Such as appointments times; agency free days; certain people dealing with certain or all agencies.</li> <li>● What is needed to improve helpful working relationships between you/your whānau and these agencies? These collaborative practices?</li> <li>● What is needed to improve helpful working relationships between the agencies that work with you in order to provide a more effective, timely and coordinated service?</li> </ul>
3. How does living in a rural community affect how you access or receive support from your community and service providers?	<ul style="list-style-type: none"> <li>● Tell me what it's like working with services in a rural community. Prompts – what are the barriers? How do you address these?</li> <li>● Tell me about your experiences of having to work with services based in the cities: prompts such as Palmerston North, Whanganui and Wellington?</li> </ul>
4. How does substance use affect how you access or receive support from your community and service providers?	<ul style="list-style-type: none"> <li>● What services have you and your whānau been referred to for this;</li> <li>● What services have you or your whānau used; Tell me about this; What types of things did you do there? How long; how often did/do you see them; how effective</li> </ul>

	<p>has this been for you/your whānau?</p> <ul style="list-style-type: none"> <li>• How does the use of substances impact on how you access or receive support from your personal support networks discussed earlier (friends, family, faith)?</li> <li>• How does the use of substances affect how other agencies engage with you or perceive you?</li> <li>• How does the use of substance affect how you engage and work with these agencies?</li> </ul>
--	--

Practitioner focus group:

Question	Prompts
1. What is collaboration?	<ul style="list-style-type: none"> <li>• What are the common collaborative practices for agencies and practitioners delivering services in the Rangitīkei?</li> <li>• What has helped these collaborative relationships happen? Policy change, people or events?</li> <li>• What are the barriers to collaboration in the Rangitīkei? Can you give me an example</li> <li>• What are the enablers of collaboration in the Rangitīkei? Can you give me an example, People? Practices? Places?</li> <li>• What do you consider were the key principles that guided these helpful working relationships? These collaborative practices?</li> <li>• What is needed to improve collaboration with whānau presenting with substance use and related problems?</li> <li>• What is needed to improve collaboration between services? What would help at the different levels (staff/agency/ governmental)?</li> </ul>
2. How does rurality impact the delivery of services in the Rangitīkei?	<ul style="list-style-type: none"> <li>• How does rurality affect whānau accessing substance use and other health and social services?</li> <li>• How does rurality affect collaborative practice with other agencies?</li> </ul>
3. How do substance use problems impact on working with whānau in the Rangitīkei	<ul style="list-style-type: none"> <li>• How do substance use problems impact on service users and/or their whānau accessing alcohol and drug services?</li> <li>• How do substance use problems impact on service users and or their whānau accessing other services? Such as health, social or mental health.</li> </ul>

## **Appendix G – Participant Demographic Forms**

Reference Number: 12/198  
23 July 2012

Participant #: \_\_\_\_\_

### **Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

#### **DEMOGRAPHIC FORM FOR COMMUNITY KEY INFORMANT PARTICIPANTS**

Iwi and Hapu affiliations: \_\_\_\_\_

Age: (tick which ones apply to you)

18-25		26-35		36-45		46-55		56-65		66 +	
-------	--	-------	--	-------	--	-------	--	-------	--	------	--

Years lived within the Rangitīkei: \_\_\_\_\_

Years delivering services within the Rangitīkei: \_\_\_\_\_

Past roles within the Rangitīkei (within services and the community):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Past roles regionally and/or nationally in relation to services for Māori by Māori:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This project has been reviewed and approved by the University of Otago Human Ethics Committee



Reference Number: 12/198  
23 July 2012

Whanau #: \_\_\_\_\_

## **Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

### **DEMOGRAPHIC FORM FOR SERVICE USER AND THEIR WHĀNAU**

The information contained in this form will not be disclosed (given) to any other participating agencies. This form assists us to understand the reality of your whānau challenges.

#### You and your whānau

Iwi and Hapu affiliations (if known): \_\_\_\_\_

Age: (tick which ones apply to you)

18-25		26-35		36-45		46-55		56-65		66 +	
-------	--	-------	--	-------	--	-------	--	-------	--	------	--

Years lived within the Rangitīkei: \_\_\_\_\_

Number of Whānau living with you: \_\_\_\_\_

Current source(s) of income (tick which ones apply to you)

Full time employment	Part-time employment		Domestic Purposes Benefit		Sickness Benefit	
Invalids Benefit	Unemployment Benefit					

Other: (Please describe): \_\_\_\_\_

#### Your and/or your whānau involvement with services

**Current** Agencies you and/or the whānau you live with are working with. You can tick the boxes below and/or list these in the lines under the box provided.

Te Kotuku Hauora o Tainui	Public Health Nurses. Whanganui District Health Board	Child Youth and Family	Department of Corrections	
Group Special Education	Marton Counselling & Education	Alcoholics Anonymous	Budget Service	
Housing NZ	ACC	Work and Income New Zealand	Community Legal Advice	

Rangitīkei Social Worker		Marton GP Health clinic	Mental Health Service. Whanganui District Health Board	Alcohol and Drug Service. Whanganui District Health Board	
Alcohol and Drug Service. Te Oranga Nui.					

Other:

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**Other** agencies you have been involved with within the last 2 years. You can tick the boxes below and/or list these in the lines under the box provided.

Te Kotuku Hauora o Tainui		Public Health Nurses. Whanganui District Health Board	Child Youth and Family	Department of Corrections	
Group Special Education		Marton Counselling & Education	Alcoholics Anonymous	Budget Service	
Housing NZ		ACC	Work and Income New Zealand	Community Legal Advice	
Rangitīkei Social Worker		Marton GP Health clinic	Mental Health Service. Whanganui District Health Board	Alcohol and Drug Service. Whanganui District Health Board	
Alcohol and Drug Service. Te Oranga Nui.					

Other:

---



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#### Issues and challenges faced by you and your whānau

Please list the concerns you are experiencing, and those experienced by the whānau you live with and/or have a responsibility for ongoing support of. You can tick the boxes below and/or list these in the lines under the box provided.

Diabetes		Asthma	Alcohol use	Drug use (such as cannabis, Methamphetamine (P), Solvents (glue/paint/petrol) or other substances)	
Heart/ Hypertension		Medical (other)	Education challenges	A mental health condition, such as Depression, Anxiety, Bipolar, Post Traumatic Stress	

Financial Challenges		Legal problems		Tobacco / Smoking		Employment	
Child Welfare							

List any other challenges that you and/or your whānau are currently experiencing (that were not included above):

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Considering the concerns listed above, are there any of these issues that you are not receiving agency support for. If yes, please list below.

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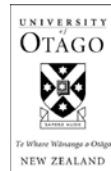


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This project has been reviewed and approved by the University of Otago Human Ethics Committee



Focus Group #: \_\_\_\_\_

## **Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitīkei.**

### **DEMOGRAPHIC FORM FOR PRACTITIONER PARTICIPANTS**

*Thank you for agreeing to participate in today's focus group.*

*This demographics form is designed to record information about the professions and demographic makeup of group participants. The information collected on this form will be used to describe the makeup of the focus group. This information is not intended to identify any persons.*

#### **Instructions**

- This questionnaire should be completed prior to the start of the focus group
- Please use a ballpoint pen to fill in your answers.
- When answering questions please place a tick in the box next to the option that best represents you.
- If you need to change an answer, please make sure that your old answer is clearly crossed out.
- The focus group facilitator will collect these prior to the end of the focus group session.

Name: \_\_\_\_\_

Iwi and Hapu affiliations: \_\_\_\_\_

Postal Address: \_\_\_\_\_

Telephone Contact: \_\_\_\_\_

Email: \_\_\_\_\_

1. What age band do you belong to?

18-25 years	
26-35 years	
36-50 years	
50-65 years	
65+ years	

2. What gender group do you belong to

Male	
Female	

Other, specify .....	

3. Which ethnic group(s) do you identify with? (*Please tick more than one if you want to*)

Māori	
NZ European Pakeha	
Pacific, specify .....	
Asian, specify .....	
Other, specify .....	

4. Which of the following BEST describes your profession? (if you have more than one profession, please document the percentage of your use of these roles in your current workplace, i.e., place 20% in administrator and 80% in Counselling if this reflects your current professions)

Nursing	
Counselling	
Doctor	
Manager	
Administrator	
Whānau/family support	
Community development	
Social Worker	
Pharmacist	
Psychology	
Educator	

5. Which of the following BEST describes your workplace?

(If more than one represents your workplace, please document the percentages that best represents your workplace, i.e., place 20% in District Health Board and 80% in Non-Governmental Organisation, if this reflects your current workplace).

Statutory body	
District Health Board	
Non-Governmental Organisation	
Iwi Social service	
Māori health/social service	
District Health Board	

6. Which of the following BEST describes the service you work for?

(If your service delivers different types of services please document the percentage of these within the organisation (relative to size of, i.e, the service within the organisation). Place 20% in Public Health Service and 80% Iwi based social service, if this reflects your current service).

Mental Health Service	
Alcohol and Drug Service	
Public Health Service	
Primary Care	
Non-Governmental Social Service	
Iwi based social service	
Māori health/social service	

7. What role(s) **best** describes your role at this service? (If you have more than one, please document the percentage of your . i.e., place 20% in Supervision of other staff and 80% Direct client contact, if this reflects your current service).

Direct client contact	
Supervision of other staff	
Management	

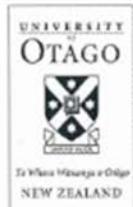
8. How long have you worked within the Waikato region, in a health or social service agency?

Less than one year	
Less than two years	
Two to five years	
Five to ten years	
10+ years	

This project has been reviewed and approved by the University of Otago Human Ethics Committee



## Appendix H – Transcriber Confidentiality Agreement



### Department of Psychological Medicine Otago University

#### Confidentiality Agreement - Transcription

**Title of Research Project:**

Barriers and Enablers of effective service delivery with and for Māori with substance use and related problems in rural Rangitikei.

**Researcher:**

Andre McLachlan

I, Audio Transcription Services, understand that the material related to this research is confidential and should not be discussed with or disclosed to anyone other than the researcher. I will not disclose any information about the participants, their companies or their thoughts to anyone other than the researcher.

All digital recordings and typed transcriptions will be deleted by Audio Transcription Services once they have been forwarded to the researcher.

Name:

Lenna K. Millar

Date:

6<sup>th</sup> November 2012

Signature:

Lenna K. Millar

Department of Psychological Medicine, Christchurch. Otago University