Characteristics of Taha Maori Tauira (Patients) at Queen Mary Hospital: A Multi-Cultural Perspective

By

Gerald A. Bunn, MA, CEAP, CCJS-MAC, CEDS
Commander, USN(Ret)
Managing Director
Evaluation & Auditing Services, Ltd.
Hanmer Springs, New Zealand

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GLOSSARY

Hapu	Sub tribe.
Iwi	Tribe. Tribal groups are made up of Hapu, which are collections of inter-related Whanau.
Kaikaranga	Female who carries out the call of welcome during Maori ceremonies.
Kaikorero	Speechmaker, spokesperson, person who delivers a speech or talk.
Kanohi ki te Knanohi	In person or face to face.
Kaupapa	Philosophy, purpose.
Kaumatua	Today the term is applied to older males. They often act as speakers or guardians of knowledge and traditions.
Kawa	Protocol(s), methodology, materials.
Kuia	The term is applied to older females who often act as guardians of knowledge and traditions.
Mahi Potara	Evaluators.
Manaakitanga	Show respect, hospitality.
Marae	Central area of village, meeting area of Whanau, hapu or iwi. The marae is a symbol of tribal identity and solidarity.
Mihi	Introducing yourself, greeting.
Pepha	Proverb.
Powhiri	Welcome ceremony.
Rangatahi	Teenager, young person.
Rangatirantanga	Right of Maori to live and develop in a Maori way.
Rongoa	Traditional medicines.
Tane	Man/men.
Tangi	Funeral.
Reo	Language, speech.
Tangata Thaiora	A term to describe a patient or client. Basically translated as a person searching/seeking after health.
Tangi	Funeral.
Tauira	Also describes patient or client.
Tikanga	Maori customs and values.
Tika	Authentic, right, realistic. *Tikanga* are customs, practices, thus *tikanga Maori* are those customs that are Maori.
Waewae Tapu	Stranger, newcomer.
Wahine	Woman/women.
Whanau	Whanau has more than one meaning and is used to describe a number of situations. Traditionally it described a family/domestic group inter-connected by kinship ties. More recently Whanau is often applied to groups who have no kinship ties but who come together for shared purposes.

SECTION I

INTRODUCTION

In 1974, Drs. Schuckit and Cahalan, assigned to the U.S. Naval Health Research Center in San Diego, California, co-authored a paper on the principles of evaluation, which remains a major guide for this writer, and has remained current for twenty-five years. A couple of observations deserve repeating, as they directly relate to the subject of this paper.

> "Evaluations" (and its handmaiden, "cost/benefit analysis"), like the so-called "policy sciences", has taken some unfortunate ritualistic and cultist characteristics that tend to lead either undue mystification and complexity in approaches to evaluations…."[1]

In the writer's experience nothing lends itself more to "mystification and complexity" than does cultural issues. Evaluations, at times, have been referred to as a "snap shot" of a fast moving train. Frequently, even before the evaluation report is completed and distributed to its stakeholders, the system or organization being evaluated has instituted change. However, in the case of developing an evaluation effort that accommodates cultural values in New Zealand, there has been more than one train moving on the same track, which can generate interesting, and, often, frustrating challenges.

Returning to Schuckit and Cahalan, they offered significant guidance relative to external influences by stating:

> "It is inevitable that 'politics' and special-interest pressures will come to the fore whenever any serious attempt is made to evaluate the effectiveness of a treatment modality that competes with other activities for funds and other limited resources. The issue should not be how to suppress the expression of special interests, but how to channel the special interests so that they will be considered openly rather than covertly, and how to conduct evaluations in an even-handed manner." [2]

The external influences that continue to effect the development of an evaluation effort for health services throughout New Zealand, including Maori patients treated at Queen Mary Hospital, came from a number of quarters. Maori health issues not only have cultural implications but political as well.

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[1] Schuckit, Marc A. & Cahalan, Don, Evaluation of Alcohol Treatment Programs, Bureau of Medicine and Surgery, Department of the Navy, Report Number 74-53, 1974, p.1.
[2] ibid.

This paper will review those external influences, which, in a small country, can directly impact organizations and individuals to a far greater magnitude than larger countries. Making changes through the political process in the U.S. has been described as, "kicking a 8 ton sponge on one side and running around to the other side to see the effect." The country is so large and has so many systems (state, county, city) that they buffer the effect. In New Zealand, change can take effect throughout the entire country almost overnight

SECTION II

THE NEW ZEALAND CONTEXT

Beginning in the year 1984 New Zealand underwent their own unique version of the political, social and economic upheaval described in Orwell's *1984*. In a fascinating account of this period a book (based on a 6 part TVNZ documentary) entitled *Revolution*,[3] claims New Zealand went from the most highly regulated society in the Western World to one of the world's most open marketplaces. It has been suggested that at no other time in world history has this much change been experienced in such a short period of time without military involvement.

The Treaty of Waitangi

While changes were occurring at all levels of New Zealand society, a revitalization of the Maori culture began to emerge in a very formidable manner. New Zealand is unique in the world in terms of its formal relationship with Tangata whenua (People of the land). The Treaty of Waitangi signed in 1840, between the Queen and the majority of the countries Maori chiefs, contained specific references to issues of "sovereignty", "property rights" and "citizenship". In the Maori version of the treaty, health was deemed to be a taonga (treasure) and came under the special protection of Article Two of the treaty dealing with property rights that included cultural values as well as material properties.

SECTION III

THE QUEEN MARY HOSPITAL EXPERIENCE

Queen Mary Hospital was opened in 1916 under the management of the War Department as a rehabilitation hospital for returning war veterans of WWI and subsequently WWII. Following the war year's, management of the hospital was taken over by the Ministry of

[3] Russell, Marcia, Revolution, Hodder Moa Beckett, 1996, Television New Zealand.

Health and the hospital's treatment became focused on psychiatric disorders. Eventually (1965) it began to exclusively treat addictions, which remains the case today.

With the health reforms came the drive to ask questions never before addressed. However, the original fears that "evaluations" might become a means to withhold, or close, services, did, in fact, become a reality. What made this situation even worse was many of the recommendations relative to the health reforms came from overseas literature, as there were so few meaningful New Zealand reports in existence. In 1993, the Crown Health Enterprise, Healthlink South, the responsible agency for the management of Queen Mary Hospital, embarked on an international search to find a leader/clinician who could re-structure the hospital along "best practice" principles. Among the first objective for the new Director and his Clinical Management team was the establishment of a Quality Assurance Programme encompassing all aspects of the hospital's operations. This process included the challenge of ensuring cultural needs were respected as the hospital holds the unique distinction of providing a bicultural approach to treatment. The hospital's treatment two treatment tracks were the Taha Maori Programme, for Maori (and Pacific Islanders), and the Hanmer Programme, for non-Maori patients.

The development of the hospital's Quality Assurance Programme faced a number of immediate practical challenges. Among these were:

1. Recruitment of a competent professional willing to take on this inaugural task of developing the first Evaluation Department in the hospital's history.
2. Creation of a hospital culture whereby Quality Assurance was understood and actively supported.
3. The lack of direction or guidelines from the Ministry of Health or its agencies for either Pakeha (non-Maori) or Maori evaluation efforts. This has recently been expressed in terms of "tensions" as: "Everybody is talking about the importance of outcomes, but they remain an unfunded mandate".[4] While this quote comes from an U.S. source, it reflects conditions within New Zealand also.
4. To buffer the hospital's clinical atmosphere from external radical political forces attempting to either take over the Taha Maori Unit or to exert pressures that would make the Unit clinically unsafe.
5. Identifying appropriate Maori advisors to assist in structuring an evaluation effort for Taha Maori.

[4] Lyon, J. S., "Tensions in the outcomes movement", Outcomes & Accountability Alert, Vol. 4, No. 7, July 1999, p. 12.

6. Developing a process of collecting data responsive to cultural values.
7. Analysis of the data in a culturally sensitive and appropriate manner.
8. Based on the findings, what changes need to be made in the Taha Maori programme that ensures it is attentive to cultural issues without jeopardizing clinical requirements.

Returning to the 1970 Schuckit and Cahalan paper on evaluations, their remarks relative to culture are:

> …Because programs function within communities and often deal with minority groups, community support is important. For example, misunderstandings with minority rights activists can cause political tidal waves severe enough to shut down even the best program. To this end it is advisable to enlist the help of community leaders in running the programs by including some of their priorities in program goals. **A word of warning, as has been shown by the Westbury Experiment (Powers, 1970), it should be clear from the start that the aim of the program is patient care – not social reform**. Confusion here can lead to feelings of frustration and betrayal with resultant destructive fighting.[5]

Striking a balance is the challenge, especially when a culture is undergoing confusion in terms of its identity through a revival.

SECTION IV

THE EXPERIENCE OF DEVELOPING ACCOUNTABILITY WITH RESPECT TO PROGRAMMES FOR MAORI (PACIFIC ISLANDERS ALSO)

The issue of evaluating programmes involving culture, or ethnicity, is one that is hotly debated among mental heath professionals. Some argue existing tools and procedures, with minor alterations, are quite sufficient. Others contend that none have applicability to Maori or Pacific Islanders.

> Researchers, educators, and scholars familiar with minority communities argue that instruments normed on majority group populations or developed Eurocentric approaches cannot be blindly applied to people of color.[6]

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[5] Schuckit & Cahalan, "Evaluation of Alcohol Treatment Programs", Navy Health Research Centre, San Diego, 1970, p. 25.
[6] Suzuki, L.A., Meller, J.G. & Ponterotto, J.C., Handbook of Multicultural Assessment, Jossey-Bass Publishers, San Francisco, 1996, p. 1.

Queen Mary Hospital, like other service providers, was faced with the challenge of meeting the clinical needs of their patients, both Pakeha and Maori alike, and waiting for the development of the New Zealand "gold standard" for either Pakeha or Maori evaluations was not considered to be a clinically or ethically safe option. Decisions had to be made then and there on how to continually meet the needs of all of the hospital's patients. Answers to questions regarding the characteristics of both of the patient groups, and what approaches were most effective in meeting their needs, were immediate requirements. The existing evaluation tools that were suitable for Pakeha patients came principally from overseas and required adaptation for the New Zealand culture. This was accomplished with much greater ease than the changes required to address Maori needs.

SECTION V

A REVIEW OF THE PROCESS AND RESULTS IN CONDUCTING THE STUDY: "CHARACTERISTICS OF TAHA MAORI TAUIRA AT QUEEN MARY HOSPITAL: A TWELVE MONTH SAMPLE

Evaluation Objectives

In mid-1999 work began on reviewing data covering the period of August 1997 through August 1999 on 128 Tauira (patients) admitted to the Taha Maori Unit at Queen Mary Hospital. The evaluand for this effort were: (1) determine the characteristics of the tauira that would shape treatment planning; (2) measure changes that may occur, between admission and discharge, in the tauira's attitudes; (3) a general comparison of information with a similar study conducted on Pakeha patients admitted to the hospital's parallel treatment track – the Hanmer Programme; and (4) ascertain the appropriateness of current treatment planning for Taha Maori.

Earlier work by the Evaluation Department Director preceded and supported this effort, which included:

- Clarify the design of the (Taha Maori) programme by looking at the underlying structures and philosophy of the Unit.
- Analyse some of the key documents used by the Unit.
- Interview some of the key people involved, to identify their values and opinions.
- Hold meetings with stakeholders to discuss the issues, and
- Come to an agreement with key stakeholders about a useful statement of the philosophy of the programme

and how it needed to proceed (that is, recommendations for the future).[7]

Stakeholders

In developing the overall evaluation effort for Taha Maori, the stakeholders fall into two general categories, immediate and wider groups. Very little difficulty existed in communicating with those listed as immediate stakeholders, with the possible exception of Te Kahui Pou Hauora (Maori Advisory Group). This group became less available as the status of the hospital (thus the Unit) changed from being a public institution to private ownership, however, efforts were made to include them whenever they made themselves available through sporadic visits to the hospital. However, the Chief Executive Officer and other members of his staff, particularly those associated with Taha Maori continued to make personal visits to individual members of the Group for consultation purposes. It should be noted that the hospital is located in a small Alpine village 135 kilometers distant from where the corporate offices are located in Christchurch.

Study Principles & Methodology

One hundred and fifty-nine tauira (patients) were eligible to participate in the study during the period of August 1997 through August 1998. Thirty-one either dropped out of the program or were discharged early, before they had a chance to complete the Initial questionnaire, and a further twenty-seven did not complete the Exit questionnaire. This represents an 80.5% rate for those completing the Initial questionnaire, with a 63% rate of those completing both the Initial and Exit questionnaire. Of the 101 who completed both, 55% were male and 45% were female. The average age was 32.

The Initial questionnaire is broken down into seven major areas.

1. General demographics (age, gender, etc.).
2. Alcohol and other drug use, abuse, and previous treatment.
3. Physical health.
4. Involvement with the Justice Department.
5. Employment and income.
6. Living arrangements.
7. Emotional maturity/ability to cope with life.

[7] Faisandier, S. & Bunn, G.A., "Evaluation of parallel addiction treatment programs: Issues and outcomes", Evaluation Journal of Australasia, Vol. 9, Numbers 1 & 2, 1997, p. 49.

The staff from the Evaluation Department of Queen Mary Hospital and, subsequently, the Evaluation & Auditing Services, Ltd, meet with all tauira admitted to the Unit during their first week. These processes begin first thing every morning with a karakia (prayers and meditation) and, at the first time the process of coming together; a mihi (greeting) was conducted. This latter process is an opportunity for tauira and staff to tell the gathering who they are and share their whakapapa (genealogy). Everything in the Unit is based on the cultural practice of Whanau (family). There are two groups, an older group, usually in their fourth week called Tuarua and the newer group identified as Tuatahi. The Tuarua takes on the responsibility for awhi (support) for the younger group. All activities, including participating in the evaluation processes, are done as Whanau. Group discussions relative to all matters affecting any member of the Whanau, including filling out questionnaires, are encouraged and supported.

SECTION VI

THE DATA

The data was collected and reported in seven sections, which coincided with the categories used by the ASI, 5th Edition. The SPSS software programme for statistical analysis was used in preparing the pages of graphs and charts, a selection of which appears in Appendix A.

Section I – General Information on Demographics. (see Appendix I, p.i]).

Clinical/Evaluation Team Comments: Factors that contribute to the low number of referrals from identifiable Maori agencies are:

- funding problems;
- the Justice systems uses Community Alcohol and Drug Services (CADS) which have Maori components (as opposed to Maori only services); and
- in the case of Te Rito Arahi (a major Maori A&D agency in Christchurch), more time is spent with tauira during the assessment process and in preparing them for residential treatment than by other non-Maori agencies. This may compel tauira to go elsewhere to seek referral (to Taha Maori).

Section II – Waipiro Me Te Taarukino/Alcohol and Other Drug Information. (See Appendix I, [p.ii])

Clinical/Evaluation Team Comments: This section supports the clinical experience whereby tauira are experiencing alcohol and/or other drug problems earlier in life (average = 12

years old). It also demonstrates the large percentage with at least one member of their Whanau with a serious alcohol/drug problem. These results are not surprising.

Ninety percent of tauira have had some kind of treatment prior to entering Queen Mary Hospital. The majority of them were still using one week before they arrived. The former figure suggests that either referrals are not being made in accordance with severity or that the earlier treatments were at times when the abuse/dependency problems had not yet advanced. The latter is more probably the case. Sometimes it takes the cumulative effect of a variety of interventions before someone becomes properly motivated to effect personal recovery.

Section III - Waiora/Physical Health Information. (See Appendix I, [p. iii]).

Clinical/Evaluation Team Comments: Although tauira are making a large number of visits to both the doctor and hospital over a 6-month period, we are unable to stipulate how many of those visits are related to their use/abuse of alcohol and/or other drugs. Overall, this section clearly shows the relationship between tauira health and their drug intake. Although we can't show the direction of causality, the extent of medical problems experienced by this group of people exceeds what one would expect in the normal Maori population in this age range.

Section IV - Ture/Justice: (See Appendix I,[p. iv])

Clinical/Evaluation Team Comments: This section highlights the close connection between addiction and criminality. These results seem particularly significant for Maori, in comparison with previous analyses of Pakeha patients attending the Hanmer Programme at Queen Mary Hospital (see Faisandier & Bunn, 1997). In the referenced report it states; "Almost two-thirds of Hanmer Programme clients (63%) have had a conviction at some time in their lives, as compared with 82.4% of Maori clients". The current report shows a slightly higher rate of 88.6% for the 128 tauira being reported. Little debate exists regarding the high rate of criminal involvement by Maori/Pacific Islanders. However, the relationship between these activities and with alcohol and/or other drugs, while commonly recognised, has yet to be adequately addressed by Justice or Social Welfare. It also must be noted that the rate of criminal involvement for Queen Mary Hospital's Hanmer patients is also quite high. All of this data clearly indicates that both Criminal Justice and the Social Welfare Systems are fertile areas for early interventions if staff were properly trained in triage evaluations and A&D resources were prescribed. Costs

associated with these added responses would be far less than incarceration. On a more positive note, a recent change has been made by Social Welfare by authorising Children & Young People & Family Support (CYPFS) field offices to refer adolescents to Queen Mary Hospital where their difficulties are clearly associated with alcohol and/or other drugs.

Section V - Mahi/Employment Information (See Appendix I,[p.v]))

Clinical/Evaluation Team Comments: This section of the report presents no surprises, indicating that seventy-six percent of tauira were on some form of benefit and spent their day's working/relaxing at home, or using drugs. In addition, one third of tauira felt that they had received no support from Whanau or other Maori based organisations. Again, this is more an indication of the scarcity for these assets rather than their competency. On the positive side, 50% of tauira have been involved in some form of Maori based training.

Section VI - Nga whatkarite mo te nohonga tanga/Living Arrangements. (See Appendix I,[p. vi])

Clinical/Evaluation Team Comments: These results confirm clinical observations. Most tauira were moderately happy with their living arrangements. However, from a clinical perspective it is noted that many tauira do not have a clear understanding of, or experience with, health relationships. It also documents a common characteristic of all alcohol and/or drug abusing/dependent people. They tend to be surrounded by people who have an active problem with alcohol or drugs. This contributes significantly to many tauira's opinion that their behaviours are not unusual or out of the norm. Relationships with partners and friends suffer the most. The severity of the ratings for relationships problems continue to support the idea that dependency affects more than just the life of the tauira.

Section VII - Comparisons between Initial and Exit Questionnaires - Indicators of emotional maturity and ability to cope with life. (See Appendix I, [p. vii])

Clinical/Evaluation Team Comments: Results from this section are positive, revealing that over a period of eight weeks, the majority of tauira have reported positive and significant changes in the following areas:

Quality of life, including major improvements in mood; anxiety; anger and violence; shame, guilt and low self-esteem. From a clinical perspective, the insights many tauira gain regarding what is "normal" are the first they

have experienced in their lives. It frequently activates a sense of "things could be different".

- Readiness to change leisure time activities, as well as readiness to change alcohol and drug use. Again, some of the activities tauira participated in while at the hospital; such as "compulsory fun" have been their first experience with doing these things without being under the influence of alcohol and/or other drugs.
- Strength of identity issues, including improved strength of Maori identity, more positive feelings about the experiences of being Maori, and more positive about their non-Maori side too. This change probably is the most pronounced that tauira experience, especially those who are admitted with little, or no, appreciation or understanding of their heritage. None are more dramatic than those who enter Queen Mary Hospital on the Hanmer Programme and then request a shift to Taha Maori after a few weeks in treatment.[8]

SECTION VII

CONCUSIONS AND RECOMMENDATIONS

The final conclusions that came from this study fall into two categories. The first relates to the process of developing and executing the study. The second pertains to the actual results of the study itself.

Study Process

The Treaty of Waitangi presents a unique situation with regard to processes that involve Maori. In every emerging set of guidelines

[8] Bunn, et al, "Characteristics of Taha Maori Tauira at Queen Mary Hospital: A Twelve Month Sample", Evlaution & Auditing Services, Ltd, P.O. Box 218, Hanmer Springs, New Zealand, 1999.

that is being developed regarding the provision of health services to Maori there is reference to respecting the Treaty and its principles.

However, at the end of the day, it is a strongly held view of the Clinical/Evaluation Team, comprised of the clinicians from Queen Mary Hospital, and in particular, the Taha Maori Unit, coupled with the EAS staff, that the treatment protocols, which have evolved over the past ten years, do strike a good balance between culture and addiction treatment.

Also, even after the publication of the various sets of recent articles and guidelines for evaluation efforts directed at Maori or Pacific Islanders, it is apparent that the evaluation tools developed by Queen Mary Hospital, and later as EAS, Ltd., do adequately reflect cultural sensitivity,
The ongoing involvement of EAS staff and QMH Hospital clinicians with the cultural activities of the Taha Maori Unit was of great benefit to all participants. The overall attitude of review regarding all aspects of the hospital's operations ensured adaptations were made in a timely manner. For the most part, the greatest challenge of avoided radicalism from either pole, that was prominent in the earlier days (1993-1996), has for the most part disappeared.

In regards to the instruments used for this study two major concerns were expressed. First, the instruments were too lengthy. While thorough, they were time consuming, and holding the tauira's interest and concentration for the whole testing period was difficult. The second concern related to the short span of time between the Initial and Exit Questionnaires being administered. Further consultations will focus on resolving these issues.

Study Results

The following comments are from the report and reflect the summary observations provided by the Clinical/Evaluation Team itself.

> "While the overall information contained in this report is not surprising, nor contrary to other reports or observations, several items deserve highlighting.
>
> - A feature of the Parallel Programming at Queen Mary Hospital is the allowance for those Tauira, who have been disenfranchised or are reluctant to see themselves as Maori for whatever reasons, to access treatment without regard to culture. Access to Queen Mary and the Taha Maori Programme remains a problematical area, as the HFA Regional Office, serving the upper North Island, will not approve referrals to the hospital. Anecdotal evidence

clearly indicates the lengths some Tauira will go in order to be admitted.

- The low number of referrals from Maori agencies has been commented in the body of the report. However, it still remains unclear what influence Maori assessors have in this process, as there are many agencies that use these professionals, while the agency itself is not identified as Maori.
- One of our clinical and financial concerns is the issue of detoxification services. HFA policies (plural due to regional differences) generally stipulated that Tauira need to be "sober/clean" and detoxified prior to admission. However, among the issues that affect this requirement are time between detoxification and admission to the hospital, and the severity of the alcohol and other drug dependencies common to those Tauira who are admitted to the hospital.
- The large number of earlier counselling/treatment experiences that Tauira have had indicate referrals are following the mandate of the HFA that community services should be utilized as much as possible. However, this does not in any way indicate if those receiving such local services should have been referred to the hospital earlier.
- As expected, alcohol and cannabis are the predominant dependencies upon admission. The prevailing experience, from clinicians, is that many new Tauria separate alcohol and other drugs in terms of difficulty. Some see themselves as only having a problem with one or the other, and believing that if they give up the alcohol, they can still smoke cannabis, or after giving up "hard" drugs, drinking a bit of alcohol and smoking cannabis will not be a problem.
- While a number of authorities warn about applying white middle class normative behavioural characteristic to other cultures, the fact remains normative behaviours have not been established that describe a pan-Maoridom position in many important functions of life, including health. This difficulty was particularly highlighted when consideration is given to the fact that the majority of Maori patients admitted to the Taha Maori programme have mixed heritages. Added to this is many in this majority live in urban settings with no affiliation to a particular iwi, hapu or marae. Thus many of the patients found it difficult, as did the staff, to balance the challenge of dealing with their identity as Maori

and learning how to function in life without the used of alcohol, other drugs, gambling, etc.

- Biases exist amongst all evaluators, but become more pronounced when middles class white professionals evaluate those from other cultures, which can lead to serious clinical consequences, especially in regards to diagnostic work and treatment planning.

It was apparent to the Clinical/Evaluation Team that while the programme at the Taha Maori Unit was appropriately targeted for the client population being admitted, the issues that face the patients admitted to the Unit once they leave treatment are often overwhelming as aftercare services are sparse and the environments that many of the patients are returning are far from supportive in terms of recovery.

APPENDIX A

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